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 _____	10/15/2020

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

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E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite 10/14/2020. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey was conducted onsite 10/14/2020 and continued with offsite review through 10/15/2020. The facility was not in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 116 certified bed facility was 64 at the time of survey. 53 Residents had tested positive for COVID-19; 1 Resident recovered from COVID-19. 25 staff had tested positive for COVID-19; 21 staff recovered from COVID-19. 5 Residents expired related to COVID-19. At the time of the survey, 44 Residents and 5 staff were currently positive for COVID-19.	F 000		
F 880 SS=D	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 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880	1. Resident #1 and Resident # 2 have been monitored and remained asymptomatic for Covid. CNA #1 and CNA #2 were immediately educated on the use of gloves when assisting covid positive residents when eating. CNA # 2 was also educated immediately on how to handle a contaminated object when it falls on the floor. 2. All residents have the potential to be affected by this defficient practice.	

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

Administrator | 10/27/2020

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 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. (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	F 880	3. All nursing staff will be educated on infection control prevention and how to prevent the transmission of communicable diseases and infection. 4. QA/designee will audit 3 CNA's at least 4 times a week during meal time and when assisting residents' with eating and passing trays for compliance with infection control procedures. Staff will be educated immediately if variances are observed. Analysis of audits will be reported to the Director of Nursing and Administrator. Summary of findings will be reported to the QA committee monthly x 3 months and then quarterly until deficient practices are resolved. 5. Staff eduaction will be completed by October 30, 2020.	

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F 880	Continued From page 2 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, staff interviews and clinical record review the facility staff failed to maintain infection control and prevention practices to ensure a sanitary environment to help prevent the development and transmission of communicable diseases to unserved food on the meal cart; and failed to ensure infection control practices were followed during feeding for 2 of 5 residents in the survey sample (Residents #1 and #2) on the COVID-19 positive unit. The findings included: 1. On 10/14/2020 at approximately 12:00 p.m., during tour of the COVID-19 positive unit, Certified Nursing Assistant (CNA) #1 was observed standing in front of the meal cart removing a meal tray. CNA #1 was trying to remove the styrofoam tray that was inside of the hard meal tray when the hard meal tray slid down out of the meal cart and the edge of the tray	F 880		

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F 880	Continued From page 3 landed on the floor. CNA #1 picked the hard meal tray up and slid it back into the meal cart. CNA #1 delivered the meal that was on the styrofoam tray. It was observed that there was one unserved meal tray still on the meal cart. CNA #1 returned to the meal cart and was observed removing the unserved meal tray from meal cart and walked down the hall to a resident's room. An interview was conducted with CNA #1 on 10/14/2020 at approximately 12:05 p.m. When reviewing the above observations with CNA #1, CNA #1 stated, "I should have put it (the tray that touched the floor) up on the top of the cart." On 10/14/2020 at approximately 1:15 p.m., the Administrator and Director of Nursing were made aware of above observations. On 10/15/2020 at 4:25 p.m., the Administrator, Director of Nursing and Clinical Managers were made aware of the findings at the exit meeting. No further information was provided about the findings. 2. Resident #1 was admitted to the facility on 05/30/2018. Diagnoses included but were not limited to, Alzheimer's Disease and Type 2 Diabetes Mellitus. Resident #1's Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 09/23/2020 was coded with a BIMS (Brief Interview for Mental Status) score of 03 indicating severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #1 as requiring total dependence of 1 with bed mobility, transfer, dressing, eating, toilet use,	F 880		

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F 880	Continued From page 4 personal hygiene and bathing. On 10/14/2020 at approximately 9:00 a.m., an interview was conducted with the Administrator and when asked how many residents were positive for COVID-19 are in the facility, Administrator stated, "Forty-four residents are positive." The Administrator stated that the residents on the unit on the left side of the facility all tested negative for COVID and the residents that tested positive for COVID were on the Bayside Unit on the right side of the facility. A list of all residents positive for COVID-19 was requested. On 10/14/2020 at approximately 9:30 a.m., the Administrator provided listing of all residents in facility which read as follows: "Sentara Life Care Virginia Beach Daily Census Date 10/14/2020 Total Census: 64; Total SNF (Skilled Nursing Facility): 8; BAYSIDE COVID POSITIVE UNIT = 44 ROSEMONT COVID NEGATIVE UNIT = 20." During tour of Bayside COVID-19 positive unit on 10/14/2020 at approximately 12:15 p.m., Certified Nursing Assistant (CNA) #1 was observed sitting at Resident #1's bedside and feeding the resident her lunch. CNA #1 was observed not wearing gloves. On 10/14/2020 at approximately 12:25 p.m., an interview was conducted with the Clinical Manager on Bayside COVID-19 positive unit. When asked if staff should wear gloves when feeding residents, the Clinical Manager stated, "Yes, they should wear gloves when feeding." When asked why the staff should wear gloves when feeding the resident, the Clinical Manager stated, "Because of the spores, transmission."	F 880		

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F 880	Continued From page 5 The Clinical Manager was made aware of the observation details. On 10/14/2020 at approximately 1:15 p.m., during a briefing the Administrator and Director of Nursing were made aware of above observation. The Administrator stated, "They should have been wearing gloves." On 10/15/2020 at approximately 3:00 p.m., a telephone interview was conducted with the Director of Nursing, when asked what PPE (Personal Protective Equipment) did she expect the staff to wear when feeding residents on the COVID-19 unit, Director of Nursing stated, "Some residents don't want staff to wear gloves, dignity issue. I would encourage the staff to wear gloves when feeding. Both of the employee's that you reported had tested positive before." Both employees had tested positive however they both had recovered effective 10/06/2020. On 10/15/2020 at 4:25 p.m., the Administrator, Director of Nursing and Clinical Managers were made aware of the findings at the exit meeting. No further information was provided about the findings. 3. Resident #2 was admitted to the facility on 05/31/2019. Diagnoses included but were not limited to, Dementia and Hypertension. Resident #2's Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 10/01/2020 was coded with a BIMS (Brief Interview for Mental Status) score of 03 indicating severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #2 as requiring total dependence of 1 with bed mobility, transfer,	F 880		

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F 880	Continued From page 6 dressing, eating, toilet use, personal hygiene and bathing. During tour of Bayside COVID-19 Positive Unit on 10/14/2020 at approximately 12:20 p.m., Certified Nursing Assistant (CNA) #2 was observed sitting at Resident #2's bedside and feeding the resident his lunch. CNA #2 was observed not wearing gloves while feeding the resident. On 10/14/2020 at approximately 12:25 p.m., an interview was conducted with the Clinical Manager on Bayside COVID-19 positive unit. When asked if staff should wear gloves when feeding residents, the Clinical Manager stated, "Yes, they should wear gloves when feeding." When asked why the staff should wear gloves when feeding the resident, the Clinical Manager stated, "Because of the spores, transmission." The Clinical Manager was made aware of the observation details. An interview was conducted with CNA #2 on 10/14/2020 at approximately 12:30 p.m. When asked, "Did you feed Resident #2 in room (number) lunch?" CNA #2 stated, "Yes." When asked, "Were you wearing gloves when you fed Resident #2?" CNA #2 stated, "No." When asked "Should you have worn gloves when you fed Resident #2?" CNA #2 stated, "I had just washed my hands. Should I have worn gloves?" On 10/14/2020 at approximately 1:15 p.m., during a briefing the Administrator and Director of Nursing were made aware of above observation. The Administrator stated, "They should have been wearing gloves."	F 880		

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F 880	Continued From page 7 On 10/15/2020 at approximately 3:00 p.m., a telephone interview was conducted with the Director of Nursing, when asked what PPE (Personal Protective Equipment) did she expect the staff to wear when feeding residents on the COVID-19 unit, Director of Nursing stated, "Some residents don't want staff to wear gloves, dignity issue. I would encourage the staff to wear gloves when feeding. Both of the employee's that you reported had tested positive before." Both employees had tested positive however they both had recovered effective 10/06/2020. On 10/15/2020 at 4:25 p.m., the Administrator, Director of Nursing and Clinical Managers were made aware of the findings at the exit meeting. No further information was provided about the findings.	F 880		