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

PRINTED: 02/10/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495344	A. BUILDING ______ B. WING ______	11/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGS DAUGHTERS COMMUNITY HEALTH & REHAB	**1410 NORTH AUGUSTA STREET STAUNTON, VA 24401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted on 11/02/2020. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted on 11/02/2020. The facility was in substantial compliance with 42 CFR Part 483.80 infection control regulations, and had implemented the CMS and Centers for Disease Control (CDC) recommended practices to prepare for COVID-19 On 11/02/2020 the census in this 117 certified bed facility was 74. The survey sample consisted of three current resident record reviews (Resident #'s 1 through 3). Fiftyeight residents were positive for COVID-19 in the facility at the time of the survey. The last completed facility wide testing was conducted on 10/25/2020 and included 21 Residents. Seven residents tested positive and 14 tested negative. Other residents were not tested due to testing positive within 90 days of the current testing. Out of 110 staff; 89 staff were tested yeilding 5 positive results and 84 negative results. The remaining staff were not testing due to prior positive results within 90 days of current testing.	F 000		

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

Electronically Signed | | 11/05/2020

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.