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

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NAME OF PROVIDER OR SUPPLIER WELLSPRINGS AT AMELIA STREET ADDRESS, CITY, STATE, ZIP CODE 8830 VIRGINIA STREET AMELIA, VA 23002 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	101 200 -000 -000	TIPLE CONSTRUCTION	(X:	(X3) DATE SURVEY COMPLETED	
WELLSPRINGS AT AMELIA (X4) ID PREFIX TAGK (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments An unannounced abbreviated Emergency Preparadness COVID-19 Focused Survey was conducted from 8/11/2020 through 8/12/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. F 000 INITIAL COMMENTS An unannounced abbreviated COVID-19 Focused Survey was conducted from 8/11/2020 through 8/12/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. F 000 INITIAL COMMENTS F 000 INITIAL COMMENTS F 000 Through 8/12/2020. Complaints [VA00049121, VA00046401, VA00046790, and VA0004787] were investigated during the survey. The facility was in substantial compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). The census in this 100 certified bed facility was 78. Of the 84 current residents, three residents were positive for the COVID-19 virus. The survey sample consisted of two current residents (Residents #5 and #6), and four closed records			495358	B. WING			C 08/12/2020	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 000 Initial Comments E 000					8830 VIRGINIA STREET	ZIP CODE	03/12/2020	
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(Residents #5 and #6), and four closed records (Residents #1 through #4).		An unannounced ab Preparedness COVII conducted from 8/11. The facility was in su CFR Part 483.73, Recare Facilities. INITIAL COMMENTS An unannounced ab Focused Survey was through 8/12/2020. CVA00046401, VA000 were investigated du was in substantial co CFR Part 483 Federa requirement(s). The census in this 1078. Of the 84 current were positive for the sample consisted of the sample consi	D-19 Focused Survey was /2020 through 8/12/2020. Ibstantial compliance with 42 equirement for Long-Term S breviated COVID-19 conducted from 8/11/2020 complaints [VA00049121, 46790, and VA00047687] ring the survey. The facility mpliance with F-880 of 42 al Long Term Care O certified bed facility was residents, three residents COVID-19 virus. The survey two current residents		000	JENCY)		
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DA	ABORATORY	(Residents #1 throug	h #4).					

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.