STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495305	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLISEUM CONVALESCENT AND REHABILITATION CENTER	**305 MARCELLA ROAD HAMPTON, VA 23666**

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 -** Few	**Provide and implement an infection prevention and control program.** Based on observations and staff interview the facility staff failed to follow manufacturers instructions on an infection control cleaning product therefore increasing the chances of spreading infections and diseases. The findings included: The facility staff failed to follow manufacturer's instructions on a cleaning product while cleaning a food cart on 9/10/20. On 9/10/20 at approximately 12:10 p.m. during an observation on a warm zone (Unit), staff was observed pushing a food cart partially through a plastic barrier separating the Warm Zone from the Hot Zone that housed COVID-19 residents. The staff from the Hot Zone were removing individual lunch bags from the food cart. Several bags were removed until CNA (Certified Nurse's Assistant) #6 on the warm zone pulled the food cart away from the barrier and started handing the remainder of the lunch bags to the staff on the Hot Zone through the plastic barrier. When CNA #6 was finished handing out the bags, she washed her hands and got a bottle of liquid from a basket located on top a file cabinet (there were several bottles filled with liquid) on the nurse's station. She began spraying the food cart inside and outside then wiping it with a cloth immediately. When she was finished she rolled the cart off of the warm unit and parked it in the hallway near dietary. On 9/10/20 at 12:30 p.m. an interview was conducted with CNA #6 concerning the above. She stated, I realized dirty was touching the clean. That's why I pulled the cart back from the barrier. She was asked what she used to spray the food cart with and she stated, I don't know, disinfectant. At 12:50 p.m. CNA #6 approached Other staff #2. She stated that it was called Simoniz (disinfectant). An inspection of the basket listed the names of several types of disinfectants with directions on how long the product should stay on surfaces before wiping it off. The Simoniz read: Follow directions. Time should be 10 (ten) minutes. Material Safety Data Sheet on SIMONIZ was received from the facility staff. It read: Disinfection/Cleaning/Deodorizing Directions: .Let solution remain on surface for a minimum of ten (10) minutes. On 9/15/20 at approximately, 10:20 a.m. an exit interview was conducted via telephone with the Administrator, the Assistant Administrator, and the Infection Control Nurse and DON (Director of Nursing). They were made aware of the findings. No further information was provided by facility staff.
F 0886 **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 observations, staff interview, and facility documentation review, the facility staff failed to implement COVID-19 testing to all staff during a facility outbreak, and failed to have procedures in place for staff who refused testing. The facility staff failed to test four staff during their COVID-19 outbreak. Therefore, increasing the chances of spreading COVID-19. A review of the testing logs dated [DATE], [DATE] and [DATE] showed that the following staff didn't receive COVID-19 [MEDICATION NAME] testing. Other Staff (dietary) #1, Certified Nursing Assistant (CNA) #3, CNA #4, and Licensed Practical Nurse (LPN) #2. The findings include: Facility COVID-19 testing dates for residents and staff include the following timeline: [DATE] Resident and staff testing performed, no reported symptoms. [DATE] Resident had a temperature, placed on droplet precaution. [DATE] The above resident plus two more residents have a temperature. [DATE] at 11:00 a.m. resident COVID test from lab returned positive. Resident moved to Hot Zone. Local health department notified. [DATE] 12:00 p.m., Staff meeting held. Overhead announcement to inform residents of current situation of COVID positive resident. Precautions being taken for residents to stay in their rooms. [DATE] 2:15 p.m.-3:00 p.m. Three more resident test returned positive. Residents moved to Hot Zone. Local Health Department (HD) informed. [DATE] 4:45 p.m. OLC (Office of Licensure and Certification) and local HD emailed notifications of positive cases. COVID screening for residents on Monroe Unit Hot Zone increased to every shift. [DATE] Contact tracing for three COVID positive residents. [DATE] Two residents with temperatures. Resident on another unit had [MEDICATION NAME] test done; result was negative. [DATE] Testing complete at 1:00 p.m., three residents had positive [MEDICATION NAME] test, all other residents were negative. [DATE] at 1:30 P.M., all three residents were moved to the Hot Zone. Local HD and OLC notified via email notification. [DATE] 4:15 p.m. automated message notification of families and residents. [DATE] No reported issues. [DATE] 11:00 a.m., no reported issues. [DATE] 10:00 a.m. COVID test returned on Resident. [MEDICATION NAME] testing for two residents. [DATE] 11:35 a.m. Spoke to local HD. informed her of positive COVID response. (5 COVID positive Residents). [DATE] 1:00 p.m., Reporting of 3 positive staff members. [DATE] 12:45 p.m., Spoke to local HD. Smaller areas is appropriate to minimize transfer residents and may cohort positive residents. [DATE] 8:00 a.m. - 9:00 a.m. Residents with new or worsened symptoms of temp.(temperature) cough or not feeling well. Nine residents were tested . Three residents came back positive. New Hot Zone established on Armistead Unit. [DATE] OLC and local HD notified of three positive [MEDICATION NAME] cases. [DATE] 10 a.m., three more residents were positive. The rest of the unit was tested . Four residents were positive. A second Hot Zone was established on the Armistead Unit. There are now a total of twenty-one residents in the facility as positive and one resident remains in the hospital. A total of twenty-two have tested positive. On [DATE] at approximately 9:55 a.m. during the entrance conference the facility Administrator stated that CNA (Certified Nursing Assistant) #5 Was recently admitted to the hospital, was given oxygen therapy and is now home. He was never on a vent.(ventilator), no resident died . We strongly encourage testing. We did the [MEDICATION NAME] testing two weeks ago for first time and on [DATE]nd all staff and residents were tested . The importance of testing was discussed. If you did not test you would be removed from the schedule. If not testing they will not be allowed in facility or we are out of outbreak. On [DATE] an email was received from the Administrator with a listing of five staff members that did not test on [DATE] or [DATE] (during the COVID-19 facility outbreak). Four were recently tested on [DATE] (two Certified Nursing Assistants, one LPN, and one dietary Staff). One nursing staff, an LPN (Licensed Practical Nurse) was considered PRN (works as needed) and last worked on [DATE]). A review of the testing logs dated [DATE], [DATE] and [DATE] showed that the following staff didn't receive COVID-19 [MEDICATION NAME] testing. Other Staff #1, CNA #3 but a declination was signed on [DATE], and on [DATE] CNA #3 received COVID-19 testing. CNA #4 didn't receive her testing on [DATE], [DATE] nor [DATE] however she stated she worked the weekend shift on ,[DATE]-[DATE]) and LPN #2 didn't receive COVID-19 tests on [DATE], [DATE] and [DATE]. On [DATE] at approximately, 3:20 p.m. an interview was conducted with CNA #3. The staff member who was observed working on the Monroe Unit (warm zone) on [DATE] serving lunch trays to residents. CNA #3 stated, Yes, I missed two tests because I was out. The ones before then I've taken. I wasn't tested any place else. I was off the schedule those days. I just recently returned this week. On [DATE] at approximately 3:36 p.m. an interview was conducted with Other Staff #1 (a cook). She stated, I was tested twice at the beginning. I thought I was finished when taking the test. I had to be quarantined in May because my son was asthmatic. I already took it and had two negative tests. I misunderstood the testing of staff. I would say that I already took it. We push the cart through the other units. I wore my PPE. I was already off. They told me that I couldn't come back if I didn't take my test. I took it today ([DATE]). On [DATE] at approximately 5:00 p.m. a phone call was received from CNA #4. She stated, I'm a nurses aide in training. I used to work in housekeeping. I don't have transportation so it's hard for me to get tested on my days off. I was tested on Friday ([DATE]). On [DATE] at approximately 1:30 p.m. an interview was conducted with the Infection Control Nurse she stated, We posted signs and encouraged everyone to do it (COVID-19 test). Per VDH (Virginia Department of Health) guidance or strongly encouraged to be tested . Received policy and

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 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) procedure from the administrator via emailed and reads as follows: The facility must test residents and staff, including individuals providing services under arrangement and volunteers,, for COVID-19 based on the county positivity rate reported in the past week. The facility should monitor their county positivity rate reported in the past week. The facility should monitor their county positivity rate every other week and adjust the frequency of performing staff testing according to CMS. Routine Testing for staff: At a minimum testing should be based on the extent of [MEDICAL CONDITION] in the community, therefore facilities should use their county positivity rate and consider testing more frequently if staff resident in higher positivity rate areas. Facilities should monitor their county's positivity rate every other week. If the county's positivity rate increases to a higher level of activity, the facility should begin testing staff at the frequency indicated by CMS. If the county's positivity rate decreases to a lower level of activity, the facility should continue testing staff at a higher frequency level until the county positivity rate has remained at the lower level frequency. If staff refuse testing, the staff must be educated, fit tested for an N-95 and must wear it at all times when in the facility. Outbreak Testing: An outbreak is defined as a new COVID-19 infection in any healthcare personnel (HCP) or any nursing home on-set COVID-19 infection in a resident. Staff and Residents: Upon any identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents should be tested , and all staff and residents that tested negative should be tested every three days to seven days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of fourteen days. An interview was conducted on [DATE] at approximately 1:30 p.m. with the Infection Control Nurse. She stated, One young man (CNA #5) was in the hospital, he was asymptomatic, tested positive for COVID-19 in the facility. He was tested regularly. His previous results were all negative. On [DATE] at approximately 4:30 p.m. the Administrator discussed the county's positivity rate and emailed the facility's COVID-19 policy and procedure. She stated, During the week of September the first the community activity (COVID-19) was high, so we tested twice per week per CMS (Centers for Medicare and Medicaid Services). During the week of September the eighth the community activity (COVID-19) was medium so we tested on ce per week per CMS. The Infection Control Nurse stated, We were strongly encouraging testing, one person declined. Three people missed one or two of those days during the outbreak. They should have been tested on [DATE] and [DATE]. An exit interview was conducted on [DATE] at approximately 10:20 a.m. with the Administrator, the Assistant Administrator, The Director of Nursing, and the Infection Control Nurse. The above concerns were addressed; no further information was provided by the facility staff.