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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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 lobby, stopped at the hand sanitizer mounted outside of room [ROOM NUMBER] 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 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 [DATE]. Resident #2 [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) 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 [MEDICAL TREATMENT] 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 #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 [MEDICAL TREATMENT] on yesterday (5/27/20). He says that he doesn't like wearing his mask. A review of nursing notes

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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) from date of admission (5/5/20-5/28/20) showed no record of the resident 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 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, 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 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 [DATE] 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, [MEDICAL TREATMENT] 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 [MEDICAL CONDITION] per CDC recommendations. Building Access: Level 2 Active Screening by a (name of the facility); all personnel, essential 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.