

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/24/2020  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>495340</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                            |                      | (X3) DATE SURVEY COMPLETED<br><br><b>06/18/2020</b> |
|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>NEWPORT NEWS NURSING &amp; REHAB</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>12997 NETTLES DRIVE<br/>NEWPORT NEWS, VA 23602</b>                  |                      |                                                     |
| (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<br><br>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<br><br>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.<br><br>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

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.