STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

(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 onsite 09/30/2020 and continued with offsite review from 10/01/2020-10/02/2020 and 10/05/2020. 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 09/30/2020 and continued with offsite review 10/01/2020-10/02/2020 and 10/05/2020. 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 120 certified bed facility was 75 at the time of survey. Eleven Residents had tested positive for COVID-19. Eight Residents had recovered from COVID-19 (7 in house and 1 discharged home). Nineteen Staff had tested positive for COVID-19. Nineteen Staff had recovered from COVID-19. Three Residents expired related to COVID-19 (1 expired in the facility and 2 expired in the hospital). At the time of survey there were no COVID-19 positive Residents or Staff.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		11/16/20

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

Electronically Signed | 10/22/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

(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 580	Continued From page 1	F 580		

representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

(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 580	Continued From page 2 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility documentation review the facility staff failed to ensure 1 of 3 Resident representatives (for Resident #1) was notified of a positive COVID-19 test result timely. The findings included: Resident #1 was originally admitted to the facility on 06/05/2020 and was discharged to the hospital on 06/30/2020. Resident #1 was readmitted to the facility on 07/11/2020, discharged to the hospital on 09/06/2020 and readmitted to the facility on 09/10/2020. Diagnoses included but were not limited to, Diabetes Mellitus and Heart Failure. Resident #1's Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 09/17/2020 coded Resident #1 with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. On 09/30/2020 at approximately 12:00 p.m. a copy of the facility COVID-19 positive Line Tracker was received from the Administrator and revealed the following information regarding Resident #1: Date Tested: 08/10/2020 Date of Result Notification: Resident was asymptomatic. Date of Negative Result: BLANK SPACE STATUS: Resident recovered and is now LTC (Long Term Care) (9/17). On 09/30/2020 review of Resident #1's clinical	F 580	The creation and submission of this Plan of Correction serves as written validation of regulatory compliance. Preparation and submission of this plan does not constitute an admission or agreement by Sentara Rehabilitation and Care Residence Chesapeake (Provider) of the truth of the facts alleged or the correctness of the conclusions set forth by the survey agency. This plan of correction is solely prepared because of the requirements set forth by state and federal law, and to demonstrate the good faith attempts by the Provider to improve the quality of life for each resident entrusted to our care. 1. Resident was educated on 08/08/20 by the Nurse Practitioner that a room change was occurring due to a potential exposure to COVID-19. Resident was placed on isolation precautions and a Polymerase Chain Reaction (PCR) swab was used to test for COVID-19. Resident #1 was identified as having a positive COVID-19 diagnosis on 08/10/20. Resident was educated by Medical Director on COVID-19 and positive diagnosis on 08/14/20. Resident's responsible party was notified by Administrator on 10/23 of resident #1's history of COVID from 08/10/20 and responsible party stated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

(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 580	Continued From page 3 record revealed the following: Review of Providers Narrative Progress Note revealed the following: Date of Visit: 08/08/2020 Reason For Visit: Progress Note Progress Note: Resident seen in medical follow up for COVID-19 testing. It was noticed today that she is in the same suite as a patient who just tested positive for COVID-19. The patients have been in their separate rooms without sharing the bathroom however given the proximity and sharing of staff members we wanted to test (Resident Name) to make sure she was not compromised...COVID-19 testing. Review of Physician Clinical Notes Report E-Signed (Electronically Signed) 08/20/2020 revealed the following: Effective Date Author: 08/14/2020 NEW DIAGNOSIS / INTERVAL HX (History) / TEST: *** regarding patient's recent lab results. Patient noted to be COVID 19 positive on 08/10/20. Patient currently in isolation and appropriate steps being taken with staff. Clinical Notes Report for the period of 08/08/2020 through 08/12/2020 was reviewed and no evidence that resident representative was notified of Resident #1's positive COVID-19 test results. Review of Daily Skilled Nurse's Notes for the period of 08/08/2020 through 08/15/2020 was reviewed and there was no evidence that the resident representative was notified of Resident #1's positive COVID-19 test results. On 09/30/2020 at approximately 2:00 p.m., an interview was conducted with the Administrator regarding Outbreak Testing. When asked if the staff document when residents test negative the	F 580	they had received notification at the time of testing as well as with results but could not recall specific details around this notification. Documentation placed in resident medical record to reflect this conversation. 2. A 100% audit was conducted on all residents who had a positive diagnosis for COVID-19 as well as a random sample of residents with changes in condition and there were no other variances found. 3. The nursing staff will receive re-education on Sentara Life Care's Policy on Notification of Changes in Condition. 4. Clinical Educator or designee will conduct weekly audits x30 days, bi-weekly x30 days, and monthly thereafter on residents who are identified as having a change in condition to ensure notification of the change has been made to the Responsible Party/POA and those residents identified as responsible for self. Aggregate findings will be analyzed, and any adverse findings immediately corrected. Findings and any applicable corrections will be presented and recorded in the monthly Quality Assurance and Performance Improvement (QAPI) meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

(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 580	Continued From page 4	F 580		

Administrator stated, "They are inconsistent unless on the COVID Unit. The staff notify the responsible party, family when the resident test positive and they document in the nurse note."

On 09/30/2020 at approximately 2:45 p.m., an interview was conducted with the Clinical Manager. When asked who contacts the family, resident representative when a resident test positive for COVID-19, the Clinical Manager stated, "If a resident is positive I think the doctor or Administrator calls the family."

On 10/01/2020 requested copy of Policy and Procedure on Notification of Resident Changes.

On 10/02/2020 received the facility policy and procedure titled "Life Care - Notification of Changes in Condition." Review of the policy and procedure revealed the following: Revision Date: 02/11/2020 Required Action Steps: 3. "The nurse on duty will notify the Practitioner and Resident / Legal Representative / Family Member when there is a need to alter treatments or a change in condition is noted."

On 10/05/2020 at approximately 2:00 p.m., an interview was conducted over the telephone with the Clinical Manager. When asked if she was able to find any documentation stating that Resident #1's representative was notified of her positive COVID-19 test results, the Clinical Manager stated, "I did not see it in the nurses notes. I don't remember seeing anything on (Resident Name)."

On 10/05/2020 at approximately 3:25 p.m., during a briefing the Administrator was made aware of finding. No further information was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

(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 580	Continued From page 5 presented about the finding.	F 580		
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 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	F 880		11/16/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

(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 6 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 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 interview, clinical record review and facility documentation review, the facility staff failed to ensure infection control measures were consistently implemented to prevent the development and/or transmission of a communicable disease (COVID-19). The facility staff failed to conduct active screening of staff for COVID-19 when entering the facility.	F 880	1. Staff were educated on the importance of accurately completing the SLC Daily Internal Tracking Facility Access Log. Facility has implemented a facility representative who is present at employee entrance who actively screens employees and ensures the tracking and facility log is completed fully and there are no blanks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

(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 7 The findings included: On 09/30/2020 at approximately 10 a.m., requested that the Clinical Manager provide directions to the entrance where staff enter when coming into work. The Clinical Manager accompanied the surveyor to the back entrance of the facility. At the back entrance was an area with overbed tables lined up against the wall along with a tracking log. Observed a staff member cleaning a thermometer with wipes. When the Clinical Manager was asked who was screening staff at the back entrance when entering the facility, the Clinical Manager stated, "Staff are checking their own temperatures." The Clinical Manager also stated, "The Infection Control Nurse goes around and checks the staff's temperatures again at noon and their temperature is checked before they leave work." Surveyor requested copy of the tracking log for the period of 09/29/2020 and 09/30/2020. Received a copy of Daily Internal Tracking Facility Access Log on 09/30/2020. Review of the log revealed the following: Column "Time In" not consistently documented; Column "Outcome" (Cleared to enter, Not cleared to enter, Employee Health Notified) not consistently documented; Column "TEMP (Temperature) at 1/2 (Half) Way point of shift" not consistently documented; Column "Time Out" not consistently documented; Column "RECORD TEMPERATURE TAKEN" not consistently documented. On 09/30/2020 at approximately 3:15 p.m., an interview was conducted with the Clinical Manager with the Administrator present, when asked if the Clinical Manager stated that the staff	F 880	During off-peak times there is a posted sign at the employee entrance which gives the telephone number of whom to call to have someone come to actively screen the employee upon entrance. 2. All residents and staff have the potential to be at risk if an employee fails to complete the proper screening protocol. 3. Education being completed facility wide on new protocol for screening employees, vendors and visitors when entering the facility. Facility transitioning to new company and education will be conducted again once the facility adopts new COVID-19 Policies and Procedures. 4. Clinical Educator or designee will conduct weekly audits x90 days of employee, vendor and visitor entrance screenings. Aggregate findings will be analyzed, and any adverse findings immediately corrected. Findings and any applicable corrections will be presented and recorded in the monthly Quality Assurance and Performance Improvement (QAPI) meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495215	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA REHABILITATION & CARE RESIDENCE-CHESAPEAKE	776 OAK GROVE RD PO BOX 1277 CHESAPEAKE, VA 23320

(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 8 check their own temperature and screen themselves when they come in to work, the Clinical Manager stated, "Yes, they've been doing it so long they know what to do." On 09/30/2020 a copy of facility policy and procedure on staff screening process was requested and received. The facility policy titled - Life Care - Staff and Non-Staff Screening for COVID-19 Procedure Original Date: 04/15/2020 Revision Date: 07/16/2020 Purpose: To provide further guidelines on how to effectively conduct staff and non-staff screenings for Covid-19. Refer to Policy for overall commitments. On 10/05/2020 at approximately 3:25 p.m., during briefing the Administrator was made aware of finding. No further information was presented about the finding.	F 880		