| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495226 | A. BUILDING _____ B. WING _____ | 06/24/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| WAYLAND NURSING AND REHABILITATION CENTER | 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, staff interview, clinical record review and facility document review, it was determined the facility staff failed to implement the infection control program to prevent infection and transmission of communicable diseases for six of six residents in the survey sample, Residents #1, #2, #3, #4, #5 and #6. Observation revealed Resident #1 without a mask in the hallway within two feet of and Resident #2, whose mask covered only his mouth and not his nose. Staff was not observed attempting to redirect Resident #1 back to her room or attempting to have Resident #1 wear a mask. The facility staff failed to perform hand hygiene and clean medical equipment before and between providing resident care for Resident #3, Resident #4, Resident #5 and Resident #6. The findings include: 1. During the onsite survey on 6/24/20 at 10:30 AM, entrance was conducted with the ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing/infection preventionist. When asked to describe isolation measures in the facility, ASM #1 stated, We have six quarantine rooms, for residents who have been admitted , readmitted or returned from physician visits. When asked what PPE (personal protective equipment) was required, ASM #3 stated, All the staff wear masks in the facility, and if performing care in any quarantined rooms, they wear masks, gown, gloves. Residents wear masks in the hallway. On 6/24/20 at 10:45 AM, observation revealed Resident #1 in the hall sitting in a chair without a mask on. Further observation revealed Resident #1 took the chair back into her room and returned to the hall and was standing without mask on. On 6/24/20 at 11:05 AM, Resident #1 walked up the hallway to the intersection of the main hall/nursing station. Resident #1 was standing within two feet of Resident #2 at the water fountain. Resident #1 was not wearing mask and Resident #2's mask was covering his mouth, but not his nose. On 6/24/20 at 11:09 AM, Resident #1 returned to her room. A staff member adjusted Resident #2's mask to cover his mouth and nose. During the period from 10:45 AM - 11:30 AM, observation revealed five staff members passing Resident #1, none of the staff attempted redirecting the resident back into her room or attempting to have Resident #1 wear a mask. Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #1's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/20/20, coded the resident as scoring 99 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of Resident #1's nurse progress note dated 5/8/20 at 11:10 AM, documented in part, She has to be constantly reminded to return to room. She refuses to wear a mask, most likely related to disease process. Continued reinforcement of six feet distancing when wandering and staying in room performed. Resident #1's care plan dated 3/17/20, documented, Focus: At risk for alteration in psychosocial well-being related to restrictions on visitations due to COVID-19 and Interventions: Monitor for psychosocial changes, observe and report any changes in mental status caused by situational stressor, encourage alternative communication with visitors. Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #2's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/18/20, coded the resident as scoring 02 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of Resident #2's nurse's progress note dated 5/23/20 at 10:30 PM, documented in part, Resident has wandered the hallways and has been in and out of other rooms, not just his own. Attempted to sit on roommate's bed while he was laying in it. Review of Resident #2's care plan dated 3/17/20, documented, Focus: At risk for alteration in psychosocial well-being related to restrictions on visitations due to COVID-19 and Interventions: Monitor for psychosocial changes, observe and report any changes in mental status caused by situational stressor, encourage alternative communication with visitors. On 6/24/20 at 11:40 AM, an interview was conducted with RN (registered nurse) #1, the clinical coordinator. When asked if Resident #1 should be wearing a mask, RN #1 stated, Yes, she should be wearing a mask. She won't and will attempt to hit you. When asked about the process staff follows for residents social distancing of six feet, RN #1 stated, Yes, we keep them (residents) apart. When asked process staff follows to separate Resident #1 who was not wearing a mask and Resident #2 who had mask only covering his mouth, RN #1 stated, We would have Resident #2 move down the hall and reposition his mask to cover his mouth and nose. He is more amiable to moving than Resident #1. An interview was conducted on 6/24/20 at 11:45 AM with ASM #2, the director of nursing and ASM #3 the infection preventionist. When asked what standard of Practice is followed in the facility, ASM #2, the director of nursing stated, We follow the corporate policy and procedures. When asked about residents wearing a mask in the hall, ASM #3, the infection preventionist stated, Yes, we expect them to wear a mask if they are out of their room. ASM #3 was asked to provide the guidelines for mask usage. The following facility policy was provided by ASM #3, Interim Guideline on Mask Usage dated 4/17/20. The policy documented in part the following, We now recommend that patients be asked to wear these masks when interacting with staff. We also recommend the use of these masks to and from shower rooms and smoking areas; need to ensure appropriate social distancing (6 feet). No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 154. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 518. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 282. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 154. (5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. (6) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 344. 2. On 6/24/20 at 11:18 AM to 11:32 AM, observation revealed, CNA (certified nursing assistant) #1 entering a semi-private room and checking Resident #3's finger pulse oximeter saturation. CNA #1 then checked Resident #4's (the roommate of Resident #3's), finger pulse oximeter saturation (1). Observation revealed CNA #1 then entered the semi-private room two rooms away and repeated the process of checking the finger pulse oximeter saturation of the two residents residing in the room Resident #5, then Resident #6. During this observation, the CNA failed to perform hand hygiene between contacts with each resident, and failed to clean the finger pulse oximeter between residents. On 6/24/20 at 11:32 AM, an interview was conducted with CNA #1 upon her leaving the second semi-private room. When asked how often she completed the pulse oximeter checks, CNA #1 stated, I do this daily. When asked if hand hygiene should be performed between each resident contact, CNA #1 stated, Yes. When asked if the pulse oximeter should be cleaned between each resident use, CNA #1 stated, Yes, it should be. An interview was conducted on 6/24/20 at 11:45 AM with ASM #2, the director of nursing and ASM #3 the infection preventionist. When asked what standard of care is followed in the facility, ASM #2, the director of nursing stated, We follow the corporate policy and procedures. When asked about the process staff follows for hand hygiene after resident contact, ASM #3, the infection preventionist stated, They are to wash their hands after each resident contact. When asked about the process staff follows for cleaning medical equipment between resident uses, ASM #3, the infection preventionist stated, The equipment should be cleaned between each resident. ASM #3 was asked to provide the policy and procedure for handwashing and cleaning of medical equipment. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/2/2020, coded the resident with both short |

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

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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>and long-term memory difficulties. The comprehensive care plan dated, 3/7/12 and revised on 6/1/2020, failed to evidence documentation related to infectious diseases or infection control. The care plan did document the resident was being treated for [REDACTED]. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/13/2020 coded the resident as scoring a 3 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The comprehensive care plan dated 4/6/18 and revised on 6/16/2020 failed to evidence documentation related to infectious diseases or infection control. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. It affects memory, thinking, language, judgment, and behavior.) (1), high blood pressure, diabetes and [MEDICAL CONDITIONS]. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 4/20/20 coded the resident as scoring 3 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The comprehensive care plan dated 5/10/19 and revised on 3/17/20, failed to evidence documentation related to infectious diseases or infection control. Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/19/2020 coded the resident as scoring 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The comprehensive care plan dated 12/4/19 with a revision on 3/17/20, failed to evidence documentation related to infectious diseases or infection control. According to the facility's Handwashing Policy dated 9/2014, which documents in part, Personnel are required to wash their hands after each direct or indirect resident contact for which handwashing is indicated by acceptable standards of practice: between resident contacts, when otherwise indicated to avoid transfer of microorganisms to other residents and environments. According to the facility's Cleaning and Maintenance of Equipment Policy dated 9/2014, which documents in part, Equipment in this facility will be cleaned and disinfected according to manufacturer's recommendations. Resident care equipment will be cleaned and disinfected between resident uses. According to the CDC (Center for Disease Control) Preparing for COVID-19 in Nursing Homes Updated June 25, 2020, the following is documented in part, Environmental Cleaning and Disinfection: Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas; Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. Use an EPA-registered disinfectant from List Nexternal icon on the EPA website to disinfect surfaces that might be contaminated with [DIAGNOSES REDACTED]-CoV-2. Ensure HCP are appropriately trained on its use. (2) No further information was provided prior to exit. Reference: (1) Pulse oximeter- finger oximeter a pulse oximeter whose sensor is attached to a finger, so that the oxygenation of blood flowing through the finger can be determined. This information was obtained from the website:https://medical-dictionary.thefreedictionary.com/pulse+oximeter (2) This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html |