STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495156	A. BUILDING _____ B. WING _____	**10/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT ROANOKE	**324 KING GEORGE AVE SW ROANOKE, VA 24016**

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, and the review of documents, it was determined the facility staff failed to properly implement COVID-19 prevention and/or control measures. The findings include: 1. Observations of the facility on 10/14/2020 revealed multiple staff members either using an incorrect mask for source control or using masks incorrectly for source control. Observations of the facility kitchen on 10/14/2020 at 1:20 p.m. revealed one (1) dietary staff member not wearing a mask and one (1) dietary staff member wearing a mask below the chin (not covering mouth and nose). These were the only two (2) staff member in the kitchen at the time of the observation. The facility's Dietary Manager was present at the time of the observation and confirmed that both of the aforementioned employees should have been correctly wearing a mask. On 10/14/2020 at 1:31 p.m., Respiratory Therapist (RT) #2 was noted to be wearing a KN95 mask. RT #2 reported he/she had been fit-tested for a N95 but wearing the N95 results in his/her glasses fogging up. RT #2 reported that he/she currently was caring for residents on the COVID-19 Positive Unit and the COVID-19 Negative Unit. The following staff members were observed to be wearing a N95 mask with an exhalation valve (no additional mask/device was covering the exhalation valve): Licensed Practice Nurse (LPN) #1, LPN #2, LPN #3, RT #1, and Staff Member (SM) #5. The following information was found in a facility document entitled Virginia COVID Plan (updated October 2020): Actions to take after COVID-19 (positive) is identified . N95 training and masks assigned to all staff, all new and existing staff at 100%. The above-mentioned observations were shared with the facility's DON on the afternoon of 10/14/2020. These findings were discussed with the facility's Director of Nursing (DON), Regional Director of Clinical Services (RDCS), and Infection Preventionist (IP) on the afternoon of 10/16/2020. The IP reported that currently no N95 masks with an exhalation valve were being used at the facility. The RDCS reported RT #2 was no longer using the KN95 mask. 2. A staff member was observed to re-enter the COVID-19 Positive Unit through the plastic barrier that was placed to separate the COVID-19 Negative Unit from the COVID-19 Positive Unit. On the afternoon of 10/14/2020 at approximately 2:15 p.m., LPN #5 was observed to return to the COVID-19 Positive Unit after leaving the unit for his/her lunch break. The facility's DON was asked which entrance LPN #5 should use when entering the COVID-19 Positive Unit; the DON reported staff members should use the COVID-19 Positive Unit's entrance/exit that leads to the outside of the building. LPN #5 was observed to enter the COVID-19 Positive Unit through the plastic barrier that was separating the COVID-19 Positive Unit and the COVID-19 Negative Unit; LPN #5 did not enter through the unit's door that opens to the outside. During an interview on 10/20/2020 at 2:40 p.m., the facility's DON and Regional Director of Clinical Services (RDCS) confirmed the expectation is that staff would enter and exit the COVID-19 Positive Unit using the door that connected the unit to the outside of the building. The RDCS reported there was no facility policy that spoke specifically to how to enter and exit the COVID-19 Positive Unit. 3. The facility staff failed to strategically place PPE (personal protective equipment) on the facility's COVID-19 Positive Unit. The COVID-19 Positive Unit did not have PPE placed at the unit's entrance and exit door leading to the outside of the building. The COVID-19 Positive Unit did not have PPE placed at the doors of the two (2) rooms on the unit that housed residents who were COVID-19 negative. The facility's COVID-19 Positive Unit was observed on the afternoon of 10/14/2020. The facility's Director of Nursing (DON) reported that individual were expected to enter and exit the facility's COVID-19 through the door that opens to the outside. It was noted that PPE equipment (gowns, gloves, eye protection, masks) was not placed at this entrance; alcohol-based hand rub and waste bins were also not placed at this entrance. LPN #3, LPN #4, and LPN #5 were interviewed separately about how the two (2) patients on the unit who were COVID-19 negative were being cared for to decrease their risk of exposure. All three (3) LPNs explained that a complete PPE change with hand hygiene is completed prior to entering the COVID-19 negative rooms on the unit. LPN #5 was observed to change PPE prior to entering one of the COVID-19 negative rooms. LPN #5 was changing PPE outside the nurse's station. No bin was available to discard the used PPE. LPN #5 was observed to attempt to hold a plastic bag with one hand while placing the gown he/she had removed in the bag with the other hand. LPN #6 assisted LPN #5 by taking the bag from LPN #5 and holding the bag while LPN #5 discarded the gown into the bag. During an interview on the afternoon of 10/14/2020, the facility's DON reported that PPE and supplies should have been placed at the outside entrance to the COVID-19 Positive Unit and outside the doors of the two (2) rooms on the COVID-19 Positive Unit that housed residents that had tested negative for COVID-19. (Clinical documentation and staff interviews revealed the two (2) residents on the COVID-19 Positive Unit, who had tested negative, were refusing to leave their private rooms on the COVID-19 Positive Unit.) 4. A facility staff member failed to perform hand hygiene at the appropriate time when changing PPE (personal protective equipment). On the afternoon of 10/14/2020, LPN #5 was observed to change PPE prior to entering the room of a resident who had tested negative for COVID-19. LPN #5 was changing PPE outside the nurse's station. There were no waste bins or hand hygiene supplies at the location where LPN #5 was changing PPE. LPN #5 was observed to remove his/her PPE and begin donning new PPE prior to performing hand hygiene. LPN #5 was asked about the failure to perform hand hygiene. LPN #5 confirmed he/she should have performed hand hygiene after removing PPE. LPN #6 obtained alcohol-based hand rub (ABHR) from the nurse's station for LPN #5 to perform hand hygiene. The following information was found in a facility policy titled Handwashing/Hand Hygiene (revised August 2015): The facility considers hand hygiene the primary means to prevent the spread of infections . 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 5. Facility staff members were unable to provide evidence of COVID-19 screening for Staff Member (SM) #3, LPN #5, and SM #6. During an interview on 10/20/2020 at 11:12 a.m., the Director of Nursing (DON) was asked if COVID-19 screening documentation had been found for: (1) SM #3 prior to his/her COVID-19 test dated as collected on 9/25/2020, (2) LPN #5 screening prior to working on 10/14/2020, and (3) SM #6's screening prior to working on 10/13/2020. During an interview on 10/20/2020 at 12:11 p.m., the DON reported the aforementioned screen documentation was not available. On 10/19/2020 at 11:38, the facility's DON reported the receptionist is usually present to complete the employee screening from 8:00 a.m. to 8:00 p.m. The DON stated if someone is not stationed at the screening locations that employees will complete the screening themselves. The following information was found in a facility document entitled Virginia COVID Plan (updated October 2020): 100% staff entering/exiting center are screened with questionnaire and temperature checks by a competent staff member. No staff with temp greater than 99.6 will be permitted to work. Screening tool will be confirmed the day following with the schedule. 6. Staff Member (SM) #7 was allowed to work after exhibiting COVID-19 symptoms but prior to receiving his/her COVID-19 test results. SM #7 was sampled for COVID-19 testing review. On 10/19/2020 the facility's Director of Nursing (DON) reported SM #7 was tested for COVID-19 at an outside provider therefore the results were not available. Facility documentation indicated SM #7 reported having cough or shortness of breath and gastrointestinal symptoms or nausea/vomiting on 9/21/2020. The facility COVID documentation indicated SM #7 had been tested on [DATE] with a positive result reported on 9/23/2020. The facility's COVID-19 Employee Sign In/Out Log indicated SM #7 worked on 9/23/2020. The facility's Director of Nursing, during an interview on 10/19/2020 at 1:15 p.m., confirmed SM #7 had worked on 9/23/2020. The following information was found in a facility policy titled Coronavirus Testing (implemented on 9/1/2020 and reviewed/revised on 9/29/2020): Staff with signs or symptoms of COVID-19 will be

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) tested and are expected to be restricted from the facility pending the results of COVID-19 testing. The aforementioned infection control findings included in this deficiency was discussed during a telephone meeting with the facility's DON, Regional Director of Clinical Services, and Vice-President of Clinical Services on 10/20/2020 at 9:29 a.m.
F 0882 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on interviews and the review of documents, it was determined the facility staff failed to ensure the facility's Infection Preventionist (IP) regularly participated in the facility's quality assessment and assurance committee. The findings include: The facility staff was unable to provide documentation to show the regular involvement of the Infection Preventionist (IP) in the facility's quality assessment and assurance committee. During the entrance conference on 10/14/2020, the facility's Director of Nursing (DON) was asked for evidence of the facility's IP being involved in the facility's quality assessment program. The DON reported the facility quality committee meets monthly and that the IP is a part of the quality committee. On 10/20/2020 at 11:12 a.m., the DON was asked about the documentation of the IP involvement in the facility's quality committee. The DON reported the only recent quality committee meeting sign-in sheet that was found was for August 2020 and that the IP was on vacation therefore was not in attendance. The DON was asked if the documentation/minutes for the quality committee meetings addressed infection control. The DON reported he/she did not see infection control specifically included in the quality committee documentation. No additional information related to this issue was provided to the surveyor prior to the conclusion of the survey.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on observations, interviews, and the review of documents, it was determined the facility staff failed to consistently implement COVID-19 testing for five (5) of seven (7) staff members sampled for COVID-19 testing review (Respiratory Therapist (RT) #2, Staff Member (SM) #3, SM #6, Licensed Practical Nurse (LPN) #4, and LPN #5). The findings include: The facility staff failed to ensure consistent testing of staff members for COVID-19. The following information was found in a facility policy titled Coronavirus Testing (implemented on 9/1/2020 and reviewed/revised on 9/29/2020: Testing of Staff and Residents in Response to an Outbreak . 1. All staff and residents will be tested upon identification of a single new case of COVID-19 infection in any staff or residents. 2. All staff and residents that test negative will be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. During an interview on 10/19/2020 at 1:15 p.m., the facility's Director of Nursing (DON) reported testing occurred at the facility on the following four (4) dates: (1) 9/25/2020 - 9/27/2020, (2) 10/8/2020, (3) 10/13/2020, and (4) 10/19/2020. 1. LPN (licensed practical nurse) #4 was not COVID-19 tested according to the facility's policy. LPN #4's COVID-19 test results were reviewed on 10/19/2020. LPN #4's most recent COVID-19 test was dated as being collected on 9/26/2020 with results reported on 9/29/2020. During an interview on 10/19/2020 at 1:15 p.m., the facility's Director of Nursing (DON) was asked if LPN #4 had a COVID-19 test since his/her 9/26/2020 test; the DON reported LPN #4 had not had a COVID-19 test since 9/26/2020. The DON was unable to provide a reason for the absence of recent COVID-19 test for LPN #4. The DON reported LPN #4 was having a COVID-19 test collected on 10/19/2020. 2. RT (respiratory therapist) #2 was not COVID-19 tested according to the facility's policy. RT #2's COVID-19 test results were reviewed with the facility's DON on the morning of 10/20/2020. RT #2's most recent COVID-19 test results were dated as being collected on 9/26/2020 with results reported on 9/30/2020. The DON reported RT #2 had been tested for COVID-19 on 10/19/2020. The DON reported no additional COVID-19 test for RT #2 was found. 3. LPN (licensed practical nurse) #5 was not COVID-19 tested according to the facility's policy. On the afternoon of 10/19/2020 at 2:40 p.m., the facility's DON was asked for LPN #5's COVID-19 test results. After looking for LPN #5's results, the DON reported the facility had no COVID-19 test results in the facility's system. The DON reported LPN #5 is an agency staff member. The DON reported LPN #5 was going home to get COVID-19 results and bring them to the facility. On 10/20/2020 at 8:35 a.m., the DON as asked about LPN #5's COVID-19 test results. The DON stated he/she would send the COVID-19 test result provided by LPN #5. The DON reported a date was missing from the COVID-19 test result form. LPN #5's COVID-19 test result form had the employee's name hand written on the form. This result report indicated the sample was collected on 10/7/2020 but did not include the date the results were available. This result report did not include the name of the laboratory or provider completing the COVID-19 test. The aforementioned issues with LPN #5's COVID-19 test results were discussed during a telephone meeting with the facility's DON, Regional Director of Clinical Services, and Vice-President of Clinical Services on 10/20/2020 at 9:29 a.m. The DON reported he/she had to write LPN #5's name on the aforementioned COVID-19 test result form. The DON confirmed LPN #5 should have been tested for COVID-19 when the facility was performing staff testing. 4. Staff Member (SM) #3 was not COVID-19 tested according to the facility's policy. SM #3's COVID-19 test results were reviewed with the facility's DON on 10/19/2020 at 3:45 p.m. SM #3's most recent COVID-19 test result was dated as being collected on 9/25/2020 with results reported on 9/30/2020. The DON reported no additional COVID-19 test results for SM #3 was found. SM #3 had been observed working in the facility on the afternoon of 10/14/2020. 5. Staff Member (SM) #6 was not COVID-19 tested according to the facility's policy. During an interview on 10/19/2020 at 11:38 a.m., the facility's DON reported SM #6 last time working inside the facility was 10/13/2020. The following information was found in a facility policy titled Coronavirus Testing (implemented on 9/1/2020 and reviewed/revised on 9/29/2020: Refusal of Testing . 1. Staff who exhibit signs or symptoms of COVID-19 and refuse testing will be prohibited from entering into the facility until the return to work criteria, as outlined previously, are met. 2. It is our position that that (sic) the employee has chosen to voluntary resign their position. 3. For asymptomatic staff that refuse routine testing, the facility will assume the staff member has chosen to voluntarily resign their position . On 10/16/2020 at 2:55 p.m., the facility's DON was asked about the Refusal of Testing section of the aforementioned policy and the previous report that SM #6 had refused COVID-19 testing. The DON wanted to consult with regional staff members. On 10/16/2020 at 3:24 p.m., the refusal of SM #6 to have COVID-19 testing performed was discussed with the facility's Regional Director of Clinical Services (RDCS). The RDCS reported SM #6 was considered terminated as of 10/16/2020. During a telephone meeting with the facility's DON, Regional Director of Clinical Services, and Vice-President of Clinical Services on 10/20/2020 at 9:29 a.m., concerns with facility staff members not being consistently tested for COVID-19 was discussed. (An interview with a representative from the facility's local health department confirmed the local health department had been made aware of the facility's COVID-19 results taking greater than 48 hours to have results reported.)