STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495340	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT NEWS NURSING & REHAB	**12997 NETTLES DRIVE NEWPORT NEWS, VA 23602**

(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 offsite from 6/8/20 through 6/12/20 and onsite and offsite on 6/15/20 and 6/18/20. 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 offsite from 6/8/20 through 6/12/20 and onsite and offsite on 6/15/20 and 6/18/20. The facility was in compliance with F-880 and F-885 of 42 CFR Part 483 Federal Long Term Care requirements. The census in this 102 certified bed facility was 101 at the time of survey. No residents had presented with COVID-19 symptoms and no residents had been tested for COVID-19. Two staff members were tested for COVID-19 and the results was negative. It was reported that the facility will be conducting a point prevalence survey 6/22/20.	F 000		

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