PRINTED: 12/23/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
		495309	B. WING		12/11/2020	
PELICAN	ROVIDER OR SUPPLIER HEALTH NORFOLK		82	REET ADDRESS, CITY, STATE, ZIP CODE 7 NORVIEW AVENUE DRFOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
E 000	COVID-19 Focused 12/08/20 and contir through 12/11/20. T	imergency Preparedness I Survey was conducted onsite nued with offsite review the facility was in compliance FR Part 483.73, Requirements	E-000			
	was conducted onsi with offsite review th was not in complian infection control reg implementation of T Medicaid Services a Control recommend COVID-19. No comduring the survey.  The census in this 6 at the time of survey tested positive for C	OVID-19 Focused Survey te 12/08/20 and continued brough 12/11/20. The facility ce with 42 CFR Part 483.80 ulations, for the the Centers for Medicare & and Centers for Disease ed practices to prepare for plaints were investigated  O certified bed facility was 43 a. Twenty-four Residents had OVID-19, four had been	F 000			
F 552 SS=E	COVID-19, one staff Right to be Informed CFR(s): 483.10(c)(1) §483.10(c) Planning The resident has the	aff had tested positive for had returned to work.  /Make Treatment Decisions (4)(5)  and Implementing Care, right to be informed of, and	F 552	This plan of correction does not constitute ither an admission or concession of the existence, scope or significance of a alleged deficiencies. Rather, it constitutes	he ny tes	
\$  -  -	§483.10(c)(1) The rig anguage that he or s	ther treatment, including:  In the best fully informed in the she can understand of his or the standing but not limited to, and ition.		actions taken and recorded to comply w federal regulations.  This plan of correction is submitted as a allegation of compliance.	ith	
RATORY/DIF	cy/a A	SUPPLIER REPRESENTATIVE'S SIGNATURE	1	Adminiskahr	(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.

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The same of the sa	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
	•	495309	B. WNG			12/11/2020
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, S 827 NORVIEW AVENUE NORFOLK, VA 23509	TATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 552	§483.10(c)(4) The rig advance, of the care of care giver or profes §483.10(c)(5) The rig advance, by the phys professional, of the ris care, of treatment and treatment options and option he or she prefet This REQUIREMENT by:  Based on resident in and clinical record revito inform three reside out of 10 residents in COVID-19 laboratory  The findings included 1. Resident #2 was of facility 10/26/20. The renal insufficiency and The admission Minimassessment with an a (ARD) of 10/29/20 co completing the Brief I (BIMS) and scoring 1 indicated Resident #2 decision making were The resident was idea Worker as her own reconstructive was conducted Resident #2 stated it	the tobe informed, in to be furnished and the type assional that will furnish care.  In the beinformed in ician or other practitioner or sks and benefits of proposed of treatment alternatives or it to choose the alternative or ers.  It is not met as evidenced terviews, staff interviews, view, the facility's staff failed int (Resident #2, 3 and 7), the survey sample, of their results.  It is not met as evidenced terviews ample, of their results.  It is not met as evidenced terviews, wiew, the facility's staff failed int (Resident #2, 3 and 7), the survey sample, of their results.  It is not met as evidenced terviews ample, of their results.  It is cognitive abilities for daily in the resident as interview for Mental Status to out of a possible 15. This is cognitive abilities for daily intact.	£ -55	Decisions  1. Residents #2, # their individual of 12/10/20, 12/16/2 also informed of the facility on this 2. All residents appractice. 3. Staff education professional nursi elements of F Tag keep residents information in the status 12/10/20, 112/31/20. The prothis education. 4. The DON or dereport 3 X weekly condition or health communicated to of these audits will QAPI committee for the status of the second to the second th	was provided to lice in staff regarding the residents timely. I be communicated to for additional oversight changes to the plan.	ned of y were tus of ficient nsed s to care l uded in 24-hour s in Results

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OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	200 000 100 100			E SURVEY PLETED
	495309	B. WING		12	2/11/2020
ROVIDER OR SUPPLIER  HEALTH NORFOLK		8	27 NORVIEW AVENUE		
(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
hallway stating ther positive residents in concerning. Reside been tested three ti 12/7/20 and not one of the test results.  Review of Resident 12/10/20, revealed was informed of any following COVID-19 documented in her 12/6/2020 12:15 Co Family/POA/Respo November 30, 2020 results of the facility we have both positi 2. Resident #3 was facility 3/25/20. The anemia and schizop The quarterly Minimassessment with an (ARD) of 9/30/20 completing the Brie (BIMS) and scoring The resident was id Worker as his own	the facility and it was an the facility and it was an #2 also stated she had mes for COVID-19, including a time had staff informed her which was not a war and mession to common the facility of the facility of the facility's Social responsible party.  The facility and it was an employees.  The facility's Clinical record on an odocumentation the resident by COVID-19 test results. The facility of the facility of the facility of the facility of the facility's Social responsible party.	F 552	ben to leave		
	ROVIDER OR SUPPLIER  HEALTH NORFOLK  SUMMARYS (EACH DEFICIEN REGULATORY OF REGULATORY	A95309  ROVIDER OR SUPPLIER  HEALTH NORFOLK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2 hallway stating there were eight more COVID-19 positive residents in the facility and it was concerning. Resident #2 also stated she had been tested three times for COVID-19, including 12/7/20 and not one time had staff informed her	ROVIDER OR SUPPLIER  #EALTH NORFOLK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2 hallway stating there were eight more COVID-19 positive residents in the facility and it was concerning. Resident #2 also stated she had been tested three times for COVID-19, including 12/17/20 and not one time had staff informed her of the test results.  Review of Resident #2's clinical record on 12/10/20, revealed no documentation the resident was informed of any COVID-19 test results. The following COVID-19 progress note were documented in her clinical record:  12/6/2020 12:15 Communication with Family/POA/Responsible Party Note Text: On November 30, 2020 I called regarding the testing results of the facility and made them aware that we have both positive patients and employees.  2. Resident #3 was originally admitted to the facility 3/25/20. The current diagnoses included; anemia and schizophrenia.  The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/30/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15.  The resident was identified by the facility's Social Worker as his own responsible party.  On 12/8/20 at approximately 12:17 p.m., an	ROVIDER OR SUPPLIER  HEALTH NORFOLK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2 hallway stating there were eight more COVID-19 positive resident #2 also stated she had been tested three times for COVID-19, including 12/7/20 and not one time had staff informed her of the test results.  Review of Resident #2's clinical record on 12/10/20, revealed no documentation the resident was informed of any COVID-19 test results.  Review of Resident #2's clinical record on 12/10/20, revealed no documentation the resident was informed of any COVID-19 test results. The following COVID-19 progress note were documented in her clinical record:  12/6/2020 12:15 Communication with Family/POA/Responsible Party Note Text: On November 30, 2020 I called regarding the testing results of the facility and made them aware that we have both positive patients and employees.  2. Resident #3 was originally admitted to the facility 3/25/20. The current diagnoses included; anemia and schizophrenia.  The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/30/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15.  The resident was identified by the facility's Social Worker as his own responsible party.  On 12/8/20 at approximately 12:17 p.m., an	A BUILDING  495309  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA. 23509  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2 hallway stating there were eight more COVID-19 positive residents in the facility and it was concerning. Resident #2's clinical record on 12/17/20, revealed no documentation the resident was informed of any COVID-19 test results. The following COVID-19 progress note were documented in her clinical record:  12/6/2020 12:15 Communication with Family/POA/Responsible Party Note Text: On November 30, 2020 I called regarding the testing results of the facility and made them aware that we have both positive patients and employees.  2. Resident #3 was originally admitted to the facility 3/25/20. The current diagnoses included; anemia and schizophrenia.  The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/30/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15.  The resident was identified by the facility's Social Worker as his own responsible party.  On 12/8/20 at approximately 12:17 p.m., an

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING		12/11/2020
	ROVIDER OR SUPPLIER HEALTH NORFOLK		82	REET ADDRESS, CITY, STATE, ZIP CODE 7 NORVIEW AVENUE DRFOLK, VA 23509	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 552	Continued From pag	ge 3	F 552		
	no documentation the his COVID-19 test in progress notes were 12/4/2020 10:12 Nu Text: resident had recommate tested possible awake alert and ver COVID 19 temp. 98 acute distress noted 12/4/2020 22:35 eM Note Note Text: resident adjust 12/4/20. The diabetes and vascu Minimum Data Set (assessment reference coded the resident all Interview for Mental out of a possible 15 The resident was id Worker as his own of 12/8/20 at approximation about of last Tuesday room. The resident any information about 12/6/20 at approximation about 15/4/20 at approximation abo	rsing Progress Note Note com change to 209 related to esitive to COVID 19. Resident bal no signs/symptoms of .1. no signs/symptoms of .1. no signs/symptoms of .1. lar - Shift Level Administration ident had room change to ins/symptoms of acute distress congestion noted, temperature ting well.  originally admitted to the current diagnoses included; lar disease. The quarterly (MDS) assessment with an inceedate (ARD) of 8/22/20 in as completing the Brief Status (BIMS) and scoring 15 incentified by the facility's Social			

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Facility ID: VA0247

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AND DI AN OF CORDECTION		The second second second second	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		495309	B. WING		1	2/11/2020
NAME OF PROVIDER OR SUPPLIER  PELICAN HEALTH NORFOLK		•	827 1	EET ADDRESS, CITY, STATE, ZIP COD NORVIEW AVENUE RFOLK, VA 23509	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 552	no documentation the any COVID-19 test is progress note was progress.  On 12/10/20 at approabove findings were Director and the Director of Clinic licensed nurse staff residents of laborate information was progressive for Could the progressive for Could the progressive on 11/25/20. All COVID-19 on 11/25/20, also on positive on 11/25/20, to the test results revewere CovID-19, poretested 11/29/20 at available to the facil revealed four reside and another resident CovID-19 symptomestics.	#7's clinical record revealed be resident was informed of results but; the following bresent:  ar - Shift Level Administration and per Centers for Disease coximately 2:20 p.m., the shared with the Executive rector of Clinical services. Cal services stated it is the responsibility to inform bry results. No additional wided.  on revealed one resident OVID-19 at the hospital on resident tested positive at the residents were tested for 1/20, secondary to three staff lititive for COVID-19 infections are resident tested COVID-19. On 11/28/20 two more staff sitive for COVID-19. On 20, the resident's test results resting arrived to the facility realed four more residents were and the results were made in the results wer	F 552			
	presented with signs	O three additional residents s of COVID-19 and tested O one resident presented with				

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STATEMENT, O AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(6)	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495309	B. WING_		12/11/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 827 NORVIEW AVENUE NORFOLK, VA 23509	CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O  (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	TION SHOULD BE COMPLETIC DATE
F 552 F 880 SS=D	covidence covide	nd tested positive for /20, six residents presented 9 symptoms; they tested 9 therefore all residents were 19 and results were pending & Control ()(2)(4)(e)(f)  ontrol ablish and maintain an and control program		F 880 Infection Preventi 1. The improper removal a resident room was observed to the second of PPE for C. No immediate correction 2. All residents are at risk	of soiled linen from rved. No immediate the improper NA #1 was observed.
	comfortable environr development and tra diseases and infection	ment and to help prevent the insmission of communicable		practice.  3. The LPTA received rer regarding the proper stora soiled linen on 12/10/202 remedial education regard	nedial education age and disposal of 0. C.NA # 1 received
	and control program a minimum, the follo §483.80(a)(1) A syst reporting, investigati and communicable ostaff, volunteers, visi providing services urarrangement based conducted according accepted national st §483.80(a)(2) Writter procedures for the put are not limited to (i) A system of surverpossible communications.	tem for preventing, identifying, ing, and controlling infections diseases for all residents, itors, and other individuals inder a contractual upon the facility assessment of to §483.70(e) and following andards;  In standards, policies, and rogram, which must include, or billance designed to identify		application of a disposabilited, and the wearing/cha 12/10/2020. Education of provided to all staff regation of soiled linen from residuse of PPE 12/28/20 and 4. The DON or designed assure prevention controlimplemented consistently audits will be communic committee for additional recommended changes to 5. Date certain: 01/25/2	anging of PPE on was additionally rding proper removal dent rooms and proper ongoing.  It will 3 X weekly to I techniques are being y. Results of these ated to the QAPI oversight and any of the plan.

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AND DUAN OF CORRECTION		32 25	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495309	B. WING		12/11/2020
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH NORFOLK		Į.	STREET ADDRESS, CITY, STATE, ZIP CODE 827 NORVIEW AVENUE NORFOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 880	communicable diseareported; (iii) Standard and trato be followed to predivible for the facility will conditive and the facility will conditive for the facilit	om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a ut not limited to: ration of the isolation, infectious agent or organism at the isolation should be the sible for the resident under the estible for the resident under the est under which the facility yees with a communicable skin lesions from direct the disease; and e procedures to be followed direct resident contact.  Item for recording incidents facility's IPCP and the ken by the facility.  In the facility of its early program, as necessary.  The is not met as evidenced ons, clinical record review, the facility's staff failed to	F 880		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			TE SURVEY MPLETED
		495309	B. WING		1	2/11/2020
	ROVIDER OR SUPPLIER  HEALTH NORFOLK		827 N	ET ADDRESS, CITY, STATE, ZIP CODE IORVIEW AVENUE IFOLK, VA 23509	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	Continued From page consistently implement development and/or transfer toommunicable disease infectious diseases.  The findings included	nted to prevent the ransmission of a se (COVID-19), and other	F 880			
	On 12/8/20, at app Licensed Physical Th was observed coming resident's room with v hand and a red ball in	roximately 11:57 a.m., a erapist Assistant (LPTA) out of a quarantined vet linen in his left ungloved the right hand. LPTA look and returned inside the				
	stated there were no therefore he brought	ately 4:55 p.m. The LPTA linen bags in the room the linen out to bag it, later a plastic bag was removed				
	Director stated LPTA bag into the room and bagged prior to bringi Rehabilitation Directo	r on 12/10/20 at m. The Rehabilitation should have carried a linen if the linen should have been ng it out the room. The r also stated LPTA should nd the LPTA had been				
	a pearl necklace was around the neck. CN	stant (CNA) #1 was				

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495309	B. WING _			12/11/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 827 NORVIEW AVENUE NORFOLK, VA 23509	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 885	rooms at approximate entered the rooms, we removed the contain waste on the cart, the room, entered, obtain place it on the meal next room where the removed prior to ent sanitized and new grentered the rooms, we removed the contain waste on the cart, the room, entered, obtain place it on the meal gloves were removed gown and gloves were and gloves were removed and gloves were removed to the room, entered, obtain place it on the meal gloves were removed gown and gloves were removed gown and gloves were removed to the rooms since COVID-19 positive to at the facility for four the facility for four above findings were Director and the Director of Clinical sit was CNA #1's four and she had been excontrol protocols as Documentation of becontrol education was	meal trays from resident tely 1:20 p.m. CNA #1 went over to the bed table er and trash and put the en proceeded to the next ned the container and waste, cart and proceeded to the gown and gloves were rance, the hands were loves applied. CNA #1 again went over to the bed table er and trash and put the en proceeded to the next ned the container and waste, cart after-which the gown and d, hands sanitized and a new ere donned.  Inducted with CNA #1 at the common container and waste, cart after-which the gown and d, hands sanitized and a new ere donned.  Inducted with CNA #1 at the common container and waste, cart after-which the gown and d, hands sanitized and a new ere donned.  Inducted with CNA #1 at the common container and waste, cart after-which the gown and d, hands sanitized and a new ere donned.  Inducted with CNA #1 at the common container and waste, cart after-which the gown and d, hands sanitized and a new ere donned.  Inducted with CNA #1 at the common container and waste, cart after-which the gown and d, hands sanitized and a new ere donned.  Inducted with CNA #1 at the common container and waste, cart after-which the gown and d, hands sanitized and a new ere donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.  Inducted with CNA #1 at the gown are donned.	F8				
SS=E	CFR(s): 483.80(g)(3		F8	05			

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	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			E SURVEY PLETED :
		495309	B. WNG	*	12	/11/2020
	ROVIDER OR SUPPLIER  HEALTH NORFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 327 NORVIEW AVENUE NORFOLK, VA 23509		10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 885	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 cumu their representatives, or by 5 p.m. the next subsequent occurrence confirmed infection of whenever three or monew onset of respirate 72 hours of each other This REQUIREMENT by:  Based on resident in clinical record review documents, the facilit residents residing in the infection of COVID-19 (Residents #2, #3 and The findings included 1. Resident #2 was or	residents, their families of those residing in enext calendar day following for a single confirmed and of three or more residents at of respiratory symptoms burs of each other. This for ally identifiable information; in on mitigating actions and or reduce the risk of and gif normal operations of the and lative updates for residents, and families at least weekly calendar day following the ce of either: each time a covidence of each to residents or staff with any symptoms occur within for sin not met as evidenced terviews, staff interviews, and review of facility y's staff failed to inform the facility of confirmed and for a facility of confirmed and facility	F 885	F 885 Reporting-Residents, Represe & Families  1. Residents #2, #3 and #7 were inforcovid outbreak status of the facility on 2. All residents are at risk from this depractice.  3. Staff education was provided to lice professional nursing staff regarding the of F Tag 885 and requirements to notice and their representative or family by 5 next calendar day. This includes mitigactions the facility is taking to protect census of the facility will be assigned Department leaders to provide updates necessary and by 5 pm the next calend Notes will be added to PCC to confirm was completed.  4. The Administrator or designee will 10% of resident records weekly to assinotifications are being made and docu Results of these audits will be commut the QAPI committee for additional ovany recommended changes to the plan 5. Date certain: 01/25/2021.	med of the 12/16/20. ficient ensed e elements fy residents pm the gating them. The to as ar day. I contact audit the are mented. Inicated to ersight and	

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NAME OF PROVIDER OR SUPPLIER  PELICAN HEALTH NORFOLK  STREET ADDRESS, CITY, STATE, ZIP CODE  827 NORVIEW AVENUE  NORFOLK, VA 23509  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (XE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIED.)		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION		TE SURVEY MPLETED
PELICAN HEALTH NORFOLK  (X4) ID (X4) I			495309	B. WING			2/11/2020
F 885  Continued From page 10  The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/29/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were intact.  The resident was identified by the facility's Social Worker as her own responsible party.  On 12/8/20 at approximately 12:12 p.m., an interview was conducted with Resident #2. Resident #2 stated she had recently been moved to that room because the facility needed the previous room for another resident. Resident #2 further stated it had not been officially reported to her but she overheard staff in the hallway stating there were eight more COVID-19 positive residents in the facility and it was concerning. Resident #2 also stated on one occasion her sister was contacted by the facility of confirmed				8	27 NORVIEW AVENUE	CODE	
The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/29/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were intact.  The resident was identified by the facility's Social Worker as her own responsible party.  On 12/8/20 at approximately 12:12 p.m., an interview was conducted with Resident #2. Resident #2 stated she had recently been moved to that room because the facility needed the previous room for another resident. Resident #2 further stated it had not been officially reported to her but she overheard staff in the hallway stating there were eight more COVID-19 positive residents in the facility and it was concerning. Resident #2 also stated on one occasion her sister was contacted by the facility of confirmed	PREFIX	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
Review of Resident #2's clinical record revealed no documentation the resident was informed of new confirmed cases of COVID-19 in the facility by 5:00 p.m., the day after the information was available to the facility's staff but; the following progress notes were present:  12/6/2020 12:15 Communication with Family/POA/Responsible Party Note Text: On November 30, 2020 I called regarding the testing results of the facility and made them aware that we have both positive patients and employees.  12/10/2020 17:14 Health Status Note Note Text: Spoke with resident Notified resident that her	F 885	The admission Mi assessment with a (ARD) of 10/29/20 completing the Br (BIMS) and scorir indicated Resident decision making volume The resident was Worker as her own on 12/8/20 at apprinterview was concessed to that room because to that room because to that room because to the state of the	nimum Data Set (MDS) an assessment reference date coded the resident as ief Interview for Mental Status ag 15 out of a possible 15. This it #2's cognitive abilities for daily were intact.  identified by the facility's Social in responsible party.  croximately 12:12 p.m., an ducted with Resident #2. d she had recently been moved use the facility needed the another resident. Resident #2 ad not been officially reported to eard staff in the hallway stating more COVID-19 positive cility and it was concerning. stated on one occasion her ted by the facility of confirmed ons in the facility.  Int #2's clinical record revealed of the resident was informed of ses of COVID-19 in the facility day after the information was cility's staff but; the following ere present:  Communication with consible Party Note Text: On 20 I called regarding the testing ity and made them aware that itive patients and employees.  Health Status Note Note Text:	F 885			

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Event ID: E63911

Facility ID: VA0247

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495309	B. WING_		1	2/11/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 827 NORVIEW AVENUE NORFOLK, VA 23509			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 885	resident that facility	were negative. Informed  will continue to perform  residents. Resident	F	385			
	facility 3/25/20. The anemia and schizo The quarterly Minir assessment with a (ARD) of 9/30/20 of completing the Brie (BIMS) and scoring indicated Resident decision making where the suspected it was about but no one in situation in the faciliown test.  Review of Resider no documentation new confirmed case by 5:00 p.m., the decision of the suspected it was about but no one in situation in the faciliown test.	num Data Set (MDS) n assessment reference date oded the resident as ef Interview for Mental Status g 15 out of a possible 15. This #3's cognitive abilities for daily ere intact.  dentified by the facility's Social responsible party.  roximately 12:17 p.m., an flucted with Resident #3. I his roommate was sick and as the virus everyone is talking informed him of the virus lity or the results of his very  at #3's clinical record revealed the resident was informed of less of COVID-19 in the facility lay after the information was everyoning the resident was everyone is talking informed him of the virus it #3's clinical record revealed the resident was informed of less of COVID-19 in the facility ity ay after the information was everyone.					
	Text: resident had	ursing Progress Note Note room change to (room roommate tested positive to					

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Event ID: E63911 Facility ID: VA0247

If continuation sheet Page 12 of 20 RECEIVED

JAN 0 4 2021

**VDH/OLC** 

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND DI AN OF CODDECTION		(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495309	B. WING	4	12/11/2020		
	ROVIDER OR SUPPLIER  HEALTH NORFOLK		82	STREET ADDRESS, CITY, STATE, ZIP CODE  827 NORVIEW AVENUE  NORFOLK, VA 23509			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION		
F 885	signs/symptoms of signs/symptoms of signs/symptoms of 12/4/2020 22:35 eN Note Note Text: resisolation unit no signoted no cough or 98.1, resident adjus 3. Resident #7 was facility 2/14/20. The diabetes and vascu Minimum Data Set assessment referer coded the resident Interview for Menta out of a possible 15 cognitive abilities for intact.  On 12/8/20 at apprinterview was cond Resident #7 stated doctor last Tuesday room. The resident hopes to remain the stated he's fully aw all on the television knows a mask mus room but no one in information about to had given him any COVID-19 test he if don't have it".	nt awake alert and verbal no COVID 19 temp. 98.1. no acute distress noted.  Mar - Shift Level Administration sident had room change to ins/symptoms of acute distress congestion noted, temperature esting well.  It originally admitted to the ecurrent diagnoses included; alar disease. The quarterly (MDS) assessment with an inceidate (ARD) of 8/22/20 as completing the Brief I Status (BIMS) and scoring 15 accompleting the Brief I Status (BIMS) and scoring 15 are daily decision making were  Doximately 12:25 p.m., an uncted with Resident #7 and uncted with Resident #7. after going out to the foot of the virus because that's are of the virus because that's are of the virus because that's are of the virus because the the facility had offered asses in the facility and no one information about the three had completed. "I figured I dentified by the facility's Social	F 885				

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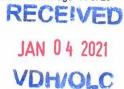
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495309	B. WING		1	2/11/2020	
	ROVIDER OR SUPPLIER  HEALTH NORFOLK		827 N	ET ADDRESS, CITY, STATE, ZIP CODE IORVIEW AVENUE FOLK, VA 23509			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 885	no documentation the new confirmed cases by 5:00 p.m., the day available to the facility progress note was progress note was progress note was progress note was progress.  12/2/2020 13:11 eMa Note Note Text: isola Control guidelines.  On 12/10/20 at approgressive was conducted to the facility dates of 11/30/20 and further stated documentated to the progressive fundings were Director and the Director of Clinic be some documentation was presidents, their reprethose residing in facility the next calendar of either a single con COVID-19, or three continuous of each of the Social Worker storicumstances, notifications and the social worker storicumstances, notifications are some continuous and the social worker storicumstances, notifications and the social worker storicumstances, notifications are social workers.	er's clinical record revealed be resident was informed of a of COVID-19 in the facility of after the information was by's staff but; the following resent:  For a Shift Level Administration ted per Centers for Disease optimized with the Receptionist. The desired with the Receptionist ted she contacted 95% of a sible Parties to provide an as COVID-19 status for the desired 12/5/20. The Receptionist tentation was not made in the still 12/6/20.  For invalid the Executive externed with the Executive externed indicated sentatives, and families of littles by 5 p.m. were notified day following the occurrence firmed infection of or more residents or staff spiratory symptoms occurring chother.	F 885				

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(X3) DATE SURVEY COMPLETED	
2/11/2020	
(X5) COMPLETION DATE	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495309	B. WING		- *	12/11/2020
The state of the s	ROVIDER OR SUPPLIER  HEALTH NORFOLK			STREET ADDRESS, CITY, ST 827 NORVIEW AVENUE NORFOLK, VA 23509	TATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	
F 886	but not limited to: (i) Testing frequency; (ii) The identification of this paragraph diagnot COVID-19 in the facility iii) The identification of this paragraph with sy consistent with COVID suspected exposure to (iv) The criteria for corrasymptomatic individual paragraph, such as the COVID-19 in a county (v) The response time (vi) Other factors specified in the prevention of COVID-19 in a county (vi) The response time (vi) Other factors specified in the prevention of COVID-19 in a county (vi) The response time (vi) Other factors specified in the prevention of COVID-19 §483.80 (h)((2) Conduction of COVID-19 §483.80 (h)((3) For eacus in the conduction of covid in the covid in	Ict testing based on by the Secretary, including of any individual specified in sed with the sed	F-886	1. Results of covid #3 and #7 were doc perpective records of involved will be mo infection. 2. All residents are deficient practice. 3. Staff education of professional nursing elements of F Tag 8 documentation of re clinical record. The or designee will upl clinical records were 4. The Administrat the 10% of resident covid testing results Results of these aud communicated to the	on 12/25/20. Resident on the continued for any signs at risk from this was provided to licensing staff regarding the safe requiring esults in the resident's the medical records clearly or or designee will author or designee will author or designee will author of the committee for t	ts of  ed  rk the dit ture ed.

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495309	B. WING		1	2/11/2020	
PELICAN HEALTH NORFOLK  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE  827 NORVIEW AVENUE  NORFOLK, VA 23509			12/11/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 886	for COVID-19, take a transmission of COV §483.80 (h)((5) Have residents and staff, it services under arran refuse testing or are §483.80 (h)((6) When emergencies due to contact state and local health departments are successing test result processing test result This REQUIREMENT by:  Based on staff intervices are suits for 3 of 3 resident's clinical recording testing for 3 of 3 resident's clinical recording from the survey sand The findings included Facility documentation tested positive for CO 11/23/20. Another refacility 11/25/20. All COVID-19 on 11/25/20, member testing position 11/25/20, testing for the 11/25/20, testing the test results reveausere COVID-19 positive on 2007.	D-19, or who tests positive actions to prevent the ID-19.  In procedures for addressing including individuals providing gement and volunteers, who unable to be tested.  In necessary, such as in testing supply shortages, artments to assist in testing ning testing supplies or its.  In is not met as evidenced wiews, and clinical record staff failed to file in the ord COVID-19 laboratory dents, (Resident #2, #3, and inple.	F 886				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495309	B. WING		12	11/2020	
100.000	ROVIDER OR SUPPLIER  HEALTH NORFOLK		8	TREET ADDRESS, CITY, STATE, ZIP CODE 27 NORVIEW AVENUE ORFOLK, VA 23509			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 886	revealed four resident and another resident COVID-19 symptoms hospital. On 12/4/20 presented with signs positive. On 12/5/20 signs of COVID-19 at COVID-19. On 12/7/ with acute COVID-19 were retested for CO pending return from to 1. Resident #2 was of facility 10/26/20. The renal insufficiency and The admission Minimassessment with an at (ARD) of 10/29/20 co completing the Brief It (BIMS) and scoring 1. Resident #2 was ider responsible party.  On 12/8/20 at approxinterview was conduct Resident #2 stated stated stated stated for COVID-19,  Review of Resident #1 no laboratory results indicating that COVID-19.	y 12/1/20. The results ts were COVID-19 positive presented with acute and was transferred to the three additional residents of COVID-19 and tested one resident presented with nd tested positive for 20, six residents presented symptoms. They tested therefore; all residents VID-19 and results were he lab. riginally admitted to the current diagnoses included; d diabetes.  um Data Set (MDS) assessment reference date ded the resident as interview for Mental Status to out of a possible 15.  httified as her own  imately 12:12 p.m., an atted with Resident #2. he had been tested three	F 886				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED	
		495309	B. WING_		12/11/2	2020
	ROVIDER OR SUPPLIER  HEALTH NORFOLK	•		STREET ADDRESS, CITY, STATE, ZIP 827 NORVIEW AVENUE NORFOLK, VA 23509		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE CO	(X5) DMPLETION DATE
F 886	facility 3/25/20. The anemia and schized The quarterly Minicassessment with a (ARD) of 9/30/20 of completing the Bri (BIMS) and scorin Resident #3 was hon 12/8/20 at apprinterview was concassedent #3 stated COVID-19.  Review of Resident no laboratory resuindicating that CO completed or not of each completed the same same and vascoministic manner of the same sessment referenced the resident Interview for Menticassessment for Menticassessment referenced the resident Interview for Menticasses and school of the resident Interview for Menticasses and	s originally admitted to the se current diagnoses included, apphrenia.  mum Data Set (MDS) an assessment reference date coded the resident as ef Interview for Mental Status g 15 out of a possible 15. his own responsible party.  roximately 12:17 p.m., an ducted with Resident #3. d he had been tested twice for ht #3's clinical record revealed lits or written documentation VID-19 testing was offered, completed and the results of	F8	886		
	interview was cond Resident #7 stated times for COVID-1	roximately 12:25 p.m., an ducted with Resident #7. d he had been tested three 9, prior to the 12/7/20 test.				

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		495309	B. WING		12/	11/2020	
	ROVIDER OR SUPPLIER		82	REET ADDRESS, CITY, STATE, ZIP ( 7 NORVIEW AVENUE ORFOLK, VÅ 23509			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 886	no laboratory result indicating that CO completed or not of each completed to each completed to the complete to the compl	alts or written documentation VID-19 testing was offered, completed and the results of est.  proximately 2:20 p.m., the re shared with the Executive birector of Clinical services. The I services stated the laboratory to the fax machine in the elicensed nurses are exing up the labs, and placing the physician's folder for review. The physician reviews the labs of the Medical Records to be filed to Medical Records and the physician reviews the labs of the physician reviews the labs of the Director of Clinical the physician reviews the labs of the Director of Clinical the physician reviews the laboratory and put a Plan of Correction the plan was provided 12/11/20. 12/9/20 Medical Records and the physician review them in the be uploaded into the medical didn't include a signature page end staff had been education to the Executive Director stated edical Records has the in the clinical record but there	F 886		RECEIV JAN 0 4 2 VDH/OI	021	



### COMMONWEALTH of VIRGINIA

### Department of Health

M. NORMAN OLIVER, MD, MA STATE HEALTH COMMISSIONER

### Office of Licensure and Certification

TYY 7-1-1 OR

1-800-828-1120

9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1485 Phone (804) 367-2102 Fax (804) 527-4502

December 23, 2020

Pelican Health Norfolk Survey Results Cycle Start Date: 12/11/2020

### **Infection Control Directed Plan of Correction (DPOC)**

Imposed in accordance with 42 CFR § 488.424

### **Timeframe**

- This DPOC must be completed no more than 21 days from the date of this letter or a DDPNA will be imposed on day 30.
- You must submit your DPOC within 15 days of the date of this letter.
- Your DPOC will not be accepted until the evidence/documentation asked for is received.
- If you encounter problems in completing this DPOC within the prescribed timeframe, notify the State Survey Agency promptly.
- A revisit will not be conducted or compliance achieved until this DPOC is completed.

#### Steps That Must Be Taken

- 1. Provide evidence of current infection control policy & procedures, including the guidance related to COVID-19 from the CMS and the U.S. Centers for Disease Control and Prevention.
- 2. Training of all nursing and rehabilitation staff regarding appropriate PPE use and linen handling. Include documentation of the training completed with a timeline for completion.
- 3. Conduct a Root Cause Analysis (RCA) that will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement committee and governing body. The RCA should be incorporated into the intervention plan.

### **Exit Summary with Scope and Severity Grid**

**Instructions:** The team leader will fill out this form after each survey and email it to the supervisor.

Provider Name: Pelican Health - Norfolk

**Survey Dates:** 

12/08/20 - 12/11/20

Exit Time: 10:30 a.m.

Team Coordinator's Name: V. Kelly

Provider Number: 49-5309

Was a Licensure survey conducted? No

Enter entrance time if 10%er: N/A

Tags cited:

(1)	(K)	(L)
(G)	(H) V552-VK	(1)
( <b>D)</b> (F-880 (VK)	<b>(E)</b> : F-885 (VK); F- 886 (VK)	(F)
(A)	(B)	(C)

#### #of Tags to be written and by which inspectors:

#### Complaints:

0 Total # of complaints investigated during the survey.

0 # substantiated, with deficiencies;

0 # unsubstantiated, with deficiencies.

0 # substantiated, with no deficiencies;

0 # unsubstantiated, with no deficiencies.

List the MFI responsible, Complaint number, and Allegation number for each complaint. Example: CS VA0004321-#1=U, #2=S, #3=U, #4=S. In addition, if any complaint was received while onsite and did not have a number, please identify that complaint in some fashion

Administrator's Name: Jacynth Gray

Administrator's Email: jgray@pelicannorfolk.com

#### The facility IS registered for ePOC

(**NOTE:** The facility may have up to four registered users but only one registered user is needed for this form. ePOC will automatically grant access to all registered users)

ePOC registered user's name:

ePOC registered user's email address:

#### The facility is NOT registered for ePOC

Email address: jgray@pelicannorfolk.com

Alternate email address: