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 _____	06/29/2020

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

(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 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey was conducted offsite from 5/11/20 through 5/15/20 and onsite 6/29/20. The facility was in compliance with F-880 and F-885 of 42 CFR Part 483 Federal Long Term Care requirements. The census at this 116 certified bed facility was 74 at the time of the on-site survey. On 4/17/20 the facility tested 74 residents. All 74 residents tested negative for COVID-19. After but not as a result of the facility's testing, three residents tested positive for COVID-19. One resident was hospitalized, recovered and returned to the facility after two additional negative COVID-19 test. Two residents remained in the facility where they were quarantined for 14 days and successfully recovered. All three residents currently resided in the facility. The facility's records also indicated approximately 15 staff had tested for COVID-19 independently and at various times. One employee tested positive for COVID-19 on 4/24/20 and was quarantined at home for approximately 45 days. The employee returned to work after two negative COVID-19 test. All residents that were cared for by the employee were quarantined for 14 days and cleared with two negative COVID-19 test before returning to the rooms they had previously resided. A point prevalence survey (PPS) had not been conducted at the facility yet.	F 000		

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.