DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER HAMPTON	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted offsite from 5/5/20 through 5/7/20 and onsite from 5/27/20 through 5/29/20. The facility was in compliance with the requirements for E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced offsite COVID-19 Focused Survey was conducted 5/5/20 through 5/7/20 and onsite from 5/27/20 through 5/29/20. The facility was not in compliance with the requirements for F-880 of 42 CFR Part 483, Federal Long Term Care requirements. No complaints were investigated during the survey. The census in this 86 bed facility was 52 at the time of survey. The survey sample consisted of 2 current resident reviews (Residents #1 and #2). One Residents had tested positive for COVID-19 and was discharged home to quarantine with COVID-19 positive family. This resident had previously tested negative at the hospital prior to discharge to the facility. Seventeen residents were located on the isolation unit because they had been out the facility for specific reasons and they had previously tested negative. No staff tested positive for COVID-19.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		

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

Dr. Zatony a. D. Hughes Administrator 6-15-2020

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 880	Continued From page 1 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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Continued From page 2

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
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 findings included:

1. The facility staff failed to implement their planned screening process to all persons entering the facility and to perform appropriate hand hygiene in accordance to Centers for Disease Control and Prevention (CDC) guidelines when handling blood and/or body fluids.

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F 880	Continued From page 3 On 5/27/20 at 7:00 a.m., two surveyors entered the facility. The screening process was observed and consisted of divulging your name and having a temperature obtained by the facility's staff. An interview was conducted with the screener, Physical Therapist Assistant #1. Physical Therapist Assistant #1 stated the screening process should also include a questionnaire of travel and symptoms indicating a possible acute illness. Physical Therapist Assistant #1 further stated she received training by the facility to include caregiver services and screenings persons entering the facility. Physical Therapist Assistant #1, offered no rationale why the screening procedure as educated was not followed. On 5/27/20 at approximately 7:42 a.m., a Phlebotomist entered Resident #1's rooms to obtain a blood sample for ordered labs. Upon the Phlebotomist entering the resident's room the supply bag was dropped on floor to the left of the entrance. The Phlebotomist proceeded to the resident's bedside, didn't draw the privacy curtain, placed the supplies on the bed, applied gloves, positioned the resident's left arm and obtained the blood sample. The Phlebotomist then removed her gloves began speaking to someone on a cell phone she had with her, gathered her supplies and the blood sample from the bed, picked up her bag of supplies from the floor and proceeded to the nurse's station. At the nurse's station the Phlebotomist continued to have a conversation by cell phone, put the bag which she had dropped on the resident's floor on the desk top, applied the label to the blood specimen, folded the requisition slip and put the items in a biohazard bag. The Phlebotomist still on her cell phone, proceeded in the corridor towards the	F 880	• How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ***No resident directly impacted.*** • How the facility will identify other residents having the potential to be affected by the same deficient practice ***No residents potentially affected.*** • What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: ***All employees assigned to perform entry assessments will be retrained on how to effectively conduct the screening assessments. The training will also include a return demonstration of competency. Training will be provided by the Administrator or designee.*** • How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ***The Administrator or designee will audit the screening process once daily for a week, weekly for four weeks and will continue weekly while the Covid-19 screening process is in place. Any additional concerns identified will be taken to QAPI and reviewed by the committee.*** • The date that each deficiency will be corrected. **June 30, 2020**	

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F 880	Continued From page 4 lobby, stopped at the hand sanitizer mounted outside of Room 102 and proceeded to the lobby. In the lobby she proceeded to the exit door with no check out process. An interview was conducted with the Phlebotomist on 5/27/20 at approximately 8:00 a.m. The Phlebotomist stated the facility requires her to utilized the plastic bag which she dropped on the floor and she didn't complete hand hygiene in the resident's room because there was no hand sanitizer present. The Phlebotomist stated there was a sink present in the room with water and soap but she received a call from her Supervisor and had to take it so she wanted to sanitize her hands. The Phlebotomist stated since the observation was brought to her attention she recognized the infection control breach and would be mindful of the standard precautions in the future. At approximately 8:30 a.m., on 5/27/20 the Business Office Manager was observed entering the facility with a facial mask on and a cell phone in hand. The Business Office Manager went behind the receptionist desk to her office and closed the door. An interview was conducted with the receptionist/screener. The receptionist/screener stated the Business Office Manager should have sanitized her hands, bagged personal belongings, completed a questionnaire of travel, contacts and symptoms with her and had a temperature obtained prior to proceeding to her office. The receptionist/screener offered no rationale why the screening procedure as educated was not followed. The Business Office Manager stated cell phones are exempted from bagging upon entry to the facility. On 5/27/20 at approximately 10:00 a.m., the	F 880	• How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ***The resident has been monitored for 14 days for signs and symptoms of COVID-19. The resident presented without signs and symptoms of COVID-19 or any other infectious disease process.*** • How the facility will identify other residents having the potential to be affected by the same deficient practice ***All residents receiving lab (phlebotomy services) have the potential of being affected.*** • What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: ***Lab personal will be trained on infection prevention and control as well as providing the resident with privacy while services are being rendered. The training will be provided by the laboratory manager or designee.*** • How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. • ***The Administrator or designee will audit the laboratory personnel infection control and prevention techniques daily for a week, weekly for four weeks and will continue weekly while the Covid-19 screening process is in place. Any additional concerns identified will be taken to QAPI and reviewed by the committee.*** • The date that each deficiency will be corrected. **June 30, 2020**	

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F 880	Continued From page 5 above findings were shared with the Administrator, Minimum Data Set Coordinator and Corporate Consultant. The Administrator stated the identified Physical Therapy Assistant and receptionist as well as multiple other staff were educated on Staff Surveillance and Screening process upon entry/exit of the facility. Documentation was presented. The Administrator stated the expectation from screening personnel is to review with all persons entering the facility a list of COVID-19 symptoms, questions of being in other health care settings and if there has been recent travel to specific areas after; proper hand hygiene had been completed and obtain a temperature. The Administrator also stated after speaking with the Phlebotomist she understood the breach in infection control. The Administrator further stated her expectation is for staff to wash their hands before and after interaction with a resident and especially blood and body fluids prior to leaving the resident's room and not utilize cell phones during the commission of care and the Business Office Manager should have bagged the cell phone as well as be screened upon entering the facility per the guidelines. 2a. The facility staff failed to assist Resident #2 to properly don (put on) his face mask while being transported out of the facility as stated per CDC guidance and facility policies. Resident #2 was originally admitted to the facility 5/05/20 from an acute hospital and discharged on 5/28/20. Resident #2 diagnoses included Campylobacter Enteritis and Sepsis. The Admission Minimum Data Set (MDS)	F 880	• How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ***No resident directly impacted.*** • How the facility will identify other residents having the potential to be affected by the same deficient practice ***No residents potentially affected.*** • What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: ***The facility's entry assessment policy will be distributed and reviewed with all employees. The training will also include a return demonstration of competency. The training will be provided by the staff development coordinator or designee.*** • How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ***The Administrator or designee will audit the screening process once daily for a week, weekly for four weeks and will continue weekly while the Covid-19 screening process is in place. Any additional concerns identified will be taken to QAPI and reviewed by the committee.*** • The date that each deficiency will be corrected. **June 30, 2020**	

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F 880	Continued From page 6 assessment with an assessment reference date (ARD) of 5/12/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring a 15 out of 15. This indicated Resident #2's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as needing extensive assistance with bed mobility, transfers, locomotion, dressing, toileting and personal hygiene. Supervision with set-up help with eating. Resident requires physical help with bathing. On 5/27/20 at approximately, 11:00 a.m., Resident #2 was observed sitting on the side of his bed. He stated that he was waiting to be picked for his dialysis appointment. When he was asked if the transportation staff wore their masks, gowns, head and foot coverings when they came to transport him he stated, "No, just the masks." On 5/27/20 at approximately, 11:10 a.m., the transport team of three men arrived into the facility on the Isolation Unit. Upon entrance the Interim Director of Nursing, Administration staff #2, asked them to give their first and last names, she checked their temperatures using the forehead thermometer, while recording the information onto the entrance log. One of the transporters asked, "You got any COVID-19 patients on this unit?" The Administration staff #2 shook her head indicating no. She then asked them to put on the PPE (Personal Protective Equipment) located on the side table near the entrance before proceeding to Resident #2's room. Other Staff #5 (Transporter) entered the unit wearing a surgical mask. No further questions were asked by the Administration Staff	F 880	• How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ***Resident #2 was re-educated on the appropriate way to wear his mask and the importance of wearing the mask.*** • How the facility will identify other residents having the potential to be affected by the same deficient practice ***Residents will be re-educated on the appropriate way to wear their masks and the importance of wearing the mask. The training will be provided by the staff development coordinator or designee.*** • What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: ***Additional signage will be placed at the exit doors that states "No resident is to exit without a mask". Photos of proper use of masks will be placed in the resident rooms.*** • How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ***The Administrator or designee will monitor residents' wearing masks. Monitoring will occur once daily for a week, weekly for four weeks and will continue weekly while the Covid-19 screening process is in place. Any additional concerns identified will be taken to QAPI and reviewed by the committee.*** • The date that each deficiency will be corrected. **June 30, 2020**	

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#2. Resident #2 was placed on a stretcher, rolled out in the hallway and observed to have his face mask between his teeth. His mouth nor his nose was covered by his mask. The facility staff was not present as Resident #2 was being rolled down the hallway. Some nurses were observed sitting or standing around the nurse's station during the Resident's departure. Other staff #5, punched in a code at the entry door and as they exited the building.

On 5/28/20 at approximately 1:15 p.m., an interview was conducted with CNA (Certified Nursing Assistant) #1. When asked, what PPE (Personal Protective Equipment) should Resident #2 be wearing when leaving the facility? CNA #1 stated, "A mask," "Residents only wear a mask if being transported out," "Before they leave their room," and "We are in the room when transportation arrives."

On 5/28/20 at approximately 1:40 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1 concerning the above issue. She was asked if residents are responsible for putting on their own masks. LPN #1 stated, "The nurses will put on their masks," "The residents are aware they need to wear their masks when leaving their rooms."

On 5/28/20 at approximately 4:20 p.m., an interview was conducted with the Interim Director of Nursing concerning the above issues. She stated, Resident #2 "Was re-educated on the proper way of wearing his mask when he returned from dialysis on yesterday (5/27/20)." "He says that he doesn't like wearing his mask." A review of nursing notes from date of admission (5/5/20-5/28/20) showed no record of the resident

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Continued From page 8 receiving education from facility staff concerning non-compliance of wearing his mask and there was no problem identified in Resident's Care plan indicating that he had been educated on being non-compliant with wearing his mask.

On 5/29/20 Resident #2's Careplan had been updated with the following: Careplan Focus Reads: Problem-Resident noncompliant with wearing face mask. Goal: Resident to wear his face mask and understand the benefits of wearing it will be reviewed in the next 90 days. Interventions: Staff will educate resident on the importance of wearing a mask when he leaves the room and continue to educate. This was added to the Careplan on 5/29/20 after the above incident had already occurred.

2b. The facility staff failed to implement their screening process to persons entering the facility's isolation unit according to CDC and facility guidelines.

On 5/27/20 at approximately, 11:10 a.m., a medical transport team of three men arrived to the facility on the Isolation Unit. Upon entrance the Administration staff #2 (Interim Director of Nursing) asked them to give their first and last names, then checked their temperatures (using the forehead thermometer) while recording the information in the entrance log book. She then asked them to put on the PPE (Personal Protective Equipment) located on the side table at the entrance before proceeding to Resident #2's room. Other Staff #5 (Transporter) entered the unit already wearing a surgical mask. No further questions were asked by the Administration Staff #2. The three medical transporters heading to Resident #2's room. Each one was asked do you

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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) COMPLETION DATE
F 880	Continued From page 9 normally put on a gown, mask, Head coverings and Shoe coverings? Transporter #5 (Other staff #5) stated, "I usually just wear my mask." Transporter #6 (Other staff) stated, "I don't know, this is my first day on orientation." Transporter #7 (Other staff #7) stated, "I usually just wear a mask." On 5/28/20 at approximately 1:15 p.m., an interview was conducted with CNA (Certified Nurses Aide) #1. She was asked what was the screening process for vendors or transport entering the unit and she stated, "We have only one entrance, after they ring the door bell, we take their temperature and give them a mask." On 5/28/20 at approximately 1:40 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1 concerning the screening process. She was asked to explain how information is relayed to transporting provider for resident on isolation and how is transportation screened. She responded, "We inform them if we have COVID cases," "We check temps, asked for signs and symptoms, get their names, make sure they wear gloves, booties, gowns, mask and bonnets," "We don't have all of the same transporters coming in." On 5/28/20 at approximately 4:20 p.m., an interview was conducted with Administrative Staff #1 (Interim Director of Nursing) concerning the COVID-19 Screening process. She was then asked if she had asked the transporters the required screening questions during the screening process on yesterday. She stated, "No, I did not it's my fault." She was asked what should have been done. "I should have asked them if they had fevers, shortness of breath, redness,	F 880	• How corrective action will be accomplished for those residents found to have been affected by the deficient practice. ***No resident directly impacted.*** • How the facility will identify other residents having the potential to be affected by the same deficient practice ***No residents potentially affected.*** • What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: ***All employees assigned to perform entry assessments will be retrained on how to effectively conduct the screening assessments. The training will also include a return demonstration of competency. Training will be provided by the Administrator or designee.*** • How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. ***The Administrator or designee will audit the screening process once daily for a week, weekly for four weeks and will continue weekly while the Covid-19 screening process is in place. Any additional concerns identified will be taken to QAPI and reviewed by the committee.*** • The date that each deficiency will be corrected. **June 30, 2020**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	05/29/2020

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diarrhea, not feeling well, have they traveled Washington, NY, California or had close contact with people."

On 5/29/20 at approximately 12:56 p.m., a telephone interview was conducted with Registered Nurse, Educator (Corporate staff #1) she was asked what questions should the screener ask transporters coming into the building? She said, "It should be the same for everyone." "I have to go back and look." "CDC (Centers of Disease Control) and VDH (Virginia Department of Health) tells you. "I'll call you back."

On 5/29/20 at approximately 1:14 p.m., the telephone interview was conducted with Registered Nurse, Educator. When asked if she could you send the surveyor a copy of the screening log dated 5/27/20 as well as last weeks screening, she responded, "I will email you the transport sheets (screening documents) concerning Resident #2."

On 5/29/20 at approximately 2:25 p.m., a phone call was received from Registered Nurse Educator concerning the above information. She stated that the transport sheets were emailed only for 5/27/20 because "Initially the pick-up transport did not come into the building." "If medical transport had to transport a resident, they waited outside for resident to be wheeled out by staff."

The Internal Tracking log was received from Registered Nurse (corporate staff #1) on 5/29/20 at approximately, 2:40 PM via secure email. The tracking log lists the Name, phone/email, Where you can be reached, Reason for Visit, Medicaid

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Transport, Time In, Record of Temperature, Outcome, Staff to record if they work at another healthcare setting (Note if COVID 19 was detected). A review of Internal Tracking log showed that the transport team that entered into the facility on 5/27/20 listed three names, reason for visit was listed as Medicaid Transport, time in was listed as 11:10 a.m., temperatures were recorded, Cleared to enter facility or not cleared to enter was listed as "C".

The nursing facility's COVID-19 plan incorporated visitor and employee screening which included:

POLICY-Life Care -Staff and Non-Staff Screening for COVID 19. Original Date: 4/15/20. Policy Statement: (name of the facility) Life Care is committed to the protection of all individuals that present to our facility to receive services or to provide services, included or not limited to staff and non staff members.

It is due to this commitment that all individuals entering any of our facilities, including employees, contractors, agency staff, volunteers, visitors, new admissions, government officials, regional or corporate staff, hospice, EMS, dialysis and lab technicians and any other healthcare professionals will be subject to the screening process.

The screening process is intended to access the presence of symptoms as well as to determine the presence of temperatures that indicate potential previous exposure to the Corona Virus per CDC recommendations.

Building Access: Level 2 "Active" Screening by a (name of the facility); all personnel, essential

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F 880	Continued From page 12 delivery persons, EMT persons are actively screened by a staff member and results logged on facility log. All individuals will be asked the following: 1. Whether appropriate hand hygiene has been practiced upon entry into the building. 2. Whether individual is experiencing the following symptoms: a fever or feeling feverish, sore throat, cough (new) shortness of breath (new) or difficulty breathing (new), reporting a loss of sense of smell and/or taste, visible redness to skin around eyes, any gastro-intestinal symptoms (e.g. diarrhea) Malaise (general discomfort and weakness). 3. Whether individual works or have worked in other healthcare settings. 4. Whether individual has been to Washington State, New York and/or California, or have you had close contact with someone that has traveled to Washington State, New York or California. On 5/29/20 at approximately 3:00 p.m., a pre-exit interview was conducted via telephone. Present were the Administrator, Interim DON, (Director of Nurses) Corporate RN Educator and Long-term Care Manager. The above issues were discussed. The Interim DON stated, "He has been educated on proper use of wearing his mask," and "He has been non-compliant." They were asked if each person that opens the door on either unit was cleared to screen; the Corporate RN Educator stated "Yes, check the in-service education sheet that was provided to you."	F 880		