STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495340	A. BUILDING _____ B. WING _____	**07/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEWPORT NEWS NURSING & REHAB	**12997 NETTLES DRIVE NEWPORT NEWS, VA 23602**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility documentation review, the facility failed to notify 1 out of 87 residents (Resident #3) in the survey of the COVID-19 test results obtained on 6/22/20. The findings included: Resident #3 was originally admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #3's Minimum Data Set (MDS) with an Assessment Reference Date of 07/06/20 coded the Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 indicating cognitive intact. On 7/28/20 at approximately, 1:50 p.m., Resident #3 was observed sitting in her room. She stated, I had the COVID test on June 26th, but don't know my results. She was asked who did her test? She stated A person wearing a white coat. On 7/28/20 at approximately 4:00 p.m. the Director of Nursing (DON) was approached concerning the above lab results. She stated, I will check, The test results took so long to get back, I think she had her test on 6/22/20. A review of progress notes dated 6/19/20 read: Written consent obtained from resident by this writer for COVID testing. Resident is her own RP (Responsible Party) Procedure explained to the resident. Resident verbalized understanding. A review of medical records dated 7/29/20 read: Resident was notified that COVID test results from 6/22/20 was negative. On 7/29/20 at approximately, 2:00 p.m. a telephone exit conference was conducted with the DON and the Administrator concerning Resident #3. The DON stated, I informed her of her results but I didn't document it. Moving forward, I will let Resident #3 know of her results.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, and staff interviews the facility's staff failed to ensure infection control measures were consistently implemented to prevent the development and/or transmission of a communicable disease (COVID-19); specifically, dirty bed linens were in an open bag in the hallway, and one resident (Resident #1), of 87 residents was not wearing a facial covering/mask appropriately. And, failed to ensure housekeeping services necessary to maintain a clean and sanitary environment on a COVID-19 unit was performed to ensure appropriate hand hygiene materials were available for use. The findings included: 1. On 7/28/20, at approximately 1:57 p.m., an open bag of bed linens were observed on the floor in the hallway outside of room [ROOM NUMBER]. Environmental Services staff #1 was observed going back and forth between room [ROOM NUMBER] and a cart with cleaning supplies. An interview was conducted with Environmental Services staff #1 on 7/28/20. The Environmental Services staff #1 stated the resident had recently been discharged and he was cleaning the room but upon entering the room a large bag of linen was observed on the floor therefore, he removed the bag, placing it outside the door to completely clean the room. An interview was also conducted with Certified Nursing Assistant (CNA) #1, on 7/28/20, at approximately 2:02 p.m. CNA #1 stated the resident had recently been discharged and the bed was stripped immediately because a great deal of dry, flaky skin from the resident's legs were on the linen. CNA #1 further stated she placed the bag of linen on the floor of the room and had not yet returned to put it in the soiled utility room. CNA #1 stated the linen shouldn't have been put on the floor. On 7/29/20 at approximately 2:20 p.m., the above findings were shared with the Administrator, and Director of Nursing. The Director of Nursing stated it shouldn't have been put on the floor but at least it was in a bag. 2. Resident #1 was originally admitted to the facility 2/12/19 and had never been discharged . The current [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/18/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were severely impaired. In section G (Physical functioning) the resident was coded as requiring extensive assistance of two people personal hygiene, extensive assistance of one person with dressing, limited assistance of one person with bed mobility, transfers, and toileting, and supervision after set-up with eating. On 7/28/20, at approximately 2:07 p.m., Resident #1 was observed seated in the hallway outside of room (number). The resident's mask was under the chin and Resident #1's mouth and nose was exposed. Two staff members were observed walking the hallway but no one assisted Resident #1 to adjust his mask or ask him to adjust the mask to cover his nose and mouth. An interview was conducted with Resident #1, on 7/28/20, at approximately 2:10 p.m. Resident #1 stated the mask wouldn't stay up and the nurses see it down but they don't help me. Resident #1 further stated he knew he had to wear the mask because there was [MEDICAL CONDITION] killing people and he didn't want to get it. An interview was conducted with Certified Nursing Assistant (CNA) #1 at approximately 2:15 p.m. CNA #1 stated she, the nurses and the Director of Nursing were caring for the residents because there was no other CNAs working on the unit. CNA #1 further stated she didn't notice that Resident #1 didn't have the mask on appropriately. On 7/29/20 at approximately 2:20 p.m., the above findings were shared with the Administrator, and Director of Nursing. The Director of Nursing stated the expectation was for staff to intervene by instructing the resident to apply the mask appropriately when in the hallway. The Director of Nursing further stated she was aware of the staffing problems on 7/28/20, but it was the most critical it had ever been. The Director of Nursing also stated staff had been asked to work an additional shift but no one accepted the day shift and agencies had been called but they weren't able to staff the facility therefore; the nurses on duty including the Charge Nurses, Unit Manager, Assistant Director of Nursing and herself and provided necessary care to ensure the resident needs were met. 3. On 7/28/20 at approximately, 2:45 p.m., an observation on the Hot Unit (Pinebrook Unit, currently housing two COVID-19 positive residents) was completed. The said surveyor asked Licensed Practical Nurse (LPN) #4 where could she doff her PPE before exiting the unit? LPN #4 escorted her to the restroom on the Hot Unit. While attempting to perform hand hygiene, the said surveyor noticed there was no soap in the dispenser nor paper towels available for use. Sitting on top of the trash can was one roll of toilet paper. Licensed Practical Nurse (LPN) #4 was informed of the above. She stated, There's a bottle of soap on the sink. I will get you some paper towels. The bottle of soap on the sink read: Soothe & Cool Cleanse, Kiwi Mango Shampoo and Body Wash. Uses: Head to toe cleanser. Directions: For use as a rinse off. Apply product to damp cloth. Shortly after LPN #4 returned with a few paper towels in her hands and handed them to the surveyor. She was asked if this was the soap to be use for hand washing? (Pointing to the bottle on the sink) She stated, It was probably left over from a patient. But I will go into the medication room if I have to wash my hands. She was asked who cleans this unit? She stated, Housekeeping. On 7/30/20 at approximately, 9:02 a.m., a telephone interview was conducted with the Housekeeping manager (Other Staff #3) concerning the above issues. He stated, We do a total cleaning once a day on the Hot Unit We check the paper towels and soap dispenser. He was asked if he was assigned to work the hot unit on 7/28/20; he responded, No ma'am. He was then asked if anyone was assigned to the Hot Unit on 7/28/20 and he replied, No ma'am. I was instructed by my manager that no one would be working there because they had a plan in place. Usually I would go in at the end of the shift

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and clean my wing (Hot Unit) last. On 7/30/20 at approximately 2:15 p.m., an exit conference was conducted with the Administrator and Director of Nursing. The above concerns were discussed. The DON stated, The unit will be cleaned daily. There was no assignment for cleaning the Hot Unit. The Administrator stated, We will tell nursing if they need supplies to let us know.