STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495286	A. BUILDING _____ B. WING _____	**09/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JAMES RIVER CONVALESCENT CENTE	**540 ABERTHAW AVENUE NEWPORT NEWS, VA 23601**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, resident/family interviews, clinical record review and facility documentation review, the facility staff failed to notify the resident representative of a positive COVID-19 test result timely for 2 residents (Resident #1 and #4) of 8 residents in the survey sample. The findings included: 1. Resident #1 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The current Minimum Data Set (MDS), a Quarterly Review with an Assessment Reference Date (ARD) of 9/08/20, coded resident #1 with a score of 2 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicates severe cognitive impairment. On 9/24/20 at 9:34 a.m., a phone interview was conducted with Resident #1's Responsible Party (RP). She stated that she was allowed to visit Resident #1 on her birthday (9/09/20). She stated, I had no idea she had it. (COVID-19). The administrator let me in the back door. They gave me PPE (Personal Protective Equipment) to wear. I put on a gown, shoe covers, mask and a face shield. She was asked if she had gotten her temperature checked upon entering the building? She stated, No, they didn't even ask me if I had been around anybody. A review of the COVID Hot Zone sign in sheet revealed on 9/09/20 at 10:00 AM that RP signed in and the time out was at 10:20 AM A review of nurses notes read as follows: Attestation note dated on 9/04/20: Resident was tested on [DATE] and results came back positive on 9/04/20. Resident was then placed on isolation droplet precautions and moved to a private room. All services are provided in the room. Family and MD were notified of changes in condition and new room assignment. Written by MDS nurse (Registered Nurse-RN #1). On 9/24/20 the Administrator provided a written statement that read: I met RP on 9/09/20 at the Jefferson entrance with all of the necessary PPE (Personal Protective Equipment) to enter the room. I did not accompany her into the room but walked her to the door-once she was in her PPE. At no point did I know that RP was not aware of Resident #1 status. On 9/24/20 at approximately 11:00 a.m. an interview was conducted with LPN #5 concerning visitations inside of the facility. She stated, we have [MEDICATION NAME] care visitors. They usually come through the back door. They are screened. On 9/24/20 at approximately, 3:45 PM an interview was conducted with CNA (Certified Nursing Assistant) #1 concerning the above allegation. She stated, The RP (Responsible Party) said they received a phone call from the building that Resident #1 was positive. She brought it to my attention (9/11/20). She wanted to know results of other patients and staff that worked here. I told her that was privacy. I can't do that. On 9/25/20 at approximately 2:40 p.m., an interview was conducted with the MDS nurse addressing the clinical note written above. She stated, I didn't notify them of COVID-19 results. The social worker told the family. I wrote a general note for skilled services for MDS purposes. I assumed they were notified. A lot of things are done on weekends and I write them on Mondays when I come in. I didn't call the family. On 9/25/20 at approximately, 2:45 p.m., an interview was conducted with Social worker (Other Staff #5) concerning the above. She stated, I left her a message once I was notified. We typically don't chart. Nursing usually does. Normally the nurse calls. I left her a message asking her to call back ASAP. The nurse and administrator were aware that I called and left a message on 9/04/20 late in the afternoon, close to 4 PM. On 9/25/20 an interview was conducted at 3:10 p.m. with the Acting Director of Nursing she stated, Usually the supervisor in charge of the nurse will call the family (notify of COVID-19 results). The SW (Social Worker) will usually contact family about other things like insurance purposes. Usually not a nursing thing. On 9/25/20 at approximately, 4:15 p.m. an interview was conducted with LPN (Licensed Practical Nurse) #4 who was the resident's nurse. She stated, If I had gotten the results I would have called the family. Those results were given to someone else. I would have documented it. No one notified me that she was positive. On 9/28/20 at approximately 4:25 p.m., a pre-exit interview was conducted via telephone with the Administrator, Director of Nursing, Assistant Director of Nursing and the Corporate Vice President. The Corporate VP (Vice President) stated, The family was notified but it wasn't put into the hard chart. 2. For Resident #4, the facility staff failed to notify the family representative of a positive COVID-19 test result timely. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #4's most recent comprehensive MDS (Minimum Data Set) was an annual with an ARD (Assessment Reference Date) of 6/25/2020. The BIMS (Brief Interview of Mental Status) for Resident #4 was coded as a 9 which indicates the resident has moderately impaired cognition. Resident #4's Comprehensive Care Plan was reviewed as is documented in part, as follows: Problems: Infectious Disease- Name (Resident #4) requires the following precautions: Contact Droplet 9/19/20 she was tested positive for Covid-19 Status-Active Effective Date: 9/21/2020-Present Interventions: Notify the physician and responsible party of any signs and/or symptoms of infection. Provide treatment as ordered by medical doctor. Keep physicians and responsible party informed of residents response to treatment. Effective: 9/21/2020-Present Resident #4's Laboratory Results were reviewed and are documented in part, as follows: Collected: 09/16/2020 Reported: 9/18/2020 [DIAGNOSES REDACTED]-Cov-2 (COVID19) - POSITIVE Resident #4's Physician order [REDACTED]. New confusion or inability to arouse, Bluish Lips or Face. Physical Monitors: Chills or feels feverish/Cough/Loss of smell or taste/Myalgia or body aches/Oxygen Saturation/Pulse/Respiration/Shortness of Breath/Sore Throat/Temperature/Vomiting or Diarrhea. Order Date: 9/18/2020 On 9/25/20 at 10:05 A.M. during a phone interview the Administrator was asked if there was any documentation to support the the Resident Representative had been notified of Resident #4's positive COVID-19 results received on 9/18/2020. The Administrator stated, We have reviewed the record and we don't see where the family was made aware of the positive results. The supervisor is usually the one who contacts the family about the positive results. The family should have been notified within 24 hours or by the next day. We are notifying the family now. Resident #4's Clinical Notes were reviewed and are documented in part, as follows: 9/25/2020 at 10:18 A.M. Attestation Note: Resident was tested for COVID 19 and results came back positive on 9/18/2020. Resident was then placed on isolation with droplet and contact precautions and moved to a private room. All services are provided for the resident in the room. Family and MD (Medical Doctor) were notified of change in Name (Resident #4's) condition and her new room assignment. 9/25/2020 at 10:18 A.M. Family notified of COVID results and updated on current status. On 9/25/2020 at 12:04 P.M. during a phone interview the ADON (Assistant Director of Nursing) was asked if she has contacted Resident #4's Representative today regarding the resident's 9/18/2020 positive COVID-19 result. The ADON stated, Yes I called her daughter today and asked her if she was aware of her mother's COVID results. The daughter said, Does she have it. I told her she was positive on the 18th. She asked me why she was not called and I apologized for her not being notified. On 9/25/2020 at 12:20 P.M. during a phone interview Resident #4's Representative was asked when she was made aware of the resident's positive COVID-19 results that were received on 9/18/2020. Resident #4's Representative stated, I just found out today that she has been positive sine the 18th of this month. Today was the first time I have heard about this. They call me for everything else but not this. The facility policy titled POSITIVE COVID-19 RESULTS last revised 5/20/2020 was reviewed and is documented in part, as follows: Policy: 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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) ensure proper precautions and steps are taken, according to CDC guidance, when a resident or employee tests positive for COVID-19. Procedure: Resident tests positive: Notify the following: Residents/Representative-by 5:00 pm the next calendar day. On 9/25/2020 at 2:45 P.M. a phone interview was conducted with the Administrator where the above information was shared. Prior to exit no further information was provided. Complaint deficiency.
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, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure infections control measures were consistently implemented to prevent the development and/or transmission of a communicable disease (COVID-19), and other infectious diseases. The facility staff failed to implement their active screening process for an off-duty staff member entering the facility. The findings included: On 9/23/20 at 12:20 p.m., a surveyor entered the facility through the visitor entrance. While entering the G.S.(NAME)Unit, a visitor was observed entering into the facility from the employee entrance. She stopped at the screening station, where no screener was present and began scanning herself with a thermoscan (a device used to take temperatures). The visitor looked at the surveyor and stated, I'm not on duty, I'm here to check paperwork. She proceeded to the nurses station on the G.S.(NAME)Unit where she was observed talking to Licensed Practical Nurse (LPN) #1. Upon leaving the unit she was asked if she worked at the facility. She stated, I'm a CNA (Certified Nursing Assistant-#3), I didn't sign in because I'm not on duty. On 9/23/20 an interview was conducted at 12:30 p.m. with Corporate Nurse #1 concerning the observed lack of screening. She stated, When staff enter, the staffing coordinator will screen staff. She should have been screened. On 9/24/20 at approximately 8:00 a.m. upon entering into the building on the G.S.(NAME)Unit several employees were observed to be waiting for staff to screen them. A staff member from housekeeping walked up and started scanning temperatures while staff completed the screening questionnaires. Shortly after, a nursing staff took over (CNA #5). On 9/24/20 at approximately, 8:10 a.m., an interview was conducted with the screener, (CNA #5) concerning the above. She stated, We ask for signs and symptoms, such as fevers, chills, headaches,scan for temperatures. They should write down their names, check yes or no and initial the form. I will sometimes write down this information myself. My office is here. (Located across from the screening station). Facility policy titled Infection Control Outcome Surveillance Guidelines For Coronavirus revised 6/8/2020 included: .Employees: -All healthcare personnel must use a face mask while in the facility. -All employees will be screened upon arrival and departure by having temperature checked and answering a series of questions . On 9/28/20 at approximately 4:25 p.m. the above findings were shared with the Administrator, Vice President, Director of Nursing and with the Director of Clinical Support. The Vice President stated, She should have been screened by someone at the door.