STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495270	A. BUILDING _____ B. WING _____	**10/15/2020**

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

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE]. [DIAGNOSES REDACTED]. 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, 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. 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 [DATE]. [DIAGNOSES REDACTED]. 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, 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. 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.

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.