STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	06/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT COURTLAND	23020 MAIN STREET COURTLAND, VA 23837

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, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure infection control measures were consistently implemented to prevent the development of transmission of communicable diseases (COVID-19 and Extended Spectrum Beta Lactamase {ESBL}) among staff and involving 10 out of 12 residents in the survey sample (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10). The findings include: 1. The facility staff failed to implement their planned screening process and use of Personal Protective Equipment (PPE) at shift change to prevent possible transmission of infection as exhibited during the following observation on 6/2/20: On 6/2/20 at 6:50 a.m., Certified Nursing Assistant (CNA) #1, dressed in a white disposable one piece jump suit and an N95 face mask, arrived through the outside door to the C Unit which was allocated as the COVID-19 resident unit. She stopped briefly in the clean room and proceeded to the C Unit nursing station. The clean room was designated for staff screening prior to starting their shift on their assigned unit and donning appropriate PPE. On 6/2/20 at 7:05 a.m. CNA # 1 returned and was screened by one of the other CNA's present in the clean room. When asked was she going to change into a disposable gown, she stated, I use this jump suit, spray it with bleach and place it in a bag in my car and use it again. What is wrong with that? I like it. I don't wash it, but bleach it and wear it again. I have worn it for awhile. I usually get a new one every week. When CNA #1 exited the clean room, another CNA (#3) was asked what the screening procedures were prior to starting their shift and to also explain PPE protocol. CNA #3 stated, We usually change out our personal face mask for the N95 that is in the paper bag with our name on it or get a new one on the third day, wash our hands here in the sink, place on the disposable gown, secure the N95 and put on the gloves. She said she was not going to comment on CNA #1's preference to wear the white jump suit in and out of the facility, spray bleach and reuse it. The CNA stated they were not to enter the unit until evaluation of any symptoms to include fever, cough, shortness of breath, fatigue or stomach problems. CNA #1 and #3 were both agency personnel. CNA #4, a facility staff aide, reiterated the process for screening and donning PPE prior to entering the C Unit. Staff development Registered Nurse (RN) #3 arrived to supplement the PPE stock with gowns and N95 masks. She stated the facility did not have a shortage of PPE and it was one of her normal tasks to stock the C Unit clean room. On 6/2/20 at 11:15 a.m., an interview was conducted with the C Unit Manager (UM), Licensed Practical Nurse (LPN) #4. She stated that all staff entered the C Unit from the outside and must be screened prior to entering the unit. She also stated she was not aware that CNA #1 was entering the unit wearing a ripped disposable jump suit PPE that she bleached and re-wore from day to day. The UM LPN said, All staff dress in the PPE provided in the clean room prior to their shift, and we have plenty. On 6/3/20 at 3:22 p.m., an interview was conducted with the Administrator and the Director of Nursing (DON). They stated all staff must be screened prior to coming on the C Unit and that PPE should be donned in the unit's clean room. In addition, the Administrator stated the staff should not wear damaged or visibly soiled PPE. 2. Based on the following observations, the facility staff failed to perform appropriate hand hygiene in accordance with the Centers for Disease Control and Prevention (CDC) guidelines, as well as the facility's policy and procedure for standard precautions, potentially cross contaminating clean surfaces and items with used/soiled gloves, and failed to properly disinfect patient equipment: On 6/2/20 at 7:53 a.m., Certified Nursing Assistant (CNA) #1 assisted another CNA (#4) to reposition Resident #11 in bed on the COVID-19 C Unit after which CNA #1 removed her gloves and was observed to wash her hands from start to finish for a total of 10 seconds. CNA #1 proceeded to deliver breakfast trays to other residents on the unit that were both assessed as symptomatic and asymptomatic COVID-19 positive. Resident #11 was admitted to the nursing facility on 3/10/15 and was diagnosed with [REDACTED]. She was assessed as a recovering asymptomatic (without symptoms) resident on the COVID-19 C Unit. On 6/2/20 at approximately 8:50 a.m., Housekeeper #2 was observed stocking her cleaning cart, changing out pads on her mops and cleaning spots on the floor on the COVID-19 C Unit asymptomatic resident hallway. A CNA called out to ask her if she could get her a box of gloves. Housekeeper #2 entered the code via key pad to the clean utility room and retrieved a box of gloves without first removing her used gloves and washing hands, thus potentially cross contaminating the clean utility room key pad. Housekeeper #2 said, I am always trying to help out. I should have taken off those gloves. The Housekeeping supervisor was interviewed on 6/2/20 at 11:25 a.m. and stated that all housekeeping staff should not enter the clean utility room with used/potentially soiled gloves and should be especially careful on the COVID-19 unit. On 6/2/20 from 9:10 a.m. to 11:15 a.m., CNA #5 was observed exiting her assigned individual resident rooms after providing a.m. care. After exiting each resident's room, she would remove her used gloves and place them on top of the linen cart in the hallway, don another set of gloves (without washing her hands), then pick up the used gloves that were on top of the linen cart and throw them in the large gray trash barrel. All of the residents assigned to CNA #5 on the COVID-19 C Unit were assessed to be asymptomatic. The items on the top of the linen cart included the following: deodorant, protective barrier cream/ointments, razors, boxes of gloves, facial tissues and briefs. On 6/2/20 at 9:10 a.m., CNA #5, who was assigned to care for COVID-19 positive asymptomatic residents, retrieved a vital sign machine from the COVID-19 positive symptomatic hall and proceeded to obtain vital signs on the asymptomatic residents. As she crossed the nurse's station, two CNA's said, Oh no she is not to take that one over there. The two CNAs waved to CNA #5, but she waved back and continued into resident rooms to obtain vital signs. She did not disinfect the vital sign machine prior to use or after obtaining individual vital signs on Resident #1 (4/18/20), #2 (4/19/20), #3 (4/19/20), #4 (4/19/20), #5 (4/18/20), #6 (4/21/20), #7 (4/19/20), #8 (4/19/20) and #9 (4/18/20). All of these residents were assessed to be recovering and asymptomatic for COVID-19 greater than 14 days as concluded by the dates beside their resident identifier numbers. None of them had been retested for COVID-19. On 6/2/20 at 11:15 a.m., an interview was conducted with the C Unit Manager, Licensed Practical Nurse (LPN) #4. She stated CNA #5 should not have taken the vital sign machine from the COVID-19 active/symptomatic hallway and that all vital sign machines were to be disinfected between each resident. She also stated, used gloves should be disposed of in the resident's rooms and afterwards hands washed before donning a new set of gloves. The Unit Manager continued to say, Placing dirty gloves on top of the clean linen cart had the potential to contaminate the items on top of the cart, plus the new set of gloves she put on to throw away the dirty gloves were also contaminated. On 6/2/20 at 11:30 a.m., this surveyor tapped on Resident #7 door. CNA #5 came to the door with a wash cloth in her hands and stated she was bathing the resident, after which she immediately put down the wash cloth and exited the room. At 11:32 a.m., she went to the medication cart and obtained a 4-ounce plastic cup on top of a tower of cups. As she removed the cup, the remaining cups began to lean and she took both hands to straighten them; touching the edges of all the cups in that one tower. The CNA proceeded to go back in Resident #7's room. Licensed Practical Nurse (LPN) #1 stated she was concerned about all the cups she touched and threw all the items away that were on the cart, disinfected the cart and replaced them. On 6/2/20 at 11:45 a.m., an interview was conducted with CNA #5. She stated she did not think she had to wash her hands after removal of gloves, but from now on would not place used gloves on top of the clean linen cart. She stated she came out to get a cup from the medication cart because the resident needed to rinse his mouth. The CNA further said, I guess I should have taken my gloves off, washed my hands and put on new gloves before I did that, maybe? She said the reason she used the vital machine from the COVID-19 hall

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	06/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT COURTLAND	23020 MAIN STREET COURTLAND, VA 23837

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	(continued... from page 1) with the active/symptomatic hall was that the two on the COVID-19 asymptomatic hall were dead. The C Unit Manager overheard CNA#5 regarding the use of the vital sign machine and said, Did you plug up the two machines so they would charge. Please plug them up now. On 6/3/20 at 3:22 p.m., a telephone interview was conducted with the Administrator and the Director of Nursing (DON). They stated the vital sign machines were designated to certain hallways based on the recovering (asymptomatic) COVID-19 residents and the active (symptomatic) COVID-19 residents. They also said the machines were to be disinfected between each resident use with antimicrobial wipes. They indicated that all staff had education on standard handwashing procedures and glove usage as a part of the required training and since the emergence of COVID-19 as a part of their Pandemic Plan. They stated CNA #5 had not been on the schedule for sometime and was an agency CNA, but should have had training from the agency, as well as training from their corporation. They stated they would look for any education/training for CNA #5. They also stated CNA #1 was agency staff, but thought her education/training covered handwashing and PPE usage. They stated they would look for the CNA education/trainings and if located would present them prior to survey exit. Upon surveyor review, CNA #1 and #5's names were not located on any inservice education sign-in sheets. No further info was provided prior to survey exit on 6/4/20 at 1:30 p.m. 3. Facility staff failed to follow infection control practices and wear the appropriate PPE (personal protective equipment) prior to entering Resident #10 room. Resident #10 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Resident #10's most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date) of 3/7/20. Resident #10 was coded as being cognitively intact in the ability to make decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #10 was coded in section H (Bowel and Bladder) as always being incontinent of bowel and bladder. Resident #10 was coded as being totally dependent on two plus persons with toileting, dressing and transfers; and extensive with two plus persons with bed mobility. Review of Resident # clinical record revealed that Resident #10 was on contact precautions for ESBL in the urine. The following active order was documented on 5/31/20: Transmission Based Precautions Q (every shift) ESBL to urine. Further review of Resident #10 clinical record revealed that she was currently on an antibiotic for the treatment of [REDACTED]. The order was also created on 5/31/20. On 6/2/20 at 9:05 a.m., an observation was made of LPN (Licensed Practical Nurse) #3, Resident #10's, nurse. LPN #3 was observed walking down the hall with Resident #10's medications in a medication cup. LPN #3 then entered Resident #10's room wearing her N95 respirator only. Resident #10's doorway had contact precautions signs hanging on her door. Resident #10's doorway also had PPE supplies hanging from the door. It was observed that the isolation gown area was empty. There was no evidence that isolation gowns were inside Resident #10's room. After LPN #3 entered Resident #10's room, she stopped at the sink, washed her hands for 20 seconds and donned gloves. LPN #3 then shut the door. On 6/20/20 at 9:10 a.m., the sink was heard running for approximately 20 seconds. LPN #3 then opened the door. On 6/2/20 at 9:12 a.m., isolation gowns were observed at the nurses station, readily available. On 6/2/20 at 9:23 a.m., an interview was conducted with RN #2, the B-Unit manager. When asked why Resident #10 was on contact precautions, RN #2 stated that Resident had ESBL in her urine. When asked what PPE staff should wear while entering Resident #10's room, RN #2 stated that staff should be putting on a gown and gloves prior to entering her room. When asked if this was the same expectation if the staff were not providing direct patient care while in her room, RN #2 stated that staff still should be wearing a gown and gloves prior to entering her room. When asked if the nurse was just handing Resident #10 her medications, if she should have donned gloves and a gown prior to entering Resident #10's room, RN #2 stated, Yes. On 6/2/20 at 9:30 a.m., an interview was conducted with LPN #3. When asked what she should have donned prior to entering Resident #10's room, LPN #3 stated that she had washed her hands and put on gloves. When asked why she did not put on an isolation gown prior to entering Resident #10's room, LPN #3 stated that she knew she wasn't going to be in direct contact with any bodily fluids. LPN #3 stated that she did not have to wear a gown if she was not coming in direct contact with the resident. LPN #3 stated that she put on gloves because she was handing Resident #10's her medications. When asked why Resident #10 was on contact precautions, LPN #3 stated that Resident #10 had E.Coli in her urine. On 6/3/20 at 3:38 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (Director of Nursing), were made aware of the above concerns via telephone conference. Facility Policy titled, Isolation-Categories of Transmission -Based Precautions, documented the following: Contact Precautions .In addition to Standards Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental services or resident -care items in the resident's environment. The decision on whether precautions are necessary will be evaluated on case by case basis. Examples of infections requiring Contact Precautions include, but are not limited to: a. Infections with multi-drug resistant organisms (determined on a case by case basis) . (1) (Extended Spectrum Beta Lactamase) - Beta Lactamase are enzymes produced by some bacteria that make them resistant to some antibiotics. ESBL is usually associated with a bacteria usually found in the bowel. This information was obtained from the National Institutes of Health. https://pubmed.ncbi.nlm.nih.gov/ 458/. The facility's policy and procedure titled Infection Control Guidelines for All Procedures dated 2012 indicated hand hygiene with either soap and water (preferred) or alcohol-hand based rub before and after direct contact with residents, when there is like exposure to spores and infection and when hands are visibly dirty or soiled. When possible, dedicate the use of non-critical resident care equipment to a single resident to avoid sharing between residents. If use of common items are unavoidable, then adequately clean and disinfect them before use for another resident. Washing your hands is easy, and it's one of the most effective ways to prevent the spread of germs. Clean hands can stop germs from spreading from one person to another and throughout an entire community. Follow these five steps every time: -Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. -Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails. -Scrub your hands for at least 20 seconds. Need a timer? Hum the Happy Birthday song from beginning to end twice. -Rinse your hands well under clean, running water. -Dry your hands using a clean towel or air dry them (https://www.cdc.gov/handwashing/when-how-handwashing.html).
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview and clinical record review, it was determined that facility staff failed to provide updates to resident and family members for each confirmed case of COVID-19 for 2 of 12 residents in the survey sample, Resident #12 and Resident #11. The findings included: 1. Resident #12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #12 most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 5/13/20. Resident #12 was coded as being moderately impaired in cognitive function scoring 10 out of 15 on the BIMS (Brief Interview for Mental Status) exam. On 6/2/20 at 11:00 a.m., an interview was conducted with Resident #12. When asked if she received updates each time there was a confirmed COVID case or updates on any respiratory illness in the building, Resident #12 stated that she wasn't sure. Resident #12 stated that she never received anything in writing regarding COVID in the facility. Resident #12 stated that she knew of a COVID case, but did not recall receiving updates on the current status of the facility. Review of Resident #12's clinical record revealed that her RP (Responsible Party) was notified on 4/16/20 regarding the first case of COVID in the facility. The following was documented in a nursing note: RP (Name of RP) aware of Covid in facility. There was no further evidence that Resident #12 and her RP received updates regarding that status of COVID in the facility. Review of the Infection Control Log revealed there were Residents positive with COVID after 4/16/20. On 6/3/20 at 3:20 p.m., an interview via telephone was conducted with ASM (administrative staff member) #1, the facility administrator. When asked how the facility was updating residents and family members regarding COVID in the facility, ASM #1 stated that the facility had sent a letter out to residents and family members with the very first COVID case in April of 2020. ASM #1 stated that after that initial letter, they have only been notifying family members if their loved ones are positive for COVID. ASM #1 stated they have not been updating residents and family about the status of COVID as a whole in the building. On 6/3/20 at 3:38 p.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing), were made aware of the above concerns. On 6/4/20 at 10:37 a.m., ASM #1, sent this surveyor another letter that was sent to residents and family members regarding COVID-19 on 3/11/2020. At this time there were no active cases of COVID in the facility. The letter documented in part the following: We will notify you if any resident or member is diagnosed with [REDACTED]. 2. Resident #11 was admitted to the nursing facility on 3/10/15 with [DIAGNOSES REDACTED]. On 4/16/20, the resident tested positive for COVID-19. The resident's Medicare 5 day Minimum Data Set assessment dated [DATE] identified the resident with a [DIAGNOSES REDACTED]. On 6/2/20 at 10:45 a.m., an interview was conducted with Resident #11. When asked if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	**06/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT COURTLAND	**23020 MAIN STREET COURTLAND, VA 23837**

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 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) she (own representative) was periodically receiving any cumulative updates of COVID-19 cases and or those with new onset respiratory symptoms in the facility, she responded, No, but maybe it is me and a couple others. I want to know and my son would like to know. We need something to read about that. She stated she was recovering from COVID-19 and had been very sick from [MEDICAL CONDITION]. On 6/2/20 at approximately 9:00 a.m., an interview was conducted with the facility Administrator. She stated once a COVID-19 test resulted as positive she would either inform the resident or the resident's representative. She stated she was not aware of any stipulation to do anything otherwise related to update of cases in the building and there was no other route offered to obtain updated information of Covid-19 confirmed or suspected cases to include, email, website, or recorded phone messages. On 6/3/20 at 3:20 p.m., an interview was conducted via telephone with the Administrator and the Director of Nursing (DON). They reiterated the same information as previously relayed on 9/2/20 at 9:00, but stated they sent the residents and families a letter with the occurrence of the very first COVID case in April of 2020. The Administrator reiterated that after that initial letter, they have only been notifying family members if their loved ones are positive for COVID, but no updates about the status of COVID-19 as a whole in the building. There was no further information regarding any other avenue the facility offered for residents and or families to obtain this information. On 6/4/20 at 10:37 a.m., the Administrator, sent the survey team another letter that was sent to residents and family members regarding COVID-19 on 3/11/2020. At this time there were no active cases of COVID in the facility. The letter documented in part the following: We will notify you if any resident or member is diagnosed with [REDACTED].