STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495086	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT BAY POINTE LLC	1148 FIRST COLONIAL RD VIRGINIA BEACH, VA 23454

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview, and facility document review, it was determined that facility staff failed to follow infection control practices and failed to don and doff personal protective equipment (PPE) in a manner to prevent the spread of infection for two of five residents in the survey sample, Resident #3 and Resident #4; and failed to appropriately wear an N95 respirator while working with Resident #3. The findings included: Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #3's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/22/20. Resident #3 was coded as being severely impaired in cognitive function scoring 4 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #3's clinical record revealed that she was placed on droplet precautions on 8/11/20 for a cough. Resident #4 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Resident #4's most recent MDS (minimum data set) was significant change assessment with an ARD (assessment reference date) of 7/21/20. Resident #4 was coded as being severely impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #4's clinical record revealed she was placed on quarantine for 14 days starting 8/4/20. The reason for quarantine was possible exposure to COVID-19. On 8/13/20 at 9:58 a.m., observation of Unit 100; Rooms 101-115 (the non-quarantine/isolation side) was conducted. Resident #3 and #4 were on enhanced droplet precautions. The sign on the doors of both rooms documented: Enhanced Precautions Anyone entering room must wear N95, gloves, gown, eye protection. On 8/13/20 at 10:00 a.m., ASM (administrative staff member) #4, the NP (Nurse Practitioner) was observed at Resident #4's doorway and donned a gown and gloves. ASM #4 donned a disposable gown that was already hanging on the front of the door next to the PPE (personal protective equipment) supplies. ASM #4 stood at the foot of Resident #4's bed with LPN (Licensed Practical Nurse) #1 assessing her lower extremities. At approximately 10:06 a.m., ASM #4 exited the room and hung up the gown on the front of the door next to the PPE supplies. On 8/13/20 at 10:26 a.m., OSM (Other Staff Member) #1, the restorative aide, was observed donning the same disposable gown that was hanging on the door of Resident #4's room. This was the same gown the NP had used previously. While OSM #1 was donning the gown; she was standing in the middle of the hallway talking to CNA (certified nursing assistant) #1. On 8/13/20 at approximately 10:33 a.m., an interview was conducted with LPN #1. When asked why Resident #4 was on droplet precautions, LPN #1 stated that Resident #4 had just recently tested negative for COVID; however she was still within her 14 day window for quarantine. LPN #1 stated that the facility will re-test for COVID after her quarantine days are up. When asked if she was being treated as if she had COVID, LPN #1 stated that she was because she was on isolation precautions. When asked if staff could wear PPE outside of Resident 4's room, LPN #1 stated, Not if it's a gown that has already been inside the room. On 8/13/20 at 10:47 a.m., OSM #2, the speech therapist was observed exiting Resident #3's room with a surgical mask underneath her N95 respirator. On 8/13/20 at 10:57 a.m., CNA #1 was observed donning all PPE; gown, gloves, face shield and a hairnet and walked into Resident #3's room. CNA #1 was also observed wearing a surgical mask underneath her N95. CNA #1 then shut Resident #3's door. At 10:59 a.m., CNA #1 walked out of the room wearing all PPE including a gown and gloves and stated, I know. You don't see me. But I didn't touch anything. CNA #1 then proceeded to the linen cart, grabbed linen and went back into Resident #3's room and shut the door. On 8/13/20 at 11:03 a.m., an interview was conducted with the unit manager; RN (Registered Nurse) #1. When asked why Resident #3 was on droplet precautions; RN #1 stated that her COVID tests were pending as of this morning but wasn't sure if the results were in yet. When asked when Resident #3 was tested , RN #1 stated that she was tested on [DATE]. On 8/13/20 at approximately 11:45 a.m., an interview was conducted with OSM #2, the speech therapist. When asked why Resident #3 was on droplet precautions, OSM #2 stated that the resident was coughing so they put her on quarantine as a precaution. OSM #2 stated that it was her first time evaluating the resident. OSM #2 stated that she put on all the required PPE to work with Resident #3 such a gown, gloves, face mask and face shield. OSM #2 also stated that she had put her clipboard in a plastic bag. When asked if she had any direct contact with Resident #3, OSM #2 stated that she did not. When asked how far away she was from Resident #3; OSM #2 stated that she was probably about two to three feet away because the resident was hard of hearing. When asked if Resident #3 was positive for COVID, OSM #2 stated that she wasn't sure if the results were in yet. When asked if a surgical mask should be worn with an N95 while working with a resident with an unknown COVID result; OSM #2 stated that she was not sure. When asked if the surgical mask interferes with the N95 seal if worn underneath the N95, OSM #2 stated that she was not sure. On 8/13/20 at 12:32 p.m., an interview was conducted CNA (certified nursing assistant) #1. When asked if she had any physical contact with Resident #3 when she was in the room. CNA #1 stated, I never touched her. I went in her room and realized there were not any linens on her bed and put new linens on. CNA #1 stated that Resident #3 was more than 6 feet away from her. Further review of Resident #4's clinical record revealed her COVID tests came back negative on 8/8/20. Further review of Resident #3's clinical record revealed a COVID swab was obtained on 8/11/20. As of 8/13/20; the results were pending. On 8/13/20 at approximately 1:30 p.m., ASM #1, the Administrator, ASM #2, the DON and ASM #3, the corporate nurse were made aware of the above concerns. On 8/14/20 at approximately 12:23 p.m., ASM #1 presented Resident #3's negative COVID result that was just sent to the facility. Facility Policy titled, Isolation-Categories of Transmission Based Precautions, documents in part, the following: Droplet .gowns .a. With COVID-19 or PUI (Patient Under Investigation) based on CDC guidance. Review of CDC (Center for Disease Control) guidance for doffing gowns documents in part, the following: How to Take Off (Doff) PPE Gear .Healthcare personnel should adhere to Standard and Transmission-based Precautions when caring for patients with [DIAGNOSES REDACTED]-CoV-2 infection .How to Doff PPE gear .Remove gloves. Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak). Remove gown. Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle. Healthcare personnel may now exit patient room .* Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate those practices . CDC's guidance for reusing gowns documents in part, the following: Extended use of isolation gowns .Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP (Health Care Personnel) when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). Review of CDC guidance titled, How to properly put on and take off a disposable respirator, documents in part, the following: Do not allow facial hair, glasses, clothing or anything else to prevent proper placement or come between your face and the respirator. No further information was presented prior to exit.

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.