COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

TYY 7-1-1 OR
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9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
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January 27, 2016

Mr. David Carter, Administrator
Sentara Nursing Center Va Beac
3750 Sentara Way
Virginia Beach, VA 23452

RE: Sentara Nursing Center Va Beac
Provider Number 495270

Dear Mr. Carter:

An unannounced standard survey, ending January 22, 2016, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Two complaints were investigated during the survey. One complaint was substantiated, with deficiencies. One complaint was substantiated, with no deficiencies. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of F), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Elizabeth Hudnall, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at "http://www.vdh.state.va.us/OLC/longtermcare/".

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
  - Directed Plan of Correction (PoC) (§488.424).
  - State monitoring (§488.422).
  - Directed In-Service Training (§488.425).
- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,
- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: "http://www.vdh.state.va.us/OLC/longtermcare/". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Elizabeth Hudnall

Elizabeth Hudnall, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joani Latimer, State Ombudsman
Jaime Desper, D M A S (Sent Electronically)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495270	A. BUILDING _____ B. WING _____	C 01/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER VA BEAC	3750 SENTARA WAY VIRGINIA BEACH, VA 23452

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/20/16 through 1/22/16. Two complaints were investigated. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 116 certified bed facility was 104 at the time of the survey. The survey sample consisted of 21 residents, 18 current Resident reviews (Resident #1 through 18) and 3 closed record reviews (Resident #19 through 21).	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, family interview and facility documentation, the facility staff failed to provide prompt efforts to resolve a grievance for 1 out of 21 residents in the survey sample, (Resident #21). The facility staff failed to resolve a grievance for Resident #21 in a timely manner. The findings include: A closed record review was done as Resident	F 166	**F 166** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the Federal and State law. 1. The facility failed to resolve a grievance with Resident #21 in a timely manner. Resident #21 will be reimbursed for missing dentures. 2. All residents who file a grievance have the potential to be affected by this deficient practice.	3/7/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/3/16

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 166	Continued From page 1 #21 was discharged to assisted living on 02/05/15. Resident #21 was admitted to the facility on 10/16/15. Diagnoses for Resident #21 included but are not limited to: Dysphagia (a swallowing disorder) and Generalized Muscle Weakness secondary to Influenza (flu). Resident #21 was admitted to skilled care for rehabilitation for strengthening so that she could return to her assisted living facility. The Admission MDS (Minimum Data Set - an assessment protocol) with an ARD (assessment reference date) of 01/22/15 coded Resident #21 as having a BIMS (Brief Interview for Mental Status) Score of 11 of 15 indicating cognition was moderately impaired. An interview was conducted with Resident #21's daughter on 01/22/16 at approximately 10:55 a.m. The daughter was listed as Resident #21's emergency contact and was the complainant alleging that Resident #21's lost dentures was not investigated. The complainant stated: she spoke with many people asking about the dentures. She stated: she spoke with the social worker, the kitchen staff and the laundry staff. She stated that she also spoke with the administrator in 2015 who she stated "he wrote something on a yellow legal pad and told me he would follow up. He never did." The complainant requests a reimbursement for expense of purchase of new dentures that her mother has already obtained as she needs them to eat properly. The daughter states: "I haven't heard anymore from the facility." An interview was conducted with the Social	F 166	3. An audit of all grievances was completed by the Administrator to ensure they were resolved in a timely manner. 4. The Administrator or designee will develop a grievance log. All grievances will be time dated and resolved within 5 business days, informing all parties involved with the grievance. All grievances and resolutions will be reviewed in monthly QAPI meetings for timeliness. 5. Completion date will be 7 **March 2016.**	3/7/16

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F 166	Continued From page 2	F 166		

Worker (employee other #6) on 01/22/16 at approximately 10:55 a.m. Social Worker (SW) stated: "Let me look at my notes. I don't recall anything. I remember ordering a wheel chair for the resident and that she was discharged next door to assisted living facility."

An interview was conducted with the Unit Manager RN # 1 on 01/22/16 at approximately 11:05 a.m. RN #1 stated: "She had upper and lower dentures. Her daughter stated they were lost. I know she had gone to hospital and then returned. I recall that we looked in the kitchen. A reimbursement request went to the administrator who is no longer here."

An interview was conducted with the Team Leader of the Kitchen staff (other #2). Employee #2 stated: I recall searching the tray and even the trash and when I didn't find the dentures I told the nurses station that I did not find them. I don't recall who I spoke with."

An interview was conducted with the Facility Administrator #1 on 01/22/16 and the Director of Nursing (DON) at approximately 10:30 a.m. Neither report having knowledge of the missing dentures.

An email document dated 02/13/15 with time of 4:42 p.m. from the administrator of the facility in 02/2015. It stated in part: "I wasn't aware that (resident #21 daughter) reported us to the State. As soon as I was notified I put out a thorough search the day she spoke to me in the hallway. I called her back promptly to inform her we did not find the teeth. I even called the CNA (certified nursing assistant) who was out on FMLA (family medical leave)... To avoid any further problems

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F 166	Continued From page 3 with State, let's pay for the teeth. Do you want me to call her?" An interview with the facility's current administrator #1 was conducted on 01/22/16 at approximately 1:00 p.m., a year after Resident #21's lower denture set was lost. Administrator #1 stated: "I have talked with daughter and agreed to reimburse." A call from daughter on 01/25/16 at approximately 1:15 p.m. was received and the daughter states: "The administrator has called and asked for our address and reports he will be reimbursing for the lower dentures." A policy related to grievances was requested on 01/23/16 at approximately 9:45 a.m., from the DON. No policy had been received as of briefing. The admission agreement was reviewed. Under section IV Rights and Responsibilities of the Facility section C. Personal Effects: it read in part: ...The Facility will not be liable or responsible for loss or damage of any personal items, including valuables, money, clothing, special equipment, eye glasses, dentures, hearing aids....or any other personal items in the possession or custody of the Resident. The facility administration consisting of the Administrator #1, the DON #2, and the Corporate RN consultant #4 were updated on the findings during a briefing on 01/23/16 at approximately 1:45 p.m. No further information was provided. COMPLAINT DEFICIENCY	F 166		

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F 371	Continued From page 4	F 371		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility document reviews, the kitchen staff failed to prepare, distribute, and service food in a sanitary manner. The findings include: During the facility survey, conducted from 01/20/16 through 01/22/16 multiple observations were made of the kitchen. 1. During the initial tour of the kitchen conducted on 01/20/16 at approximately 2:55 p.m. the Dietary Aide #5 and the Cook # 4 did not have facial hair covered. When Dietary Aide #5 was asked if today was the first day he learned that he needs to have facial hair covered, he stated: "I plead the fifth." Cook #4 was asked if he knew to wear a covering over his short mustache, he stated: "You can see this is very short, I don't need a mask, and I have trouble breathing from this."	F 371	**F 371** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the Federal and State law.	

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F 371	Continued From page 5 An interview was conducted with Food Service Director #1 on 01/20/16 at approximately 3:00 p.m. He was asked if his staff knew to wear coverings over their facial hair. He stated: "Yes." 2. On an observation during the initial tour conducted on 01/20/16 at approximately 2:55 p.m and again on 01/21/16 at approximately 11:30 a.m. the cook stove top was observed to have a substance looking like grease all over the top. When the temperature control knob was pulled off, it was observed to have a large amount of caked on grease on the handle and under the handle. An interview with the Food Service Director was conducted at each observation, he stated: "It needs to be cleaned." On the second day observation, the Food Service Director #1 requested a dietary aide to "scrub this area again." On 01/20/16 at approximately 2:55 p.m. and again on 01/21/16 at approximately 11:30 a.m. the grease trap was observed to be extremely soiled with grease and hunks of debris. An interview with the kitchen Team Leader #2 was conducted on 01/21/16 at approximately 11:30 a.m. The Team Leader stated: "The trap needs a screen to collect the hard particles coming out of the grease drain. With a screen, we could empty the particles. The rim is white and old and it shows dirt." The Food Service Director #1 was shown the drain on 01/22/16 at approximately 1:15 p.m., with the Administrator #1. The Administrator stated: "I see what you mean about the grime and I can understand the need for a screen. Our building is old and there are several things that need to be replaced. I understand that this could be an area rodents would like."	F 371	1. The stove temperature control knob and floor drain (grease trap) observed during kitchen survey have been removed and cleaned of food debris and grease. Education of the kitchen staff present on the day of these observations has been completed. The two staff members (Dietary Aide #5 and Cook #4) observed without all facial hair covered have been in-serviced on use of hair/beard coverings. The expired cheese spread observed to be expired was discarded during the survey rounds. The missing puree bread was made and provided to residents on puree diets before end of meal. Cook #4 was in-serviced on following puree recipes and how to read the diet spreadsheets by meal. 2. All residents that are potentially at risk to be affected	

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F 371	Continued From page 6 3. An observation was made during the initial kitchen tour on 01/20/16 at approximately 2:55 p.m. of the refrigerated area. A 5 pound container of cheese spread was on the shelf with an expiration date of 1/2/16. The Food Service Director #1 was questioned if the cheese spread should be there, he stated: "No, it should be removed." He immediately removed the cheese spread container. 4. During an observation of the lunch food temperatures being taken and of the plating of the lunch menu. the puree food plate was observed not to have the listed bread item pureed. After the tray was completed and topped with the lid to go out to the unit, the Food Service Director #1 was notified that the tray did not have bread pureed on it. He was asked if it should have bread pureed as the menu stated. He stated: "yes, we will get bread pureed for the pureed diets." A document provided by dietary for the Nutrition Information for A #16 scoop serving size for sliced wheat bread was reviewed. It noted that the serving of pureed bread contained 69 calories, 1 Gram of total fat, 14 Grams of Carbohydrate and 2 Grams of Dietary Fiber and 2 Grams of Protein. This nutrient value would have been omitted by the residents requiring pureed diet. 5. During an observation of the lunch food plating observed on 01/21/16 at approximately 11:30 a.m. the pureed food was noted to be inconsistent. The potatoes were stiff and the beets were runny. The cook #3 was asked how he made the pureed foods. He stated: "Some of the patients like their food runny and some like it thick. It changes based on what the patients	F 371	3. All Dining Services Staff will be educated on appropriate sanitation practices and puree therapeutic diet requirements to include use of beard/hair restraints, daily cleaning, daily rounding, understanding and use of recipes and interpreting menu spreadsheets. Daily rounding and observation form has been revised to more fully incorporate issues observed. 4. The Dining Services Director or designee will review completion of rounding/observation forms daily for 4 weeks and visually inspect for expired food, use of beard/hair coverings, recipe use and puree consistency; then 2 times per week for 8 weeks. Findings will be reported to QAPI. 5. Corrections to be made by: 7 **March 2016**	3/7/1 3/7/1

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F 371	Continued From page 7 want." Cook #3 was asked if he used a specific recipe to ensure consistency of pureed food and he stated: "No." The Food Service Director was asked at that time if he had cooks that used the puree menus. He stated: "Some do." The administration consisting of the Administrator #1, the Director of Nursing #2, and Corporate RN Liaison #4 were updated of the findings during a briefing conducted on 01/22/16 at approximately 1:45 p.m. No further information was provided.	F 371		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interviews and facility documentation the facility staff failed to ensure that essential resident equipment was maintained in a safe and operational manner for 1 of 21 residents in the survey sample (Resident #14). The facility staff failed to ensure that the sit to stand lift was maintained in a safe and operational manner for Resident #14. The findings include: Resident #14 was admitted to the facility on 10/16/15. Diagnoses included but were not limited to: COPD (Chronic Obstructive Pulmonary Disease - a disease resulting in	F 456	**F 456** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the Federal and State law.	

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F 456	Continued From page 8 difficulty breathing) and Diabetes Mellitus (a disease where the body's blood sugar levels are elevated). Resident #14 most recent MDS (Minimum Data Set - an assessment protocol) with an ARD (assessment reference date of 12/25/15 coded Resident #14 as having a 15 of 15 BIMS (Brief Interview for Mental Status) indicating no impairment to her cognition. Resident #14 stated in Group Interview conducted on 01/21/16 between 10:30 a.m. and 11:15 a.m., "the building needs to have more than two sit to stand lifts." She continued to state: "the battery is always dying in the lifts and then staff leave you hanging while they go to the opposite end of the building to find a battery pack from the other lift." In an interview conducted on 01/22/16 at 12:45 p.m., Resident #14 stated: "I know now who knows the trick to lower the sit to stand lift when the battery runs out of juice. I will only let CNAs (certified nursing assistants) who know how to do this trick get me up or down with the lift." Observations were made of the sit to stand lift on the following occasions: 01/21/16 at approximately 4:30 p.m. Bayside Unit: sit to stand in shower room not plugged in for charge 01/22/16 at approximately 12:30 p.m. Bayside Unit sit to stand in hall not plugged in for charge 01/21/16 at approximately 4:35 p.m. Rosemont Unit sit to stand in shower room not plugged in for	F 456	1. The facility failed to use safe operation of the sit-to-stand lift with Resident #14. 2. All residents requiring a sit-to-stand lift can be affected by this deficient practice. 3. All nursing staff members were in-serviced on the safe operation of the sit-to stand lift per the manufacture instructions. 4. The DON or Designee will round weekly for four weeks then monthly for two months on residents requiring the sit-to-stand lift to ensure safe operation of the sit-to- stand lift and report the finding to the monthly QAPI meeting. The Staff Development Coordinator or designee will provided in-services on the safe operation of the sit-to-stand lift to all new nursing employees during their orientation.	3/7/1

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
F 456	Continued From page 9 charge 01/21/16 at approximately 6:45 p.m. Rosemont Unit sit to stand lift in shower room not plugged in for charge 01/22/16 at approximately 12:45 p.m. Rosemont Unit sit to stand in shower room not plugged in for charge. An interview was conducted with CNA #2. She stated: "Quite often the residents have to wait for the sit to stand lift battery pack to be gotten from the other unit when the battery charge goes down. When it happens, I have to get someone either to stay with the resident left in the lift and then one of us goes to the other unit to find the battery pack to hook up so that the lift can be lowered." CNA #2 was asked if she was aware of the emergency method to lower the lift. She stated: "No, can you show me?" The instruction guide for the Sit to Stand Lift provided to the surveyor by the facility notes on page 7: "Mechanical emergency lowering: Pull the red emergency lowering regulator straight upward. The mechanical emergency lowering device functions only when the lift arm is loaded, ... when the patient is in the lift. Lowering starts after a short delay." Resident #14 stated "some of the CNAs know that they can stick a pen into a hole in the machine to lower the lift." This fact is noted in the Lift Instruction Guide on page 11. Resident #14 stated that once she was left hanging while a battery pack was being looked for and it resulted in "underarm soreness for a	F 456	**5. To be completed by 7 March 2016.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495270	A. BUILDING _____ B. WING _____	C 01/22/2016

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F 456	Continued From page 10 couple of days." The two unit sit to stand lifts were observed multiple times unplugged, not being charged which could result in the potential for a resident to be left hanging while a CNA not knowing the emergency lowering techniques looks for the other battery pack. The administration consisting of the Administrator #1, the DON (Director of Nursing) and the Corporate RN Consultant #4 was informed of the findings during a briefing conducted on 01/21/16 at approximately 1:45 p.m. No further information was provided.	F 456		