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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G009	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNEY AVE RESIDENCE	404 FINNEY AVE SUFFOLK, VA 23434

(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 onsite COVID-19 Focused Emergency Preparedness Survey was conducted 08/14/20 and 8/17/20 through 8/18/20. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations, for the implementation of The Centers for Medicare and Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19.	E 000		
W 000	INITIAL COMMENTS An onsite COVID-19 Focused Infection Control Survey was conducted 08/14/20 and 8/17/20 through 8/18/20. The facility was in compliance with 42 CFR Part 483.470 (I) (1) infection control regulations, for the implementation of the Centers for Medicare and Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. Twelve facility individuals were tested for COVID-19 and five facility Individuals tested positive; all five recovered. Twenty-nine staff were tested for COVID-19 and five tested positive; all five recovered. The census in this 12 bed facility was 12 at the time of the onsite survey.	W 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.