STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	05/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTH ROANOKE NURSING HOME	3823 FRANKLIN RD, SW ROANOKE, VA 24014

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, facility documentation review, and in the course of a COVID-19 focused survey, it was determined the facility staff failed to consistently implement infection control plans/practices designed to attempt to prevent the development and/or transmission of COVID-19 in the facility; two (2) of seven (7) sampled residents (Resident #6 and Resident #7) were included in these findings. The findings include: 1. Facility staff members failed to consistently implement planned COVID-19 source control measures as evidenced by not completing COVID-19 screen of Resident #7's family prior to an end-of-life visitation and by allowing Resident #7's adult-child into the building to collect the resident's belongings (after the resident had been transported to the funeral home). Resident #7's minimum data set (MDS) assessment with an assessment reference date (ARD) of [DATE] indicated the resident required extensive assistance with bed mobility, transfers, and eating. The resident's [DIAGNOSES REDACTED]. Resident #7's documentation indicated the resident died at 10:00 PM and that family came to the facility to be with the resident shortly after this time. Review of the facility's visitor screening log failed to provide evidence of any visitors being screened into the building after 5:00 PM on the day Resident #7 died . Resident #7's clinical record documented that family arrived at 10:15 PM to be with (the) resident. Nursing documentation indicated the family (was) in with (the) resident until 1:15am and reported they would return later in the morning to collect the resident's belongings. (The COVID-19 visitor screening log included visitor names, date, time, visitor temperatures, and questions related to potential exposure to and symptoms of COVID-19.) Resident #7's adult-child was interviewed via telephone on [DATE] at 12:44 PM. The adult-child reported that they and the resident spouse came to the facility when the resident died but the adult-child was the only one to return to the facility the next morning to collect the resident's belongings. The following information was found in a facility policy titled Discharging a Resident to the Mortuary (with a revision date of [DATE]): Nursing Services will be responsible for preparing the resident's personal effects for the family to pick up. During an interview on [DATE] at 10:35 AM, with the facility's acting Administrator, Regional Corporate Nurse, and Director of Nursing, it was reported that visitation restrictions were implemented on [DATE] that restricted visitation to end-of-life situations. During a survey team telephone interview on [DATE] at 4:37 PM, with the facility's acting Administrator, Regional Corporate Nurse, and Director of Nursing, it was confirmed that during the aforementioned days, referenced in this report, that visitation at the facility had been limited to residents' end-of-life situations. Communication from the facility's acting Administrator indicated Resident #7's adult-child was allowed back into the building to collect the resident's belonging, after the resident expired, because the room they were going to was the first room near the door and would not require them to pass any residents. Resident #7's adult-child was provided full PPE and then was allowed to get Resident #7's personal belongings. 2. Resident #6's clinical record failed to include documentation of the resident's positive COVID-19 results; the resident's clinical record also failed to have documentation of funeral home staff being informed of the resident being COVID-19 positive when they arrived to transport Resident #6 to the funeral home. Resident #6's minimum data set (MDS) assessment with an assessment reference date (ARD) of [DATE] indicated the resident required extensive assistance with bed mobility, transfers, dressing, and toilet use. The resident's [DIAGNOSES REDACTED]. A funeral home staff member was interviewed via telephone on [DATE] at 8:55 AM. This individual reported that neither the funeral home secretary who received the call from the facility nor the individual who transported Resident #6 from the facility to the funeral home had been told by facility staff that the resident had tested positive for COVID-19. (The secretory was on vacation and could not be interviewed by the surveyor.) This individual reported infectious disease information was usually provided verbally by nursing facility staff. This individual reported that the paperwork provided by the facility did not state Resident #6 was COVID-19 positive. This individual reported only becoming aware of Resident #6 being COVID-19 positive six days after the resident was transported to the funeral home when, after multiple requests, the facility provided the funeral home with the resident's death certificate. The funeral home staff member who transported Resident #6 from the facility to the funeral home was interviewed via telephone on [DATE] at 2:18 PM. This individual reported they had not been told that the resident had tested positive for COVID-19. This individual reported they had not been told about the facility's COVID-19 status. This individual reported they had been told it was necessary to wear personal protective equipment (PPE). This individual reported it was days later when they became aware of the facility's COVID-19 situation from the news. The following information was found in a facility policy titled Discharging a Resident to the Mortuary (with a revision date of [DATE]): When it becomes necessary to discharge a resident to the mortuary, the following procedures will be implemented: . f. The Charge Nurse or the resident's representative (sponsor) will notify the undertaker to pick up the body. (Note: The Charge Nurse must inform the undertaker of any isolation precautions and the type of precautions the resident was on, if applicable.) g. The name of the funeral home and the name of the person removing the body must be entered in the resident's chart . The local funeral home staff provided the survey team with copies of the documentation they had received from the facility; these documents did not include information indicating Resident #6 had tested positive for COVID-19. The facility's acting Administrator, Corporate Nurse Consultant, and Director of Nursing were interviewed, on [DATE] at 10:38 AM, during a survey team telephone interview. The absence of Resident #6's COVID-19 test results being documented in the resident's clinical record was discussed. (The surveyor had found Resident #6's test results documented as positive on the facility's Family Call Tracker spreadsheet.) It was confirmed that Resident #6's COVID-19 status was not documented in the resident's clinical record. The acting Administrator stated COVID-19 results was reported to the Vice-President of Clinical Services (VPCS) by the entity performing the tests. Then VPCS would then convey the results to the Resource Center (corporate office) and the facility. Staff at the Resource Center would notify residents' families but staff at the Resource Center did not have access to document the notifications in the clinical records. The following information was found in a facility policy titled Charting and Documentation (with a revised date of [DATE]): All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate . During a survey team interview on [DATE] at 4:37 PM, with the facility's acting Administrator, Regional Corporate Nurse, and Director of Nursing, the process for notifying funeral home staff of the COVID-19 status of a resident they would be picking up was discussed for a final time. The Director of Nursing confirmed the expectation was that the funeral home staff would be informed verbally; and that the resident's COVID-19 status would not necessary be written in the information provided to the funeral homes staff. 3. The facility staff failed to ensure biohazard waste was stored appropriately. On [DATE] at 4:35 pm, two surveyors observed two cardboard boxes with a biohazard label sitting on top of a pallet in the parking lot. On the ground next to

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 -** Some	(continued... from page 1) the pallet, the surveyors observed a red biohazard bag with items inside of the bag. The surveyors observed that the red biohazard bag was inside of an open cardboard box that did not have a biohazard label on the side of the box, and the open cardboard box that contained the red biohazard bag was covered with clear plastic. On [DATE] at 5:40 pm, the surveyor looked through the window of the door next to the nurse's station on wing 2 that led to outside. The surveyor observed a black bin that was uncovered and filled with full red biohazard bags. The surveyor observed that there were biohazard bags that were full on the ground around the black bin. On [DATE] at 6:27 am, the surveyor observed 10 cardboard biohazard boxes that were stored on a pallet in the parking lot and covered with clear plastic. On [DATE] at 7:04 am, the surveyor walked around the back of the facility to the outside area near the nurse's station on wing 2 where the black bin that was filled with red biohazard bags had been observed on [DATE] at 5:40 pm. Upon approaching the area, the surveyor observed a squirrel run from underneath an uncovered black bin that was overflowing with full red biohazard bags. The surveyor observed a large amount of full biohazard bags that were piled up around the overflowing black bin that contained biohazard bags. The surveyor observed that several of the biohazard bags were on the ground had holes picked in them and the items that had been inside the red biohazard bags were scattered on the ground around the area. On [DATE] at 7:42 pm, the surveyor observed three employees outside in the back of the facility near the wing 2 nurse's station, picking up the red biohazard bags and placing them in cardboard boxed with a biohazard label on the side. The surveyor conducted an interview with the housekeeping supervisor. The surveyor asked the housekeeping supervisor if this was normally how the facility stored the biohazard waste. The housekeeping supervisor stated, No, we usually keep it in the bio room on wing 2. The housekeeping supervisor informed that surveyor that the facility has seen a big increase in biohazard waste since the coronavirus outbreak, and the room where the biohazard waste was normally stored cannot hold the amount of biohazard waste the facility produces and that the biohazard waste was being stacked in cardboard boxes and covered in plastic until the vendor picked it up. On [DATE] at 10:30 am, the administrator, director of nursing, and regional nurse consultant were made aware of the findings as stated above. On [DATE] at 4:37 am, the surveyor asked the administrative team which consisted of the administrator, director of nursing, and regional nurse consultant if they felt the facility has stored the biohazard waste appropriately. The administrator stated, It's one of those situations where it's not ideal, but it was the best we could come up with at the time. No further information regarding this issue was provided to the survey team prior to the exit conference on [DATE]. 4. The facility staff failed to minimize the risk to exposure to COVID-19 by failing to screen emergency medical services staff upon entering the building. On [DATE] at 5:49 pm, the surveyor observed two emergency medical technicians (EMT) as they entered the building through the doors on wing 2, to transport a resident back from the hospital. The surveyor observed that unit manager LPN # 1 (licensed practical nurse) assessed temperature on each emergency medical technician. The surveyor observed that unit manager LPN # 1 did not ask the emergency medical technicians any screening questions prior to allowing then to enter into the facility. On [DATE] at 5:57 pm, the surveyor interviewed EMT # 1. The surveyor asked EMT # 1 if he/she had been asked a series of screening questions prior to being allowed to enter the facility. EMT # 1 stated, No, they didn't ask me any questions. The facility policy for Coronavirus contained documentation that included but was not limited to, .2. Manage Visitor Access and Movement Outside and Within the Facility One entrance only (Front door) with log We are limiting all visitors to our facilities unless it is absolutely necessary including the following situations: end of life situations Screening questions will be asked upon entry to the building. If any visitor has signs or symptoms of respiratory illness or fever, have traveled outside of the country within the last 14 days, or have come in contact with COVID-19, the facility may restrict their visit or request they return when their symptoms have resolved. The center will continue to provide ambulance service at a separate entrance. A log will be stationed at this entrance point and anyone entering will be monitored using the same screening tool used at the front entrance or the visitor will be asked to return to the front using the outside of the building. . On [DATE] at 10:30 am, the administrator, director of nursing, and regional nurse consultant were made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on [DATE]. 5. Based on observation, facility staff failed to follow respiratory isolation precautions while serving meals on Unit 2. On [DATE] at 5:20 PM, an aid exited room [ROOM NUMBER] (which did not have a sign indicating the resident was Covid-19 positive) wearing the room isolation gown to remove a food item from the dining cart and returned to the room to assist the resident. The employee did not perform hand hygiene or change gloves on leaving or re-entering the room. At 5:27 PM, a nurse entered room [ROOM NUMBER] (which had a sign indicating the resident was Covid-19 positive) with a meal tray. The nurse observed the resident was already eating dinner and exited the room with the meal and replaced it on the meal cart. Two meals remained on the cart, on a different shelf and were immediately removed by two staff members for delivery. The nurse removed her isolation gown, hung it over her arm and returned to room [ROOM NUMBER] and hung it on a hook. At 5:33, nurse aids discarded the meal that had been taken into room [ROOM NUMBER] and wiped down the meal cart. The administrator, director of nursing, and regional clinical consultant were notified of the concerns with infection control during a summary conference call on [DATE]. No additional information was available. The administrator stated that corrective education would be conducted with the employees involved.