PRINTED: 09/23/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		ECONSTRUCTION	(X3) DATE	SURVEY PLETED
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		495201	B. WING	_		09	/09/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PORTSIDE	E HEALTH & REHAB CE	NTER			201 GREENWOOD DRIVE		
				Р	PORTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	COVID-19 Focused S 9/2/2020 and continu through 9/4/20 and 9/ facility was in complia Part 483.73, Required Facilities. INITIAL COMMENTS		F	000			
	was conducted onsite with offsite review 9/3 9/8/20 through 9/9/20 compliance with 42 Control regulations, for Centers for Medicare Centers for Disease 0 practices to prepare f	e 9/2/2020 and continued 8/20 through 9/4/20 and 0. The facility was not in 0. The facility was not in 0. The facility was not in 0. The implementation of The 8. Medicaid Services and 0. Control recommended for COVID-19. One igated during the survey.					
	the survey was 81. The positive for COVID-19 staff members tested 2 recovered. At the times the survey of the surv	14 bed facility at the time of hirty-three residents tested 9 and 21 recovered. Nine positive for COVID-19, and me of the survey, there were and 2 staff positive for the					
	(Residents #1 throug Right to be Informed/ CFR(s): 483.10(c)(1)(§483.10(c) Planning	Make Treatment Decisions	F!	552			
ABORATORYD		ner treatment, including:			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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 75UG11

Facility ID: VA0217

Administrator

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	COMPLETED
		495201	B. WING		C 09/09/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
DODTSIDE	LIEALTU O DEUAD CE	NTED		4201 GREENWOOD DRIVE	
PURISIDE	E HEALTH & REHAB CE	NIER		PORTSMOUTH, VA 23701	
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F 552	Continued From page	e 1	F 55	2	
	§483.10(c)(1) The rig	ht to be fully informed in he can understand of his or s, including but not limited to,		E 552 Dicht to be Informed Make	
	§483.10(c)(4) The rig advance, of the care	ht to be informed, in to be furnished and the type		F 552 Right to be Informed/Make Treatment Decisions	
		ssional that will furnish care.		1. Resident #1, Resident #5, and Res #6 were all made aware of previous	
	advance, by the phys	ician or other practitioner or sks and benefits of proposed		current COVID results.	
	care, of treatment an	d treatment alternatives or I to choose the alternative or		2. All residents are risk when there i effective process in place to notify re	
	option he or she prefe			of COVID-19 laboratory results.	
		is not met as evidenced		DON/designee completed a quality is	review
	by:	tamian, staff interviews and		of all resident records to verify appre	- 1
		terview, staff interviews, and , the facility staff failed to		notification was completed on all Co	
		esident #1, #5 and #6) out of		19 laboratory results. No other resident	
		rvey sample, of COVID-19		were affected by this deficient practi	ce.
	laboratory results for	all COVID-19 test		a post sport 1 i iii 1	
	performed.			3. DON, ADON or designee will edu	
	The findings included			current licensed nursing staff on not residents and/or responsible parties of	
	The infalligs included			COVID-19 laboratory results.)1
	1. Resident #1 was o	riginally admitted to the		CO v ID-13 laboratory results.	
		has never been discharged.		4. DON, ADON, or designee will co	mnlete
		t diagnoses included;		daily quality reviews to ensure resid	•
		hout ascites, anemia and		and/or responsible parties have been	
	chronic diarrhea.			notified of COVID-19 laboratory res	
	The quarterly Minimu	m Data Set (MDS)		Variances will be reviewed for patte	
		assessment reference date		and/or trends, staff re-educated when	
		d the resident as completing		deficient practice is identified and re	
	the Brief Interview for	Mental Status (BIMS) and		reported to QAPI for input and guide	
		ossible 15. This indicated			1
	Resident #1's cognition making were intact.	ve abilities for daily decision		5. Date of Compliance: 10/08/2020	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDIN		IPLE CONSTRUCTION	(X:	(X3) DATE SURVEY COMPLETED C		
		495201	B. WING_			09/09/2020
	ROVIDER OR SUPPLIER E HEALTH & REHAB C E	NTER		STREET ADDRESS, CITY, STATE, ZIP COD 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 552	On 9/2/20 at approxin #1 was observed star of (number of the roo his hands above his I staff near the nurse's cart. A total of 4 staff with the food tray ser unable to get their att proceeded to say, "I vinfection test, I had a about seven days aganything about the restated, "I had two frie friends), who lived in they are gone. We witime together; I believ no one will tell me, I v#1 also stated "I slep tired, I'm not hungry, therapy. Yesterday I I today." On 9/2/20, at approximateries was concassistant (CNA) #1.0 were present in (numaccepted the assignment one mentioned anyth residents. Resident #1 was integrowing assessed him of the staff of the responded to test, assessed him of the staff of the root his hand approximately 3:00 pone had responded to test, assessed him of the staff of the root his hand approximately 3:00 pone had responded to test, assessed him of the root has a staff of the root had responded to test, assessed him of the root had responded to test, assessed him of the root had responded to test, assessed him of the root had responded to test, assessed him of the root had responded to test, assessed him of the root had responded to test, assessed him of the root had responded to test, assessed him of the root had responded to	mately 12:25 p.m., Resident ading in the hallway outside m), without a mask, waving head and yelling out to the station with the food service were observed assisting vice and Resident #1 was ention. Resident #1 want another COVID test completed last week, or and no one has said sults." The resident further ands (stated the names of the (number of the room), and ere close and spent a lot of the they have the infection but want another test." Resident at for 14 hours and I am still and I was unable to do had a headache but not mately 12:44 p.m., and fucted with Certified Nursing CNA #1 stated no residents ber of the room), when she ment that morning and no ing about the previous rviewed again on 9/2/20 at m. Resident #1 stated no on his request for another reven spoken with him if weakness, sleeping for any hungry or about	F 5	552		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	' '	E SURVEY PLETED
		495201	B. WING			1	C /09/2020
	ROVIDER OR SUPPLIER E HEALTH & REHAB CE	NTER		420	REET ADDRESS, CITY, STATE, ZIP CODE D1 GREENWOOD DRIVE DRTSMOUTH, VA 23701		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ON SHOULD BE HE APPROPRIATE	
F 552	Review of facility recordose friends (Resider of the room) were no observation of Resider revealed storage of management of Review of Resident # laboratory results for which was completed dated 6/16/20 and it magative for genetic nother COVID-19 laborational record. A Social Services Not p.m., read "Resident status in the facility. Four retresident who covide the concerns regarding factor of the resident was informed the test results. A telephone interview Administrator and Dinat approximately 2:45 was also tested for Covide and 9/4/20. Throughout interview and 9/4/20. Throughout if yield the packground repeating the resident was measured to the packground repeating the resident was also tested for Covide and 9/4/20. Throughout if yield the packground repeating the resident the background repeating the resident was measured to the packground repeating the resident was measured to the packground repeating the resident the packgro	and revealed Resident #1's and #10 and #11) in (number longer in the facility. An ent #10 and #11's room nultiple items. 1's clinical record revealed a COVID-19 assay test 6/11/20. The result was evealed the resident was narkers of the virus. No ratory results were on his resident made aware of has tested positive for ade aware of facility protocol 19. Resident encouraged to puestions, comments or acility status". No clinical record read the dof his 6/16/20, COVID-19 are conducted with the encouraged to puestions on 19/16/20, COVID-19 are conducted with the encouraged to puestions on 19/16/20, COVID-19 are conducted with the encouraged to puestions on 19/16/20, COVID-19 are conducted with the encouraged to puestions on 19/16/20, COVID-19 are conducted with the encouraged to puestions on 19/16/20, COVID-19 are conducted with the encouraged to puestion of Nursing on 19/16/20, p.m., revealed Resident #1 DVID-19 on 19/16/20, 8/27/20 at the conversation about of his test results, others in a tedly stated the results were about informing Resident dless if they were negative since the resident was his	F	552			

-	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		495201	B. WING	-		l	09/2020
	ROVIDER OR SUPPLIER E HEALTH & REHAB CE			42	TREET ADDRESS, CITY, STATE, ZIP CODE 201 GREENWOOD DRIVE ORTSMOUTH, VA 23701	09/	03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 552	expressing concerns The clinical record refor the 7/8/20 testing during the 9/7/20, into p.m., that each reside independent laborato form wasn't available had not documented resident's individual r stated the 7/8/20, laboraceived in the facility The following notes or COVID-19 test was or clinical record; 7/11/2 Family/Responsible Funable to reach family member), regarding upon in the facility and mace of COVID-19 and taking Resident has been or encouraged to call arcomments or concern clinical record read the first 7/8/20, COVID-19 Information obtained during the 9/7/20 integral to the facility of the graph of the grap	about receiving the results. Vealed no laboratory results The Administrator stated erview at approximately 2:45 ent didn't receive an ry results form therefore; a to put in the record and staff the results into each ecord. The Administrator oratory results were y 7/11/20. Lelated to the 7/8/20, bserved in Resident #1's 2020 16:15 Party Contact Note Text: ly member (name of family update of COVID-19 status de aware facility protocol. Lilly/Responsible Party mable to reach family mily member), regarding status in the facility and rotocol pertaining to y necessary precautions. Lade aware. Family mytime with questions, las. No documentation in the me resident was informed of	F	5552			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				ATE SURVEY OMPLETED		
		495201	B. WING _			C 09/09/2020
	ROVIDER OR SUPPLIER E HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 552	for the 8/27/20, COV documentation in his informed him of his 0 arrived to the facility The clinical record reseen by his primary papproximately 2:35 pweak, sleeping 16 - expressing he believ because his friends in COVID-19 infection. Note dated 9/3/20 rearoom, both of them green like he is worn too. But he was cheen negative for infection log, it does not show physician's documentation in her during the resident was informed test results during her an interview was con 9/8/20 at approximation stated it's not her during their COVID-19 labors seeing the resident stresults. The physicial documentation in her informed the residen while she was seeing results of his 8/27/20 negative. The following progre Resident #1's clinical Alert Note Text: Pleas	contain the laboratory results ID-19 test and there was no clinical record stating staff COVID-19 test results which 9/2/20. Evealed Resident #1 was obysician 9/3/20, at e.m., for feeling tired and I8 hours per day and ed he had the infection in another room had the The physician's progress ad; "He has friends in other tot COVID-19 infection, ried that he probably got it eked last week, which was in I reviewed his temperature he had fever". The estation didn't state the ed of his 8/27/20, COVID-19 er visit with him 9/3/20. Inducted with the physician on eley 3:30 p.m. The physician on eley 3:30 p.m. The physician of each resident of ratory results but if she is the will talk to them about the in stated there wasn't ar progress note that she tof his COVID-19 results but ghim she likely told him the	F 5	52		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495201	B. WING				09/2020
NAME OF PROVIDER OR SUPPLIER PORTSIDE HEALTH & REHAB	ENTER		4:	TREET ADDRESS, CITY, STATE, ZIP CODE 201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
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negative. He was geractitioner reques without any signs/s. He voiced he was a he watches the new on 9/9/20 at approfindings were share the Director of Nurstated they had no residents and/or at laboratory results. 2. Resident #5 was COVID-19 virus. The results of this test devidence in the clir was notified of infowhich was negative. Resident #5 was a on 8/7/19 with diagonal parkinson's disease Resident #5's mos (MDS) assessmen coded the resident Mental Status (BIM possible score of 1 was cognitively into decision making. On 9/2/20 at approfinterview was conducted the interview was no need the resident the r	COVID Machine Sophia and iven his result. The Nurse ted the test. The resident was symptoms noted by this writer. afraid he had COVID because we and feels it's everywhere". Eximately 4:32 p.m., the above ed with the Administrator and sing. The Director of Nursing policy for notification of athorized representatives of tested on 8/25/20 for the ne nursing facility obtained the en 9/2/20. There was no ical record that the resident med of his own test results a for the COVID-19 virus.	F	552			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUILDI		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
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		495201	B. WING			09/	/09/2020
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PORTSIDI	HEALTH & REHAB CE	NTER			4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTION		(X5)
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F 552	Continued From page		F :	552	2		
	resident would be told result.	d if there was a positive					
	notes from 8/27/20 th and nursing indicated	of Resident #5's progress rough 9/9/20, both physician the resident was engaged					
	him regarding care ar	and shared information with nd services, but no evidence of his COVID-19 status that					
	9/8/20 at approximate stated it's not her duty their COVID-19 labora seeing the resident shape of the stated it's approximate stated it's not her duty their COVID-19 labora seeing the resident shape of the stated it's not her duty their coving the stated it's not her duty	ducted with the physician on bly 3:30 p.m. The physician y to inform each resident of atory results but if she is ne may have possibly the results. The physician					
	stated there wasn't do progress note dated 9 his routine long-term evaluation that she in	ocumentation in her 1/3/20 when she saw him for					
	he was capable of ab- the care and services nursing facility. During Director of Nursing or stated he felt the pers be concerned about nauthorized represents	corded "self" which indicated sorbing information about rendered to him by the g an interview with the n 9/8/20 at 5:09 p.m., he con as primary would want to nedical issues and the ative (AR) concerned about sions. There was no reason					
	given why Resident # outcome of his COVID information.	5 was not told of the 0-19 tests based on that					
		nately 4:32 p.m., the above with the Administrator and					

	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	TIPLE CONSTRUCTION NG			PLETED
		495201	B. WING_				C /09/2020
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	ZIP CODE	00/	00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TO THE APPROPRIA		(X5) COMPLETION DATE
F 552	stated they had no peresidents and/or authoratory results. 3. Resident #6 was to COVID-19 virus. The results of this test on evidence in the clinic was notified of inform which was negative for the vas notified of inform which was negative for the vas no need to COVID-19 test result resident would be toleresult. Upon random review notes from 8/27/20 thand nursing indicated and that they elicited her regarding care are that she was informed that resulted on 9/2/2. An interview was con 9/8/20 at approximate stated it's not her duty their COVID-19 labor seeing the resident so informed them about stated there wasn't deprogress note dated \$2.00.	ng. The Director of Nursing olicy for notification of norized representatives of ested on 8/25/20 for the nursing facility obtained the 9/2/20. There was no all record that the resident ned of his own test results for the COVID-19 virus. mately 2:45 p.m., a phone cted with the Administrator, DON) and Corporate Nurse. view, they repeatedly stated of inform a resident if their is were negative, and that a diff there was a positive of Resident #6's progress arough 9/9/20, both physician of the resident was engaged and shared information with not services, but no evidence diff of her COVID-19 status in the covidence difference of the covidence difference of her covidence	F 5	552			
		formed the resident of the					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495201	B. WING		C 09/09/2020
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	
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F 775 SS=D	Resident #6 was admon 8/23/16 with diagn with left sided hemiple recorded the resident representative (AR). I DON on 9/8/20 at 5:00 person listed as prima concerned about mediauthorized representational matters/deci was a reason why Reform of her COVID-19 tests. Resident #6's most reform (MDS) assessment would be coded the resident on Mental Status (BIMS) possible score of 15 was cognitively intact decision making. On 9/9/20 at approximating were shared the Director of Nursing stated they had no poresidents and/or author laboratory results. Lab Reports in Record CFR(s): 483.50(a)(2)(2)(2)	itted to the nursing facility oses that included stroke egia. The clinical record was the authorized During an interview with the 9 p.m., he stated he felt the eary would want to be lical issues and the etive (AR) concerned about sions. If was not clear if this sident #6 was not informed is. Incent Minimum Data Set as an Annual dated 8/3/20 of the Brief Interview for with a score of 15 out of a which indicated the resident in the skills for daily Inately 4:32 p.m., the above with the Administrator and in the State of the process of the Director of State of the Carlot of State of the Carlo	F 775		
	reports that are dated address of the testing	t's clinical recordlaboratory and contain the name and			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION	(X3	O DATE SURVEY COMPLETED
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F 775	by: Based on resident in clinical record review in the resident's clinical laboratory results for out of 11 residents in The findings included Resident #1 was orig 11/16/19, and has ne resident's current diaghepatitis without ascit diarrhea. The quarterly Minimu assessment with an a (ARD) of 7/1/20 code the Brief Interview for scoring 15 out of a portion of the resident #1's cognitive making were intact. On 9/2/20 at approximum #1 was observed star of (number of the room his hands above his hands above his hataff near the nurse's cart. Resident #1 production another COVID infect completed last week, no one has said anyther Review of Resident #1 laboratory results for interview of Resident #1	terview, staff interviews, and the facility staff failed to file al record all COVID-19 one resident (Resident #1), the survey sample. : nally admitted to the facility ver been discharged. The gnoses included; alcoholic es, anemia and chronic m Data Set (MDS) assessment reference date dithe resident as completing Mental Status (BIMS) and ssible 15. This indicated re abilities for daily decision that the food service and and yelling out to the station with the food service seeded to say "I want ion test, I had a test about seven days ago and an about the results." 1's clinical record revealed a COVID-19 assay test	F 7	F 775 Lab Reports in Record Name/Name Address 1. Resident #1's COVID-19 la results were uploaded to his con 9/25/2020. 2. All residents are at risk whan effective process in place to COVID-19 laboratory results clinical record. Medical Recordinical record. Medical Recordinical records to verification and resident records to verification and resident records to verification affected by this deficient practical record. No other residentical records coordinator of laboratory results are filled in medical records. 4. DON, ADON, or designee daily quality reviews to verify COVID-19 laboratory results in resident's clinical record. We reviewed for patterns and/ore-educated when deficient pridentified and results reported input and guidance. 5. Date of Compliance: 10/08.	en there is to upload in resident for COVIDed in their dents were ctice. will education ensuring resident's will comply resident are upload ariances wor trends, stactice is a to QAPI	te g lete
	dated 6/16/20 and it r negative for genetic n	6/11/20. The result was evealed the resident was narkers of the virus. No ratory results were on his				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		NSTRUCTION		E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	03/	70372020
PORTSID	E HEALTH & REHAB CE	NTER			GREENWOOD DRIVE TSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 775	clinical record. An interview with the of Nursing on 9/7/20, revealed Resident #1 COVID-19 on 7/8/20, The clinical record refor the 7/8/20 testing National Guard. The the 9/7/20, interview that each resident dicaboratory result form available to put in the documented the result individual record. The 7/8/20, laboratory resfacility 7/11/20. Information obtained during the 9/7/20 intep.m., also revealed R COVID-19 test complindependent laboratoreceived in the facility Nursing. As of 9/7/20 record didn't contain the 8/27/20, COVID-19 test complindependent laboratoreceived in the facility Nursing. As of 9/7/20 record didn't contain the 8/27/20, COVID-19 test complindependent laboratoreceived in the facility Nursing. As of 9/7/20 record didn't contain the 8/27/20, COVID-19 test complindependent laboratoreceived in the facility Nursing. As of 9/7/20 record didn't contain the facility Nursing. As of 9/7/20 record didn't contain the facility Nursing at approximation in his informed Resident #1 results. On 9/9/20 at approximation policies/procedures for should reach the clinical procedures f	Administrator and Director at approximately 2:45 p.m., was also tested for 8/27/20 and 9/4/20. Vealed no laboratory results which was conducted by the Administrator stated during at approximately 2:45 p.m., dn't receive an independent of therefore; a form wasn't be record and staff had not alts into each resident's each Administrator stated the sults were received in the states were received in the states at approximately 2:45 desident #1 had another letted 8/27/20 (by an arry), and the results were resident #1's clinical the laboratory results for the lest and there was no clinical record stating staff of his COVID-19 test mately 4:32 p.m., the above with the Administrator and g. They stated they had no or when laboratory results cal record or when the least of the laboratory results cal record or when the laboratory results cal record or when the laboratory should receive	F	775			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495201	B. WING _		- 1	C /09/2020	
	ROVIDER OR SUPPLIER E HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD				LD BE	(X5) COMPLETION DATE	
F 885 SS=E	S483.80(g) COVID-19 must— §483.80(g) COVID-19 must— §483.80(g)(3) Inform representatives, and facilities by 5 p.m. the the occurrence of eith infection of COVID-19 or staff with new-onse occurring within 72 ho information must— (i) Not include person (ii) Include information implemented to preve transmission, includin facility will be altered; (iii) Include any cumulation their representatives, or by 5 p.m. the next of subsequent occurrence confirmed infection of whenever three or monew onset of respirator 72 hours of each other This REQUIREMENT by: Based on clinical receand review of facility of staff failed to inform representatives and on in the facility, by 5 p.m. confirmed infection of	residents, their families of those residing in enext calendar day following are a single confirmed and of respiratory symptoms ours of each other. This ally identifiable information; on mitigating actions and of reduce the risk of g if normal operations of the and lative updates for residents, and families at least weekly calendar day following the ce of either: each time a a COVID-19 is identified, or or residents or staff with any symptoms occur within are. It is not met as evidenced ord review, staff interviews documentation, the facility esidents, their or families of those residing in the next calendar day of COVID-19 for 9 of 11 #8, #9, #1, #2, #3 and #4)	F 88	F 885 Reporting-Residents, Repr & Families 1. Residents #5, #6, #7, #8, #9, # #4 and their responsible parties heen updated on cumulative COV cases and subsequent cases that hoccurred. 2. All residents are at risk when the an effective process in place to not residents of cumulative COVID-1 and subsequent cases by 5 p.m. of calendar day. DON/designee completed a quality to verify that all residents and/or responsible parties are notified of cumulative COVID-19 cases and subsequent cases that have occurred p.m. the next calendar day. No ot residents were affected by this depractice. 3. DON, ADON or designee will current licensed nursing staff on the residents and/or responsible particumulative COVID-19 cases and subsequent cases that have occurred p.m. on the next calendar day. 4. DON, ADON, or designee will daily quality reviews to verify responsible parties are noticumulative COVID-19 cases and	1, #2, #3, ave all /ID-19 ave here is not otify 9 cases in the next ty review red by 5 her ficient educate notifying es of red by 5 complete idents		
		idents were tested for the		subsequent cases by 5 p.m. the ne calendar day. Variances will be re for patterns and/or trends, staff re	viewed		

DEPARTMENT OF HEALTH AND HUMAN SERVICES	FORM APPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICES	OMB NO. 0938-0391		
	when deficient practice is identified and results reported to QAPI for input and guidance.		
	5. Date of Compliance: 10/08/2020		

PRINTED: 09/23/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495201	B. WING_				C /09/2020
	ROVIDER OR SUPPLIER E HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		03	103/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 885	COVID-19 virus on 8/residents results were 9/2/20 (Wednesday), evidence on or before format or discipline, the updates. The findings included 1. Resident #5 was of from the list. Although negative for the virus, or before 9/3/20 by 5 discipline, that relayed Resident #5 that there confirmed cases of Confacility. Resident #5 was admitted with diagnoses that in and diabetes. The resident's most re (MDS) assessment was and coded the resident possible score of 15 confacility in the confirmed cases of Confacility. Zero Resident #6 was on from the list. Although negative for the virus, or before 9/3/20 by 5 discipline, that relayed Resident #6 that there Resident #6 that there	27/20. Ten out of the 48 e positive for the virus on however there was no e 9/3/20 by 5 p.m., in any nat relayed COVID-19 : ne of the sampled residents in this resident tested there was no evidence on p.m., in any format or d updates to inform e were one or more OVID-19 in the nursing iitted to the facility on 8/7/19 cluded Parkinson's Disease ecent Minimum Data Set as an Annual dated 8/8/20 not with a score of 15 out of a on Brief Interview for Mental indicated the resident was e skills needed for daily ne of the sampled residents it this resident tested there was no evidence on p.m., in any format or d updates to inform	F 84	85			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495201	B. WING			C 09/09/2020			
PORTSIDE HEALTH & REHAB CENTER				4.	TREET ADDRESS, CITY, STATE, ZIP CODE 201 GREENWOOD DRIVE ORTSMOUTH, VA 23701				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 885	Resident #6 was adm 8/23/16 with diagnose left hemiparesis (left some continuous left hemiparesis left some continuous left hemiparesis left some continuous left some c	itted to the facility on es that included stroke with sided weakness). ecent Minimum Data Set as an Annual dated 8/3/20 int with a score of 15 out of a on the Brief Interview for which indicated the resident in the skills needed for daily ne of the sampled residents in the scident tested there was no evidence on p.m., in any format or displayed updates to inform a were one or more DVID-19 in the nursing itted to the facility on est that included oliving multiple bone joints trolled atrial fibrillation (right lar heart rate). ecent Minimum Data Set as an Admission dated a resident with a score of 15 as an Admission dated a resident with a score of 15 as of 15 on the Brief tatus (BIMS) which was cognitively intact in the decision making.	F	385					
	negative for the virus, or before 9/3/20 by 5	there was no evidence on o.m., in any formator							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED	
		A. BUILDING			C			
		495201 B. WING			l	/09/2020		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
PORTSID	PORTSIDE HEALTH & REHAB CENTER				4201 GREENWOOD DRIVE			
				PORTSMOUTH, VA 23701				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI: TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 885	J		F	885	5			
	discipline, that relayed Resident #8 that there confirmed cases of Co facility.							
	Resident #8 was adm 4/24/18 with diagnose heart failure (CHF), st	es that included congestive						
	(MDS) assessment w 7/31/20 and coded the out of a possible scon resident was not cogn	e resident with a score of 00 e of 15 which indicated the nitively intact in the skills						
	from the list. Although negative for the virus, or before 9/3/20 by 5 discipline, that relayed Resident #9 that there	ne of the sampled residents this resident tested there was no evidence on p.m., in any format or d updates to inform						
	Resident #9 was adm 12/11/17 with diagnos Rheumatoid arthritis a	ses that included						
	(MDS) assessment wa and coded the resider possible score of 7 wh	ecent Minimum Data Set as a Quarterly dated 7/8/20 at with a score of 00 out of a act in the skills needed for						
	on 9/8/20 at 5:09 p.m.	iew with the Administrator , he stated the method date residents, guardians						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED	
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		495201	B. WING _		09	/09/2020
	ROVIDER OR SUPPLIER E HEALTH & REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 885	and families of one or residents and or staff direct "Robo" calls. The was a template used a documented in each or Administrator stated the procedure to support the federal regulatory evidence that the resinotified via the method Administrator. 6. Resident #1 was or facility 11/16/19, and or The resident's current alcoholic hepatitis with chronic diarrhea. The quarterly Minimur assessment with an an (ARD) of 7/1/20 coded the Brief Interview for scoring 15 out of a portion of the Brief Interview for	in the facility was through the Administrator said there in the "Robo" calls that is resident clinical record. The there was no policy or the mandate, but they used guidance. There was no dents or families were d described by the riginally admitted to the	F 88	35		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495201	B. WING			1	C /09/2020		
	ROVIDER OR SUPPLIER E HEALTH & REHAB CE	NTER		420	EET ADDRESS, CITY, STATE, ZIP CODE 1 GREENWOOD DRIVE RTSMOUTH, VA 23701				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 885	care hospital returnir resident's current dia schizophrenia and a The quarterly Minimu assessment with an a (ARD) of 6/19/20 cocompleting the Brief (BIMS) and scoring 1 indicated Resident #2 decision making were Review of facility's de Resident #2 tested noresidents tested positionand the results were 9/2/20. Review of the revealed the resident representative, yet the the resident's clinical resident was informed COVID-19 in the facil 8. Resident #3 was of facility 4/24/14, and he The resident's current and PVD The quarterly Minimu assessment with an a (ARD) of 7/2/20 code the Brief Interview for scoring 15 out of a position of the scoring 15 out of a position of the scoring 15 out of a position and a control of the scoring 15 out of a position of the scoring 15 out of a pos	g to the facility 4/29/20. The gnoses included; seizure disorder. Im Data Set (MDS) assessment reference date led the resident as interview for Mental Status 5 out of a possible 15. This 2's cognitive abilities for daily a intact. Incumentation revealed egative but ten other ive for COVID-19 on 8/27/20 made available to the facility resident's clinical record was his own authorized ere was no documentation in record revealing the dof new confirmed cases of ity by 5:00 p.m., on 9/3/20. Inginally admitted to the as never been discharged. It diagnoses included; COPD Im Data Set (MDS) assessment reference date do the resident as completing Mental Status (BIMS) and insible 15. This indicated we abilities for daily decision cumentation revealed	F	385					
		ive for COVID-19 on 8/27/20							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495201	B. WING _		C 09/09/2020	
PORTSIDE HEALTH & REHAB CENTER (XA) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
(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 CORRECTIC ((EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION	
F 885	9/2/20. Review of the revealed the resident representative, yet the the resident's clinical resident was informed COVID-19 in the facility 2/26/15, and we care hospital returning resident's current diagrailure requiring dialys. The quarterly Minimum assessment with an a (ARD) of 6/25/20 code completing the Brief In (BIMS) and scoring 18 indicated Resident #4 decision making were Review of facility's don Resident #4 tested ne residents tested positing and the results were in 9/2/20. Review of the revealed the resident representative, yet the the resident's clinical in resident was informed COVID-19 in the facility of the prector of Nursing the facility utilizes a Roresident and/or the au	resident's clinical record was his own authorized are was no documentation in record revealing the dof new confirmed cases of the facility admitted to the as discharged to an acute go to the facility 4/29/19. The gnoses included; renalisis and diabetes. In Data Set (MDS) assessment reference date and the resident as an acute go to the facility 4/29/19. The gnoses included; renalisis and diabetes. In Data Set (MDS) assessment reference date and the resident as an acute go to the facility and the resident as an acute gnoses included; renalisis and diabetes. In Data Set (MDS) assessment reference date and the resident as an acute gnoses included; renalisis and diabetes. In Data Set (MDS) assessment reference date and the resident as an acute gnoses included; renalisis and diabetes. In Data Set (MDS) assessment reference date and the resident as a previous for daily intact. In Data Set (MDS) assessment reference date and the resident as a previous for daily intact. In Data Set (MDS) assessment reference date and the resident as a previous for daily intact. In Data Set (MDS) assessment reference date and the resident as a previous for daily intact.	F8	185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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495201			B. WING			09/	09/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE			
PORTSIDI	E HEALTH & REHAB CE	NTER		4201 GREENWOOD DRIV	E			
		WI EX		PORTSMOUTH, VA 237	701			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'	S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR I	/ MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG	((EACH CORRE CROSS-REFERE	ECTIVE ACTION SHOULD B NCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 885	the facility within the r	equired time span. There	F	885				
	was no evidence that authorized representa described method.	the residents and/or utives were notified by the						
		onsible Party COVID-19						
	each responsible part	of Positive Case: Call y and inform them of the						
	Weekly Updates follow Positive case or three							
	responsible party and COVID status until no	s within 72 hours: Call each inform them of the facility's more positive or probable						
	cases are present in t	he facility.						