PRINTED: 07/29/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED		
		49G013	B, WING	B, WING			07/17/2020	
	ROVIDER OR SUPPLIER	TH INC		4211 COU	DDRESS, CITY, STATE, ZIP CODE UNTY STREET MOUTH, VA 23707			
(X4) ID PREFIX TAG	FEIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT AG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
E 000	Survey was conducted 07/17/20. The facility compliance with 42 C preparedness regulated of The Centers for Mesorvices and Centers recommended practice COVID-19.  INITIAL COMMENTS  A COVID-19 Focused was conducted onsite Corrections are required CFR Part 483.470 (I)(regulations, for the imfor Medicare and Medicare and Medicare and Medicare for COVID-19 consisted of 17 Individent 17, #8, #9, #10, #11, #17). Six facility Individent COVID-19 and one repositive for COVID-19  The census in this 28 time of the onsite survive for COVID-19.  The census in this 28 time of the onsite survive for COVID-19.  The census in this 28 time of the onsite survive for COVID-19.  The census in this 28 time of the onsite survive for COVID-19.  There must be an action prevention, control, and communicable distance of the communication of the communica	FR Part 483.73 emergency ions, for the implementation edicare and Medicaid for Disease Control ses to prepare for  d Infection Control Survey 07/14/20 through 07/17/20. Fed for compliance with 42 1) infection control plementation of the Centers licaid Services and Centers for ecommended practices to 2. The survey sample duals (#1 #2, #3, #4, #5, #6, #12, #13, #14, #15, #16 and duals tested positive for covered. Seven staff tested 1.  bed facility was 28 at the rey.  DL  ve program for the and investigation of infection seases.	W C	Poin accon have Direct positi study detern negat accon have Due to Direct positi study the	t #1: How corrective action will be mplished for those individuals found to been affected by the deficient practice. to Individual #11 coming in contact with a ct Support Professional with a confirmed ive test for COVID-19; A point prevalence was completed on 7/16/2020 and it was mined that individual #11 was COVID-19		8/20/2020	
	Based on observation	ot met as evidenced by: ns, record review, staff						
ABORATORY	DIRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE	Chris	Admi	inistrative Officer	8/4	(X6) DATE	

Any deficiency statement ending with an aserisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other saleguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G013	B. WING		07	//17/2020	
	ROVIDER OR SUPPLIER	rh inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1211 COUNTY STREET PORTSMOUTH, VA 23707	ř.		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 455	and policies, the facili implement 14-day quaprevent the spread of individuals (#10, #11, #17, #1, #2, #3, #4, # survey sample that w COVID-19 positive Di (DSP), and potentially also tested positive for Additionally, 14-day quant planned or implementative facility staff failed their Personal Protectinclude the use of the The findings include:  1. Individual # 10 was 5/30/13 and readmitted diagnoses that include Autistic disorder and Aut	of facility documentation ty staff failed to identify and arantine procedures to infection for 17 of 17 #12, #13, #14, #15, #16, 5, #6, #7, #8, and #9) in the ere exposed to a known rect Support Professional of three additional DSPs that or the virus.  uarantine procedures were mented for 3 of the 17 and #2) that either returned eave of Absence (LOA) to lence of COVID-19.  on of the COVID-19 area, to properly utilize and store tive Equipment (PPE) to N95 respirator.  admitted to the facility on ed on 12/7/18 with ed but were not limited to ADHD (Attention Deficit b. Individual #10 was g mild intellectual  facility staff that Individual intact with DSP (Direct in #1 on 6/26/20. This staff th symptoms of suspected SP #1 tested positive for	W 455	Point #1: How corrective action will be accomplished for those individuals found to been affected by the deficient practice.  Due to Individual #12 sharing a room with an individual who had been in close contact with Direct Support Professional with a confirmed positive test for COVID-19. A point prevaler study was completed on 7/16/2020, and it was determined that individual #12 was COVID-positive. Environmental modifications were include that the Individual #12 have been more than the Red Zone and will be isolated within the designated space. The individual's room was and disinfected after 24 hours of being vacan CDC guidelines. Individual #12 nursing care has been updated to include that the Individual be on isolation due to testing positive for CO 19. Individual was supported from nursing s with notifying his physician immediately with health status changes. Individual was offered hourly to ensure adequate hydration. Individual supported from nursing staff with having his taken 3 times daily. Individual was supported from nursing staff with checking his oxygen saturatimes daily. Individual was supported from nursing staff with a focal assessment (ensuring that Individual #12 is free from respiratory distrest every 2 hours. Individual #12 received his modisposable plates and utensils for all of his mod	ce s 19 nade to ved to cleaned it per plan hal will VID- aff n any fluids hal was vitals from tions 3 harsing s) cals on ceals chorted	8/20/2020	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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NAME OF PROVIDER	OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
HOLIDAY HOUSE	OE DODTEMOU	TH INC		4211 COUNTY STREET				
HOLIDAT HOUSE	SF FUR I SWICO	ITING		PORTSMOUTH, VA 23707				
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141.455 0 11							8/20/2020	
Review (intelled notes a dated #10 was design	ectual disability and his nursing 7/11/20), failed as placed on a	#10's clinical record i.e. (ID) notes, health status monthly summary note it to evidence that Individual 14 day quarantine with staff on a designated unit	W 4	until a negative test result can Individual meets the time crite green zone based on current C removal of transmission-based House will monitor guidance procedures for cohorting acco of Residential Services assign RED zone with Individual #12	be achieved or the cria to return to the CDC guidance for d precautions. Ho from CDC and adordingly. The Direct staff to work in 2.	ne the diday ljust		
reveal freely in note di "(Namin the late sna (Name in the late sn	ed that Individual in and out of the ated 7/5/20 dode of Individual in ec room. At 3 pack independent of Individual in the rec room. (Name the rec room part the computer of Individual in the Individual in Individual in the Individual individual in the Indivi	sident #10's ID notes ual #10 was able to move e cottage after 7/3/20. An ID cumented the following: #10) was received by staff pm (Name of Individual #10) ntly in the rec room At 5pm 10) ate dinner independently ne of Individual #10) spent blaying checkers and in the"  #10's ISP (Individualized 6/30/20 through 6/29/21 wing interventions related to OVID-19, maintaining health ve been revised to include 2 x daily, monitoring for any of respiratory illness 2 times rved with a focal health hours from nursing ed routine scheduled address good hand hygiene overing when tolerated"  #10's ISP change note dated above COVID-19 ded to his ISP on 3/12/20. nge note failed to document #1 on 6/26/20 and any		Point #1: How corrective ac accomplished for those individual #13 coming a Direct Support Professional positive test for COVID-19. A study was completed on 7/16/determined that individual #12 positive. Environmental modi include that the Individual #13 the Red Zone and will be isol designated space. The individual disinfected after 24 hours CDC guidelines. Individual # has been updated to include the on isolation due to testing 19. Individual was supported with notifying his physician in health status changes. Individual hourly to ensure adequate hyd supported from nursing staff taken 3 times daily. Individual mursing staff with checking hit times daily. Individual was su staff with a focal assessment (Individual #13 is free from reevery 2 hours. Individual #13 disposable plates and utensils while on isolation. Individual with other confirmed individual with other confirmed individual placed on transmission-based negative test result can be ach meets the time criteria to return based on current CDC guidant transmission-based precaution monitor guidance from CDC afor cohorting accordingly.	viduals found to at practice.  It in close, contact with a confirmed a point prevalence (2020, and it was 3 was COVID-19 fications were ma 3 have been move ated within the ual's room was cloof being vacant plant the Individual positive for COVI from nursing staff mmediately with a ual was offered filleration. Individual with having his vil was supported from nursing that spiratory distress) received his meal for all of his mea #13 was only cohals in red zone. He precautions until ieved or the Individual with the green zone for the remova is. Holiday House is contact to the green zone for the remova is. Holiday House with a practice of the remova is. Holiday House with a process with the process of the remova is. Holiday House with a practice of the remova is.	with  ande to bed to leaned ber lan will ID- ff any uids I was ttals rorm ons 3 sing  Is on ls ls on ls le was a vidual ne ll of e will		

	DER/SUPPLIER/CLIA FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  HOLIDAY HOUSE OF PORTSMOUTH INC			. 4211	EET ADDRESS, CITY, STATE, ZIP CODE  1 COUNTY STREET  RTSMOUTH, VA 23707		
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(i.e. 14 day quarantine with desi assigned on a designated unit).  On 7/17/20 at at approximately (administrative staff member #1 Administrator and ASM #2, the Nursing) were made aware of the concerns. No further information prior to exit.  2 Individual #11 was admitted 7/6/10 with diagnoses that inclu limited to Autistic disorder, and dysregulation. Individual #11 was having profound intellectual disability staff #11 had come into contact with Professional (DSP) #1 on 6/26/2 member presented with sympto COVID on 6/26/20. DSP #1 test COVID -19 on 7/3/20.  Review of Individual #11's clinic (intellectual disability notes heal and his nursing monthly summa evidence that Individual #11 was day quarantine with designated a designated unit after his expositive for the cottage affollowing note in part, was docur 7/15/20: (Name of Individual #11's review of Individual #11 by staff while he relaxed in loung Review of Individual #11's ISP (individual #11's review of Individual #11's review of Individual #11 by staff while he relaxed in loung Review of Individual #11's ISP (individual #11's	4:30 p.m., ASM ) the DON (Director of ne above n was presented  to the facility on ded but were not disruptive mood as documented as abilities.  If that Individual Direct Support 20. This staff ms of suspected red positive for  all record i.e. Ith status notes any notes), failed to s placed on a 14 assigned staff on sure to DSP #1.  Is ID notes as able to move ter 7/3/20. The mented on 1) was received ge with peers"	W 4	55	The Director of Residential Services assigned staff to work in RED zone with Individual #1  Point #1: How corrective action will be accomplished for those individuals found thave been affected by the deficient practice.  Due to Individual #14 coming in contact with Direct Support Professional with a confirmed positive test for COVID-19; A point prevaler study was completed on 7/16/2020 and it was determined that individual #14 was COVID-negative.  Point #1: How corrective action will be accomplished for those individuals found thave been affected by the deficient practice.  Due to Individual #15 sharing a room with an individual who had been in close contact with Direct Support Professional with a confirmed positive test for COVID-19; A point prevaler study was completed on 7/16/2020, and it was determined that individual #15 was COVID-negative.  Point #1: How corrective action will be accomplished for those individuals found thave been affected by the deficient practice.  Due to Individual #16 coming in contact with Direct Support Professional with a confirmed positive test for COVID-19; A point prevalent study was completed on 7/16/2020 and it was determined that individual #16 was COVID-negative.  Point #1: How corrective action will be accomplished for those individuals found thave been affected by the deficient practice.  Due to Individual #17 coming in close, contact with a Direct Support Professional with a confirmed positive test for COVID-19. A point prevalence study was completed on 7/16/202 and it was determined that individual #17 was covid-19 positive.	3.  o e.  i a l  i acce s  i 9  o e.  i a l  i acce s  i 9  o e.  c t  int o o,	8/20/2020

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER HOUSE OF PORTSMOUT	TH INC	42	REET ADDRESS, CITY, STATE, ZIP CODE 111 COUNTY STREET DRTSMOUTH, VA 23707	07/17/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION	
W 455	documented the follow COVID-19: "Due to Covid and hygiene goals had temperature checks 2 signs and symptoms of daily, and being observances assessment every 2 histaffresuming misses appointments, and to and wearing a face concerns were additional interventions were additional intervention (i.e. 14 day quarantine assigned, on a design On 7/17/20 at at approximate (administrator and ASI Nursing) were made a concerns. No further in prior to exit.  3. Individual #12 was a 8/9/18 with diagnoses limited to Autistic disort Individual #12 was doprofound intellectual of the standard and the standard	wing interventions related to OVID-19, maintaining health we been revised to include a x daily, monitoring for any of respiratory illness 2 times reved with a focal health ours from nursing ad routine scheduled address good hand hygiene overing when tolerated"  11's ISP change note dated above COVID-19 ded to his ISP on 3/12/20. In the money of the signated staff ated unit).  21 on 6/26/20 and any some sures put into place with designated staff ated unit).  22 on the property of the above information was presented admitted to the facility on that included but were not over and conduct disorder. Coumented as having	W 455	Environmental modifications were made to in that the Individual #17 have been moved to the Zone and will be isolated within the designate space. The individual's room was cleaned and disinfected after 24 hours of being vacant perguidelines. Individual #17 nursing care plan be updated to include that the Individual will be isolation due to testing positive for COVID-19. Individual was supported from nursing st with notifying his physician immediately will health status changes. Individual was offered hourly to ensure adequate hydration. Individual supported from nursing staff with having his taken 3 times daily. Individual was supported nursing staff with checking his oxygen saturatimes daily. Individual was supported from nursing staff with a focal assessment (ensuring that Individual #17 is free from respiratory distres every 2 hours. Individual #17 received his medisposable plates and utensils for all of his medisposable plate	te Red ed it CDC tas been ton aff in any fluids al was vitals from tions 3 tursing s) als on tals chorted He was til a tividual tone ral of se will dures	

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W 455   Continued From page 5   This staff member presented with symptoms of suspected COVID -19 on 7/3/20.   Review of Individual #12's clinical record i.e. (intellectual disability notes health status notes and his nursing monthly summary notes), failed to evidence that Individual #11 and DSP #1.   Further review of Resident #12's ID notes revealed that Individual #12 was able to move freely in and out of the cottage after 7/3/20. An ID note dated 7/5/20 documented in part, the			49G013	B, WING	B, WING		07	07/17/2020	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 455  Continued From page 5  This staff member presented with symptoms of suspected COVID on 6/29/20. DSP #1 tested positive for COVID -19 on 7/3/20.  Review of Individual #12's clinical record i.e. (intellectual disability notes health status notes and his nursing monthly summary notes), failed to evidence that Individual #12 was placed on a 14 day quarantine with designated assigned staff, on a designated unit after being in close contact with Individual #11 and DSP #1.  Further review of Resident #12's ID notes revealed that Individual #12 was able to move freely in and out of the cottage after 7/3/20. An ID note dated 7/5/20 documented in part, the	HOLIDAY HOUSE OF PORTSMOUTH INC			42	211 COUNTY STREET ORTSMOUTH, VA 23707				
W 455 Continued From page 5 This staff member presented with symptoms of suspected COVID on 6/29/20. DSP #1 tested positive for COVID -19 on 7/3/20.  Review of Individual #12's clinical record i.e. (intellectual disability notes health status notes and his nursing monthly summary notes), failed to evidence that Individual #12 was placed on a 14 day quarantine with designated assigned staff, on a designated unit after being in close contact with Individual #11 and DSP #1.  Further review of Resident #12's ID notes revealed that Individual #12 was able to move freely in and out of the cottage after 7/3/20. An ID note dated 7/5/20 documented in part, the	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION DATE	
following: "went to the gym and ran around and swing outside and in the gym and had snack at 10 clock and he play with a music toy and then we went for a walk outside on ground and stop the bus stop this morning with other friends and DSP and had a good day."  Review of Individual #'12's ISP (Individualized Support Plan) dated 9/9/19 through 9/8/20 documented the following interventions related to COVID-19: "Due to COVID-19, maintaining health and hygiene goals have been revised to include temperature checks 2 x daily, monitoring for any signs and symptoms of respiratory illness 2 times daily, and being observed with a focal health assessment every 2 hours from nursing staff with a focal assessment (ensuring that Individual #1 received his meals on disposable plates and utensils for all of his meals while on isolation due to testing positive for COVID-19. Individual was supported from nursing staff with notifying his physician immediately with any health satus changes. Individual was supported from nursing staff with having his vitals taken 3 times daily. Individual was supported from nursing staff with checking his oxygen saturations 3 times daily. Individual was supported from nursing staff with a focal assessment (ensuring that Individual #1 is free from respiratory distress) every 2 hours. Individual #1 received his meals on disposable plates and utensils for all of his meals while on isolation. Individual #1 was only cohorted with other confirmed individuals in red zone.	W 455	This staff member presuspected COVID on positive for COVID -1:  Review of Individual # (intellectual disability and his nursing month evidence that Individuday quarantine with da designated unit after Individual #11 and DS  Further review of Resurevaled that Individual freely in and out of the note dated 7/5/20 door following: "went to the swing outside and in the 10 clock and he play we went for a walk out the bus stop this more DSP and had a good we went for a walk out the bus stop this more DSP and had a good following: "Due to Cound hygiene goals have temperature checks 2 signs and symptoms of daily, and being observant every 2 he staffresuming misses appointments, and to and wearing a face cound.	esented with symptoms of 6/29/20. DSP #1 tested 9 on 7/3/20.  #12's clinical record i.e. notes health status notes help summary notes), failed to the first and the signated assigned staff, on the being in close contact with SP #1.  #12's ID notes and #12 was able to move the cottage after 7/3/20. An ID cumented in part, the the gym and ran around and the gym and had snack at with a music toy and then atside on ground and stop oning with other friends and day."  #12's ISP (Individualized 8/9/19 through 9/8/20 wing interventions related to OVID-19, maintaining health we been revised to include the x daily, monitoring for any of respiratory illness 2 times are averaged and responded and hygiene overing when tolerated"	W	455	accomplished for those individuals found thave been affected by the deficient practice.  Due to Individual #1 being assigned to a DS confirmed positive test for COVID-19. Indiv #1 presented symptoms for COVID-19, receive testing, and tested positive on 7/4/2020.  Environmental modifications were made to it that the Individual #1 have been moved to the Zone and will be isolated within the designar space. The individual's room was cleaned and disinfected after 24 hours of being vacant perguidelines. Individual #1 nursing care plan have been updated to include that the Individual won isolation due to testing positive for COVI 19. Individual was supported from nursing swith notifying his physician immediately with health status changes. Individual was offered hourly to ensure adequate hydration. Individual was supported from nursing staff with having vitals taken 3 times daily. Individual was supported mursing staff with checking his oxygen saturations 3 times daily. Individual was supported individual #1 is free from resp distress) every 2 hours. Individual #1 received meals on disposable plates and utensils for all his meals while on isolation. Individual #1 wonly cohorted with other confirmed individual	P with idual ved nelude e Red ded ded ded ded ded ded ded ded	8/20/2020	

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NAME OF PROVIDER OR SUPPLIER  HOLIDAY HOUSE OF PORTSMOUTH INC  STREET ADDRESS, CITY, STATE, ZIP CODE  4211 COUNTY STREET  PORTSMOUTH, VA 23707	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455  Continued From page 6  The ISP and ISP change note failed to document his exposure to Individual #11 and DSP #1 on 6/26/20 and any additional interventions/measures put into place (i.e. 14 day quarantine with designated staff assigned, on a designated unit).  On 7/17/20 at at approximately 4:30 p.m., ASM (administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.  As a result of the Point Prevalence Survey (PPS) conducted on 77/6/20, Individual #12 tested positive for COVID-19.  A lindividual #13 was admitted to the facility on 8/6/18 and readmitted on 7/26/19 with diagnoses that included but were not limited to mood disorder, and epilepsy with recurrent seizures. Individual #13 was documented as having profound intellectual disabilities.  It was determined by facility staff that Individual #13 had come into contact with Direct Support Staff (DSP) #1 on 6/26/20. DSP #1 tested positive for COVID-19 on 7/3/20.  Review of Individual #13's clinical record i.e. (intellectual disability notes health status notes and his nursing monthly summary notes), failed to evidence that Individual #13's was placed on a 14 day quarantine with assigned designated staff, on	8/20/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON A, BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	TH INC	4	STREET ADDRESS, CITY, STATE, ZIP CODE 4211 COUNTY STREET PORTSMOUTH, VA 23707	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
W 455	freely in and out of the note dated 7/9/20 do following: "(Name of I in the right wing porch the rest of the afternoon Review of Individual # Support Plan) dated 8 documented the follow COVID-19: "Due to Cand hygiene goals hat temperature checks 2 signs and symptoms daily, and being observations and wearing a face control of the ISP and ISP charm his exposure to DSP additional intervention (i.e. 14 day quaranting assigned, on a design Further review of his of he had been sent out The following note was "Called to DSP superhaving a seiure (sic). fallen from chair and right eye with noted signs and signs a seiure (sic).	ident #13's ID notes al #13 was able to move a cottage after 7/3/20. An ID aumented in part the individual #13) was received at 1500. He watched TV on in the living room."  E13's ISP (Individualized a/24/19 through 8/23/20 wing interventions related to OVID-19, maintaining health we been revised to include ax daily, monitoring for any of respiratory illness 2 times red with a focal health hours from nursing ad routine scheduled address good hand hygiene evering when tolerated"  E13's ISP change note dated above COVID-19 ded to his ISP on 3/12/20. Inge note failed to document #1 on 6/26/20 and any is/measures put into place as with designated staff	W 455	Point #1: How corrective action will be accomplished for those individuals found to been affected by the deficient practice.  Due to Individual #3 receiving direct caservices from a DSP who tested positive for C19. A point prevalence study was completed for COVID-19.  Point #1: How corrective action was negative for COVID-19.  Point #1: How corrective action was negative for those individuals found to been affected by the deficient practice.  Due to Individual #4 receiving direct caservices from a DSP who tested positive for C19. A point prevalence study was completed for COVID-19.  Point #1: How corrective action will be accomplished for those individuals found to been affected by the deficient practice.  Due to Individual #5 receiving direct caservices from a DSP who tested positive for C19. A point prevalence study was completed for those individuals found to been affected by the deficient practice.  Due to Individual #5 receiving direct caservices from a DSP who tested positive for C19. A point prevalence study was completed for those individuals found to been affected by the deficient practice.  Due to Individual #6 receiving direct caservices from a DSP who tested positive for C19. A point prevalence study was completed for those individuals found to been affected by the deficient practice.  Due to Individual #6 receiving direct caservices from a DSP who tested positive for C19. A point prevalence study was completed for those individuals found to been affected by the deficient practice.  Due to Individual #7 receiving direct caservices from a DSP who tested positive for C19. A point prevalence study was completed for those individuals found to been affected by the deficient practice.  Due to Individual #7 receiving direct caservices from a DSP who tested positive for C19. A point prevalence study was completed for those individuals found to been affected by the deficient practice.	ine and COVID- eted on dual #3  itill be to have are and COVID- eted on dual #4  io have are and COVID- eted on dual #5  itill be to have are and COVID- eted on dual #6  io have are and COVID- eted on dual #6

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G013	B. WING	B. WING		07/17/2020	
HOLIDAY	ROVIDER OR SUPPLIER			421	REET ADDRESS, CITY, STATE, ZIP CODE 11 COUNTY STREET DRTSMOUTH, VA 23707		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	۲	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 455	leaving resident awal to some question was and walk to stretcher 118/84 blood pressur oxygen bleeding under DON (Director of Nurnotified."  The next note dated a following: "resident reof eye swollen shut a commade (sic) vital s 97.6 no new orders onero (sic) asap (as so (Name of DON) made.  There was no evident 14 day quarantine up with precautions in pla 5/17/20, documented supported Shawn for peers"  On 7/17/20 at at apported supported Shawn for peers"  On 7/17/20 at at apported supported Shawn for peers"  Administrator and AS Nursing) were made a concerns. No further in prior to exit.  As a result of the Poir conducted on 7/16/20 positive for COVID-19.	ke able to answer yes and no is able to stand on his own with no problems. Vitals re 102 pulse with 98 percent er control before (sic) leaving. Tring) (Name of DON)  5/16/20 documented the enturned 05:55 am right side allert and able to follow some signs 121/84 108 pulse temp on return to follow up with boon as possible) DON re aware."  ce that he was placed on a soon arrival back to the facility ace. An ID note dated in part the following: " Staff or a movie with his roximately 4:30 p.m., ASM member #1) the side Shawn outside with his end Shawn outside with his roximately 4:30 p.m., ASM member #1) the side #2, the DON (Director of aware of the above information was presented on the Prevalence Survey (PPS) D, Individual #13 tested 9.	W	155	Point #1: How corrective action will be accomplished for those individuals found to been affected by the deficient practice. Due to Individual #8 receiving direct car services from a DSP who tested positive for CO 19. A point prevalence study was comple 7/16/2020, and it was determined that Individuals negative for COVID-19.  Point #1: How corrective action with accomplished for those individuals found to been affected by the deficient practice. Due to Individual #9 receiving direct car services from a DSP who tested positive for CO 19. A point prevalence study was comple 7/16/2020, and it was determined that Individuals negative for COVID-19.	re and OVID- ted on dual #8  ill be o have re and OVID- ted on	8/20/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/F IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G013	B. WING			07/	17/2020
	ROVIDER OR SUPPLIER	TH INC		42	REET ADDRESS, CITY, STATE, ZIP CODE 111 COUNTY STREET DRTSMOUTH, VA 23707		.,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 455	14 had come into con Professional (DSP) # member presented with COVID on 6/26/20. Die COVID -19 on 7/3/20. Review of Individual # (intellectual disability and his nursing month failed to evidence that on a 14 day quarantin staff, on a designated DSP #1.  Further review of Restrevealed that Individual freely throughout the note dated 7/4/20 door following: "(Name of with staff and peers at (Name of Individual # engaged in structured around."  Review of Individual # Support Plan) dated 4 documented the follow COVID-19: "Due to Cound hygiene goals have temperature checks 2 signs and symptoms of daily, and being observances assessment every 2 h staffresuming misses."	disabilities.  facility staff that Individual tact with Direct Support 1 on 6/26/20. This staff ith symptoms of suspected DSP #1 tested positive for  #14's clinical record i.e. notes, health status notes haly summary dated 7/5/20), t Individual #14 was placed with designated assigned unit after his exposure to  ident #14's ID notes al #14 was able to move cottage after 7/3/20. An ID sumented in part the f Individual #14) watched TV and ate his morning snack 14) went to the gym and I media time and walked  #14's ISP (Individualized #/16/20 through 4/15/21 wing interventions related to OVID-19, maintaining health we been revised to include at daily, monitoring for any of respiratory illness 2 times rved with a focal health ours from nursing	W	455	Point #1: How corrective action will be accomplished for those individuals found to been affected by the deficient practice. (Pl The Director of Nursing will specifically DSP#2 and Housekeeper #1 on properly and storing Personal Protective Equipminclude the use of the N95 respirator.  Point#2: How the facility will identify of individuals having the potential to be affer the same deficient practice:  A Point Prevalence Study was completed on 7/16/2020 for all individuals residing in the fit to determine baseline COVID-19 status. The National Guard tested all individuals for COV Based on testing results Holiday House of Portsmouth initiated the mitigation plan and the individuals into color-coded groups for cohorting. Individuals who are designated in "Red" are confirmed positives cases. The stuindicated five individuals were positive for C19. Individuals who were designated in the "Yellow" are those waiting for test results an exposed to someone with positive COVID; Individuals designated Green are confirmed and/or have recovered from COVID-19.  The Support Coordinators will complete an Inchange note for any individual who required quarantine procedures.  (PPE)  The Director of Nursing/Designee will re-trainally for test results and the host of the host of the strain includes that the face shields and N95 respirators and/or facemasks. This traincludes that the face shields and N95 respiratuse will be limited to no more than 5 uses per devices to ensure an adequate or safe marginatraining also includes donning and doffing techniques including physical inspection and seal check. The respirators will be stored in a breathable container such as a paper bag between the facility-training roster.	re-train utilizing ment to  ther cted by  divided the dy OVID-d/or negative  SP  n  use of ining tors re- This user clean reen	8/20/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G013	B. WING	B. WING		07/17/2020	
	ROVIDER OR SUPPLIER HOUSE OF PORTSMOU	THINC		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 COUNTY STREET PORTSMOUTH, VA 23707			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 455	and wearing a face of Review of Individual: 3/12/20, revealed the interventions were at The ISP and ISP chahis exposure to DSP additional intervention (i.e. 14 day quarantin assigned, designated On 7/17/20 at at appr (administrative staff in Administrator and AS Nursing) were made concerns. No further prior to exit.  6. Individual #15 was 3/29/00 with diagnose limited to Autistic disc was documented as I disabilities.  It was determined by #15 shared a room w 6/26/20. Individual #1 with Direct Support P 6/26/20. This staff in symptoms of suspect #1 tested positive for Review of Individual a (intellectual disability and his nursing mont evidence that Individual quarantine with discontinuous control of the control of t	#14's ISP change note dated above COVID-19 ided to his ISP on 3/12/20. Inge note failed to document #1 on 6/26/20 and any ins/measures put into place with designated staff I unit).  Foximately 4:30 p.m., ASM inember #1) the ism #2, the DON (Director of aware of the above information was presented information was presented information was presented information was presented in admitted to the facility on est that included but were not order, ADHD. Individual #15 in aving mild intellectual in a difficult in a dif	W 455	Point #3: What measures will be systemic changes made to ensure deficient practice will not reoccu.  The Director of Nursing implement Policy that indicates Holiday Hous will implement a 14-day quarantin individuals who have been exposed COVID-19 or have been to the ER admissions and /or readmissions. It individual has become in close corsomeone with a positive diagnosis exposed from ER hospital visit, ne and/or readmissions HHP nursing implement a quarantine protocols at The Director of Nursing/and or dest the Support Coordinator of the ind and need of 14 day quarantine. The Coordinators will coordinate an ID individual to discuss, Relocation of Care, Family notifications, Acti Treatment/activities, Therapy. The stay in the designated area on trans precautions utilizing the proper PP Protective Equipment) which includinted to face shields, facemasks, gloves. During this period, individuarantined to their bedrooms with designated bathroom. Equipment whetween units. The Support Coordidocument the ISP change note of the status change. The Nursing Depart physician immediately if there are changes. If any signs or symptoms individuals will be tested. If positive will be moved to the COVID-19 undividual will have discontinuation transmission-based precautions and 4 days have passed or they test not COVID-19. New admissions and/owhose COVID-19 status is unknow single negative test will be in a single available.	e that the ar:  Inted a Quarantine se of Portsmouth the procedure for do to someone with R, hospital, or In the event an intact with the of COVID-19, and department will and procedures. Signee will notify lividuals exposure the Support of meeting for the of individuals, Plantice individual will smission-based PE (Personal and so but not a gowns, and luals will be the a use of a will notify any health status to f COVID-19 we, the individual mit, red zone. On of different different contents of the contents	8/20/2020	

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MAME OF PROVIDER OR SUPPLIER  HOLIDAY HOUSE OF PORTSMOUTH INC    201				1 ' '		
## A STANDARD PROPOSED FOR TANDOTH INC    (A)   ID   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY PILL   TAG   TAG   TAG			49G013	B. WING	*	07/17/2020
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  W 455  Continued From page 11  Further review of Resident #15's ID notes revealed that Individual #15 was able to move freely throughout the cottage after 7/3/20. An ID note dated documented in part the following on 7/15/20: "cottage living room area where he lounged and played on the laptop until he received his snack and independently ate it. He than (sic) continued to lounge and played on the laptop until he computer until he received his dinner and independently ate it. He than (sic) continued to lounge and play on the computer until he received his fine for the evening and was received by the next staff for the evening and was received by the next staff for the evening in and was received by the next staff for the evening for any signs and symptoms of respiratory illness 2 times daily, and being observed with a focal health assessment every 2 hours from running staffresuming missed routine scheduled appointments, and to address good hand hygiene and wearing a face covering when tolerated"  Review of Individual #15's IS Po hange note dated 3/12/20, revealed the above COVID-19 interventions/measures put Into place (i.e. 24 day quarantine with designated staff assigned, on a			TH INC	42	11 COUNTY STREET	-1
Further review of Resident #15's ID notes revealed that Individual #15 was able to move freely throughout the cottage after 7/3/20. An ID note dated documented in part the following on 7/15/20: "cottage living room area where he lounged and played on the laptop until he received his snack and independently ate it. He than (sic) continued to lounge and play on the computer until he received his finer and independently ate it than continued to lounge with his peers and staff until he was supported to his bedroom for the evening,"  Review of Individual #15's ISP (Individualized Support Plan) dated 6/30/19 through 6/29/20 documented the following interventions related to COVID-19: "Due to COVID-19, maintaining health and hygiene goals have been revised to include temperature checks 2 x daily, monitoring for any signs and symptoms of respiratory illness 2 times daily, and being observed with a focal health assessesment every 2 hours from nursing staffresuming missed routine scheduled appointments, and to address good hand hygiene and wearing a face covering when tolerated"  Review of Individual #15's ISP change note failed to document his exposure to Individual #14 and DSP #1 on 6/26/20 and any additional interventions/measures put into place (i.e., 24 day quarantine with designated staff assigned, on a	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETION
On 7/17/20 at at approximately 4:30 p.m., ASM	W 455	Further review of Res revealed that Individual freely throughout the note dated document 7/15/20: "cottage live lounged and played or received his snack arthan (sic) continued to computer until he received his snack arthan (sic) continued to computer until he received his peers and state his bedroom for the ethe next staff for the ethe	sident #15's ID notes tal #15 was able to move cottage after 7/3/20. An ID ted in part the following on ving room area where he in the laptop until he tal independently ate it. He to lounge and play on the eleved his dinner and than continued to lounge off until he was supported to vening and was received by evening."  #15's ISP (Individualized 5/30/19 through 6/29/20 wing interventions related to OVID-19, maintaining health eve been revised to include ex daily, monitoring for any of respiratory illness 2 times even with a focal health fours from nursing ed routine scheduled address good hand hygiene evering when tolerated"  #15's ISP change note dated above COVID-19 ded to his ISP on 3/12/20. The provided to document dual #14 and DSP #1 on tional tes put into place (i.e. 24 day mated staff assigned, on a	W 455	The Mitigation Plan and Pandemic Plan was to include properly utilizing and storing Pers Protective Equipment to include the use of the respirator and/or facemasks. These updates it that the face shields and N95 respirators re-ube limited to no more than 5 uses per device ensure an adequate or safe margin. These up also include donning and doffing techniques including physical inspection and user seal of the respirators will be stored in a clean breat container such as a paper bag between uses. has designated an infection preventionist; which murse or designee on duty on all shifts to rounds and monitor correct utilization, storageness of PPE.  Point #4: How the facility plans to monito performance to make sure that solutions a sustained:  The Support Coordinator will bring a copy of ISP change note to the Risk Management me monthly (if applicable) to evidence Quarantip procedures were implemented.  The identified "infection preventionist" on ewill sign off on the 24 hour report sheet to exitat rounds were made to ensure the correct utilization, storage, and re-use of PPE.  Dates when the corrective action will be	s updated sonal he N95 include use will sto odates scheck. Athable HHP hich is make ge, and for its are

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A, BUILDING			(X3) DATE SURVEY COMPLETED			
		49G013	B. WING			07/	17/2020
	ROVIDER OR SUPPLIER	TH INC		4	STREET ADDRESS, CITY, STATE, ZIP CODE 211 COUNTY STREET PORTSMOUTH, VA 23707		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 455	(administrative staff m Administrator and ASI Nursing) were made a concerns. No further i prior to exit.  7. Individual #16 was 11/12/15 with diagnos not limited to Autistic of Individual #16 was do intellectual disabilities.  It was determined by the #16 had come into content of the Professional (DSP) #1 member presented with COVID on 6/26/20. District of the COVID -19 on 7/3/20.  Review of Individual #1 (intellectual disability in and his nursing monther that in the content of th	member #1) the M #2, the DON (Director of aware of the above information was presented admitted to the facility on es that included but were disorder and ADHD. Cumented as having severe facility staff that Individual intact with Direct Support if on 6/26/20. This staff the symptoms of suspected SP #1 tested positive for a support in the symptoms of suspected in the symptoms of symptoms	•	455			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G013	B. WING_		07	/17/2020	
	ROVIDER OR SUPPLIER	THINC		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 COUNTY STREET PORTSMOUTH, VA 23707			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 455	Support Plan) dated documented the follo COVID-19: "Due to Cand hygiene goals hat temperature checks? signs and symptoms daily, and being obse assessment every 2 I staffresuming misse appointments, and to and wearing a face concerns were actively and ISP chat his exposure to DSP additional intervention (i.e. 14 day quarantin assigned, on a design On 7/17/20 at approximately	#16's ISP (Individualized 12/12/19 through 12/11/20 wing interventions related to COVID-19, maintaining health live been revised to include 2 x daily, monitoring for any of respiratory illness 2 times reved with a focal health hours from nursing ed routine scheduled address good hand hygiene overing when tolerated"  #16's ISP change note dated above COVID-19 lided to his ISP on 3/12/20. Inge note failed to document #1 on 6/26/20 and any ins/measures put into place e with designated staff nated unit).  stimately 4:30 p.m., ASM member #1) the M #2, the DON (Director of aware of the above information was presented admitted to the facility on see that included but were disorder and asthma.	W 4	55			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		49G013	B. WING			07/17/2020
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
W 455	-19 on 7/3/20.  Review of Individual (intellectual disability and his nursing mon 7/11/20), failed to ever was placed on a 14 designated assigned after his exposure to evidence that any according the revealed that Individing freely in and out of the ID note dated 7/5/20 following: "remain where, where was rowhile continuing to lot for a walk around the support. He went to support, where he replaying with his toy on the sofa. He woke with peers and staff if went to the gym with relaxed at the table at Review of Individual Support Plan) dated documented the following: "Due to and hygiene goals have temperature checks signs and symptoms daily, and being obseassessment every 2	#17's clinical record i.e.  In notes health status notes thly summary note dated Individual #17 day quarantine with It staff, on a designated unit In DSP #1. There was no Iditional monitoring had cent exposure to DSP #1.  It sident #17's ID notes ual #17 was able to move the cottage after 7/3/20. An adocumented, in part, the tend in the cottage living room tocking in the rocking chair, tock out the window. He went the facility grounds with staff the recreation room with staff the recreation room. He the staff support, where he and played on the swing"  #17's ISP (Individualized 1/11/20 through 1/10/21 towing interventions related to COVID-19, maintaining health ave been revised to include 2 x daily, monitoring for any to of respiratory illness 2 times terved with a focal health	W 4	55		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G013	B. WING _			07/17/2020	
	ROVIDER OR SUPPLIER	TH INC		STREET ADDRESS, CITY, STATE, ZIP COI 4211 COUNTY STREET PORTSMOUTH, VA 23707	DE		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ES PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)		
W 455	and wearing a face of Review of Individual # 3/12/20, revealed the interventions were ad The ISP and ISP chains exposure to DSP additional intervention (i.e. 14 day quarantine assigned, on a design Further review of his che went out of the faction 7/2/20 at 12:29 p.m. Individual #17 did not until 7/2/20 at 9:32 p.m. in Individual #17's climplaced on 14 day qua LOA with precautions On 7/17/20 at at appropriate the concerns. No further in prior to exit.  As a result of the Point conducted on 7/16/20 positive for COVID-19 9. For Individual #1: plan, identify and imminum quarantine procedure #1 when it was reveal provide this individual tested positive for COVID-19 provide this individual tested provide this indiv	address good hand hygiene overing when tolerated"  #17's ISP change note dated above COVID-19 ded to his ISP on 3/12/20. Inge note failed to document #1 on 6/26/20 and any ins/measures put into place with designated staff inated unit).  clinical record revealed that illity LOA (Leave of Absence) in. with a family member. In return back to the facility in. There was no evidence inical record that he was rantine upon return from in place.  Doximately 4:30 p.m., ASM inember #1) the information was presented interval of the above information was presented interval of the facility staff failed to rediately implement in the story #1 assigned to direct care and services,	W 4	55			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(	(X3) DATE SU COMPLE	
		49G013	B.WING_			07/17	//2020
	ROVIDER OR SUPPLIER HOUSE OF PORTSMOUT	TH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 COUNTY STREET PORTSMOUTH, VA 23707			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
W 455	Care Facility for Individual Bisabilities (ICF/IID) of intellectual disabilities.  The facility staff determindividual #1 from 6/2-positive for the COVID #1's last day was 6/26 symptoms of the virus returned for work.  Review of Individual #7/3/20 at 12:57 p.m., rof the cottage, had ear in the kitchen, cleaned mat. He walked aroun the gym. The progress p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, moved abtime in the living room 7/4/20 at 2:11 p.m., indicated he conthe kitchen, indicated he con	widuals with Intellectual on 1/27/10 with severe is.  Imined DSP #1, assigned to 1/4/20-6/26/20, tested D-19 virus on 7/3/20. DSP 6/20 due to presenting is and to date has not in the interpretation of the interpretation	W 4	55			

STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		49G013	B. WING _			07 <i> </i>	17/2020
	IDER OR SUPPLIER	TH INC		STREET ADDRESS, CITY, STATE, ZIP C 4211 COUNTY STREET PORTSMOUTH, VA 23707	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
tes was systim lace de inci information in	was tested due to sted positive for CO as not until the individuals and staff at fection.  The face shield and Natural Protective Eastarted on 7/4/20 the face in place when In the individual's bedrooms commodate the "side of a facility did not refersitive on 7/3/20, not on escorted the individual's and subsequents on 7/9/20.  The face shield and Natural Protective Eastarted on 7/4/20 the face in place when In the hospital.  The investigation reported on 7/5/20 to ensure in place. The report dated 7/4-14/20 at 6 facility did not refersitive on 7/3/20, not no escorted the individual with a face on 7/9/20.  The face on the Right of assigned bedrooms sed precautions.	ealth status, that Individual his exposure to DSP #1 who VID-19 on 7/3/20, but that it dual presented with and sore throat and at that pospital to be tested. This trantine of Individual #1 with staff placed other trisk for the transmission of mask distribution and include donning and doffing quipment (PPE) was dated brough 7/11/20, thus it was sesion precaution procedures dividual #1 returned from the indicated a meeting was are appropriate measures port indicated that some were moved to with follow-up emails from the rence DSP #1 who tested indicated to the hospital on the interference DSP #3 vidual to the hospital on the interference DSP #3 vidual to the hospital on the interference DSP #3 vidual to the hospital on the interference DSP #1 was a Wing's COVID-19 area in on droplet transmission	W	455			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3	3) DATE SURVEY COMPLETED		
		49G013	B. WING			07/17/2020		
	ROVIDER OR SUPPLIER House of Portsmou	TH INC		STREET ADDRESS, CITY, STATE, ZIP COD 4211 COUNTY STREET PORTSMOUTH, VA 23707	E			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
W 455	maintaining health arevised to include terdaily, monitoring for respiratory illness 2 to observed with a heal every 2 hours.  Another ISP change indicated missed rou would be resumed, be into the community, and face covering where Plan of Care dated 3 interventions.  A third ISP change in the Individual's vitals obtained three times assessments to ensure respiratory distress edisposable plates and The Nursing Plan of the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.  There was no ISP change in the same intervention.	pandemic, COVID-19, and hygiene goals were imperature checks 2 times any signs and symptoms of imes daily and being the status focal assessment.  Inote was dated 3/16/20 time scheduled appointments but he was not able to go out ensure good hand hygiene men tolerated. The Nursing 1/16/20 indicated the same.  Inote was free from every 2 hours and meals on dutensils while on isolation. Care dated 7/4/20 indicated ins.  Individual #1 had been in 14-day quarantine (7/3/20) ignated staff on a designated in the facility staff failed to	W 4	55				

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE : COMP	SURVEY LETED
		49G013	B. WING _			07 <i>/</i>	17/2020
	ROVIDER OR SUPPLIER HOUSE OF PORTSMOU	THINC		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 COUNTY STREET PORTSMOUTH, VA 23707			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
W 455	14-day observation p aforementioned precupon his return from Absence (LOA).  Individual #2 was adron 10/18/18 with diagintellectual disabilities.  The facility staff deternative and to date has Review of Individual #2 on 6/24 COVID-19 virus on 7 was 6/26/20 due to p virus and to date has Review of Individual #7/3/20 at 12:18 p.m. ithe individual to recretaken out on a senso peers.  The progress notes dindicated Individual #7/16/20, the progress individual returned fro observation area and precautions with dedicated due to the pmaintaining health an revised to include tendaily, monitoring for a respiratory illness 2 times.	period with the same autions for Individual #2 an extended Leave of mitted to the ICF/IID facility gnoses that included severe is.  Immined DSP #1, assigned to -26/20, tested positive for the /3/20. DSP #1's last day resenting symptoms of the indicated staff walked with eation room and he was ary ride along with other indicated staff walked with eation room and he was ary ride along with other indicated the indicated staff donning full PPE.  Individualized Support Plan through 11/15/20. A change is ISP dated 3/12/20 indicated staff donning full present indicated staff donning full present individualized Support Plan through 11/15/20. A change is ISP dated 3/12/20 indicated staff donning full present individualized Support Plan through 11/15/20. A change is ISP dated 3/12/20 indicated staff donning full present indicated staff don	W4	455			

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		49G013	B. WING_	<u>"</u>		07 <i>/</i>	17/2020
	ROVIDER OR SUPPLIER	TH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 COUNTY STREET PORTSMOUTH, VA 23707			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
W 455	indicated missed routi would be resumed, but into the community, e and face covering who Plan of Care dated 3/2 interventions.  There was no ISP chat Care that indicated Intimmediately placed or observation on a design staff donned with full if to DSP #1 or that the for a 14-day observation aforementioned precaupon his return from a 11. For Individual #3: plan, identify and immediately placed or with dedicated staff and Individual #3 when it wassigned to provide the services tested positive Individual #3 was admon 8/11/15 with diagnor intellectual disabilities.  The facility staff determindividual #3 on 6/24-2 COVID-19 virus on 7/3 was 6/26/20 due to provirus and to date has a Random review of Individual #3 was admon review of Individual #3 and to date has a Random review of Individual #3 was admon review of Individual #3 and foliated the provirus and to date has a Random review of Individual #3 was admon review of Individual #3 was admon foliated the province of Individual #3 and foliated the province of Individual #3 was admon foliated the province of Individual #3 on foliated the province of Individual #3 was admon foliated the province of Individual #3 on foliated the province of Individual #3 was admon foliated the province of Individual #3 on foliated the province of Individual #3 was admon foliated the province of Individual #3 was	ine scheduled appointments at he was not able to go out insure good hand hygiene en tolerated. The Nursing 16/20 indicated the same  ange note or Nursing Plan of dividual #2 had been in 14-day quarantine (7/3/20) gnated unit with designated PPE based on his exposure facility staff created a plan ion period with the same nutions for Individual #2 an extended LOA.  The facility staff failed to rediately implement is on an observation unit and full PPE for 14 days for was revealed the DSP (#1) his individual direct care and we for COVID-19 on 7/3/20.  Initted to the ICF/IID facility is sess that included moderate included moderate included moderate included possible for the 3/20. DSP #1's last day resenting symptoms of the not returned for work.	W	155			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G013	B, WING _			07/17/2020	
	ROVIDER OR SUPPLIER	HINC	STREET ADDRESS, CITY, STATE, ZIP CODE  4211 COUNTY STREET  PORTSMOUTH, VA 23707				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE		
W 455	staff and peers. On 7/ walked with the individed he was taken out on a other peers. On 7/10/3 continued to take a continued to	04 p.m. he interacted with 4/20 at 12:18 p.m., the staff dual to recreation room and a sensory ride along with 20 at 6:46 p.m., he ammunity rides with staff andividualized Support Plan arough 9/10/20. A change is ISP dated 3/12/20	W 4	55		200	
	daily, monitoring for a respiratory illness 2 tire	d hygiene goals were perature checks 2 times ny signs and symptoms of					
	indicated missed routi would be resumed, bu into the community, et and face covering who	note was dated 3/16/20 ne scheduled appointments at he was not able to go out asure good hand hygiene en tolerated. The Nursing 16/20 indicated the same					
	Care that indicated Inc immediately placed or observation on a design	inge note or Nursing Plan of dividual #3 had been n 14-day quarantine (7/3/20) gnated unit with designated PPE based on his exposure				ε.	
	plan, identify and imm quarantine procedures with dedicated staff ar	The facility staff failed to ediately implement s on an observation unit ad full PPE for 14 days for was revealed the DSP #1					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		49G013	B. WING _		07/17/2020
	ROVIDER OR SUPPLIER	TH INC		STREET ADDRESS, CITY, STATE, ZIP COE 4211 COUNTY STREET PORTSMOUTH, VA 23707	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION DATE
W 455	Individual #4 was ad on 8/26/14 with diagrintellectual disabilities. The facility staff dete Individual #4 on 6/24 COVID-19 virus on 7 was 6/26/20 due to p virus and to date has Random review of Individual #4 on 6/24 COVID-19 virus on 7 was 6/26/20 due to p virus and to date has Random review of Individual freely through by staff. On 7/5/20 at other individuals water music. On 7/10/20 at leisure time with peer Individual #4 had an (ISP) dated 9/25/19 to note to the individual indicated due to the province to the individual indicated due to the province to include tendally, monitoring for a respiratory illness 2 to observed with a health every 2 hours.  Another ISP change indicated missed rout would be resumed, be into the community, and face covering with a face indicated missed rout would be covering with a face cov	his individual direct care and ive for COVID-19 on 7/3/20.  mitted to the ICF/IID facility noses that included severe s.  mined DSP #1, assigned to -26/20, tested positive for the /3/20. DSP #1's last day resenting symptoms of the enot returned for work.  dividual #4's progress noted p.m., indicated the individual nout the cottage, supported enot the cottage, supported enoty and listening to enoty and enough 9/24/20. A change is ISP dated 3/12/20 pandemic, COVID-19, and hygiene goals were enperature checks 2 times any signs and symptoms of	W 4	55	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3	3) DATE SURVEY COMPLETED
		49G013	B. WING			07/17/2020
	ROVIDER OR SUPPLIER	TH INC		STREET ADDRESS, CITY, STATE, ZIP COI 4211 COUNTY STREET PORTSMOUTH, VA 23707	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
W 455	Care that indicated In immediately placed of observation on a destaff donned with full to DSP #1.  13. For Individual #5 plan, identify and immediately and im	nange note or Nursing Plan of ndividual #4 had been on 14-day quarantine (7/3/20) signated unit with designated PPE based on his exposure : The facility staff failed to	W 4	55		
	ate dinner in the cotta On 7/7/20 at 8:00 a.r cottage 2 kitchen. Or on 7/15/20 at 3:51 p.	p.m., indicated the individual age 2 kitchen independently, n. he ate breakfast in the n 7/13/20, at 2:44 p.m. and m. the individual walked th staff between cottage one				
	(ISP) dated 1/10/21 t note to the individual	Individualized Support Plan hrough 1/9/21. A change 's ISP dated 3/12/20 pandemic, COVID-19,				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION  NG		(X3) DATE COMP	SURVEY PLETED
		49G013	B, WING			07/	17/2020
	ROVIDER OR SUPPLIER	TH INC	•	STREET ADDRESS, CITY, STATE, ZIP COD 4211 COUNTY STREET PORTSMOUTH, VA 23707	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
W 455	daily, monitoring for a respiratory illness 2 tin observed with a health every 2 hours.  Another ISP change indicated missed routh would be resumed, but into the community, e and face covering when Plan of Care dated 3/2 interventions.  There was no ISP change of the care that indicated indicated indicated indicated indicated indicated indicated indicated with full but to DSP #1.  14. For Individual #6: plan, identify and immediately placed or observation on a design staff donned with full but to DSP #1.  14. For Individual #6: plan, identify and immediated staff ar Individual #6 when it with the delicated staff ar Individual #6 when it with the community in the services tested por 7/3/20.  Individual #6 was admontally staff determindividual #6 on 6/24-2.  The facility staff determindividual #6 on 6/24-2.  COVID-19 virus on 7/3	d hygiene goals were aperature checks 2 times any signs and symptoms of mes daily and being a status focal assessment anote was dated 3/16/20 and scheduled appointments at he was not able to go out a nsure good hand hygiene en tolerated. The Nursing 16/20 indicated the same ange note or Nursing Plan of dividual #5 had been and 14-day quarantine (7/3/20) anated unit with designated PPE based on his exposure.  The facility staff failed to ediately implement and full PPE for 14 days for was revealed that the DSP let this individual direct care ositive for COVID-19 on anitted to the ICF/IID facility sees that included profound	W	455			

NAME OF PROVIDER OR SUPPLIER  #IOLIDAY HOUSE OF PORTSMOUTH INC    MATTER   MATTER		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
MAKE OF PROVIDER OR SUPPLIER  HOLIDAY HOUSE OF PORTSMOUTH INC  MA1D  MA1D  REGULATORY OR LSC IDENTIFYING INFORMATION)  W 455  Continued From page 25  virus and to date has not returned for work.  Random review of Individual #6's progress noted dated 71/20 at 7:10 a.m., indicated the individual spent time sitting on the grass interacting with staff and peers.  Individual #6 had an Individualized Support Plan (ISP) dated &8/31/19 through &3/02/0. A change note to the individual's ISP dated sold 31/22/0 indicated due to the pandemic, COVID-19, maintaining health and hygiene goals were revised to include temperature checks 2 times daily, monitoring for any signs and symptoms of respiratory ilmess 2 times daily and being observed with a health status focal assessment every 2 hours.  Another ISP change note was dated 3/16/20 indicated missed routine scheduled appointments would be resumed, but he was not able to go out into the community, ensure good hand hygiene and face covering when otherated. The Nursing Plan of Care that indicated Individual #6 had been immediately placed on 14-day quarantine (7/3/20) observation on a designated unit with designated staff donned with full PPE based on his exposure			49G013	B. WING			07/17/2020	
### (EACH OBECTURE Y MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE COWNESTION PATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  W 455  Continued From page 25 virus and to date has not returned for work.  Random review of Individual #6's progress noted dated 71/4/20 at 7:10 a.m., indicated the individual spent time in the common living room. On 7/8/20 at 6:11 p.m., he watched movie with peers. On 7/1/3/20 at 1:10 p.m., the individual spent time in the common living room. On 7/8/20 at 0:11 p.m., the individual spent time sitting on the grass interacting with staff and peers.  Individual #6 had an Individualized Support Plan (ISP) dated 8/31/19 through 8/30/20. A change note to the individuals ISP dated 3/16/20 indicated due to the pandemic, COVID-19, maintaining health and hygiene goals were revised to include temperature checks 2 times daily, monitoring for any signs and symptoms of respiratory illness 2 times daily and being observed with a health status focal assessment every 2 hours.  Another ISP change note was dated 3/16/20 indicated missed routine scheduled appointments would be resumed, but he was not able to go out into the community, ensure good hand hygiene and face covering when tolerated. The Nursing Plan of Care dated 3/16/20 indicated the same interventions.  There was no ISP change note or Nursing Plan of Care dated 3/16/20 indicated the same interventions and face covering when tolerated. The Nursing Plan of Care dated 3/16/20 indicated individual #6 had been immediately placed on 14-day quarantine (7/3/20) observation on a designated unit with designated staff donned with full PPE based on his exposure			JTH INC		4211 COUNTY STREET	≣		
virus and to date has not returned for work.  Random review of individual #6's progress noted dated 7/4/20 at 7:10 a.m., indicated the individual spent time in the common living room. On 7/8/20 at 6:11 p.m., he watched movie with peers. On 7/13/20 at 1:10 p.m., the individual spent time sitting on the grass interacting with staff and peers.  Individual #6 had an Individualized Support Plan (ISP) dated 8/31/19 through 8/30/20. A change note to the individual's ISP dated 3/12/20 indicated due to the pandemic, COVID-19, maintaining health and hygiene goals were revised to include temperature checks 2 times daily, monitoring for any signs and symptoms of respiratory illness 2 times daily and being observed with a health status focal assessment every 2 hours.  Another ISP change note was dated 3/16/20 indicated missed routine scheduled appointments would be resumed, but he was not able to go out into the community, ensure good hand hygiene and face covering when tolerated. The Nursing Plan of Care dated 3/16/20 indicated individual #6 had been immediately placed on 14-day quarantine (7/3/20) observation on a designated unit with designated staff donned with full PPE based on his exposure	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION	
15. For Individual #7: The facility staff failed to plan, identify and immediately implement quarantine procedures on an observation unit	W 455	virus and to date has Random review of Ir dated 7/4/20 at 7:10 spent time in the cor at 6:11 p.m., he wate 7/13/20 at 1:10 p.m. sitting on the grass is peers. Individual #6 had an (ISP) dated 8/31/19 note to the individual indicated due to the maintaining health a revised to include te daily, monitoring for respiratory illness 2 observed with a heal every 2 hours.  Another ISP change indicated missed row would be resumed, it into the community, and face covering will Plan of Care dated 3 interventions.  There was no ISP ch Care that indicated is immediately placed of observation on a des staff donned with full to DSP #1.	dividual #6's progress noted a.m., indicated the individual mmon living room. On 7/8/20 ched movie with peers. On the individual spent time interacting with staff and lindividualized Support Plan through 8/30/20. A change lis ISP dated 3/12/20 pandemic, COVID-19, ind hygiene goals were imperature checks 2 times any signs and symptoms of times daily and being lith status focal assessment interacting with staff and lith status focal assessment interacting with staff and hygiene interaction and hygiene interaction individual #6 had been on 14-day quarantine (7/3/20) signated unit with designated interaction in the proposure in the same on the same o	W 4!	55			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(>	(X3) DATE SURVEY COMPLETED	
		49G013	B. WING			07/17/2020	
	ROVIDER OR SUPPLIER	TH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 COUNTY STREET PORTSMOUTH, VA 23707			
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	ı
W 455	Individual #7 when it assigned to provide the services, tested position of the services. The facility staff deter individual #7 on 6/24-COVID-19 virus on 7/was 6/26/20 due to provirus and to date has Random review of indicated 7/3/20 at 6:05 periodicated of the services indicated he has staff, removed his disfinished. On 7/14/20 anotes indicated he was breakfast independent stop with peers.  Individual #7 had an I (ISP) dated 10/06/19 note to the individual's indicated due to the periodicated due to the periodicated to include termination of the services of the s	and full PPE for 14 days for was revealed that DSP #1 his individual direct care and five for COVID-19 on 7/3/20.  Initted to the ICF/IID facility ses that included severe in the included in the inclu	W 4:	55			
		note was dated 3/16/20 ine scheduled appointments					

	MENT OF DEFICIENCIES AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49G013	B. WING _		07	/17/2020
	ROVIDER OR SUPPLIER	UTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 COUNTY STREET PORTSMOUTH, VA 23707		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 455	into the community, and face covering well and face with a face covering with fut to DSP #1.  16. For Individual # plan, identify and imquarantine procedu with dedicated staff Individual #8 when assigned to provide services, tested post Individual #8 was and 12/18/14 with diaprofound intellectual. The facility staff defindividual #8 on 6/2 for the COVID-19 well and was 6/26/20 duthe virus and to date Random review of Individual and peers. On 7/7/2 notes indicated he sporch for social stores.	but he was not able to go out a ensure good hand hygiene when tolerated. The Nursing 3/16/20 indicated the same 3/16/20 indicated the same shange note or Nursing Plan of Individual #7 had been on 14-day quarantine (7/3/20) esignated unit with designated II PPE based on his exposure see the facility staff failed to amediately implement res on an observation unit and full PPE for 14 days for it was revealed that DSP #1 this individual direct care and sitive for COVID-19 on 7/3/20.	W 4	55		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G013	B. WING			07/17/2020	
	ROVIDER OR SUPPLIER	THINC		STREET ADDRESS, CITY, STATE, ZIP CO 4211 COUNTY STREET PORTSMOUTH, VA 23707			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
W 455	(ISP) dated 1/18/20 to note to the individual indicated due to the parameter daily, maintaining health are revised to include tendaily, monitoring for a respiratory illness 2 to observed with a health every 2 hours.  Another ISP change indicated missed rout would be resumed, bound to the community, and face covering whe Plan of Care dated 3/2/20 interventions.  There was no ISP charce that indicated in immediately placed of observation on a desistaff donned with full to DSP #1.  17. For Individual #9: plan, identify and immediated staff and Individual #9 when it assigned to provide the services, tested position in the procedure with dedicated staff and Individual #9 was additional #9 was	Individualized Support Plan hrough 1/19/21. A change is ISP dated 3/12/20 bandemic, COVID-19, and hygiene goals were inperature checks 2 times any signs and symptoms of imes daily and being the status focal assessment.  Inote was dated 3/16/20 bine scheduled appointments at the was not able to go out ensure good hand hygiene are tolerated. The Nursing 1/16/20 indicated the same ange note or Nursing Plan of adividual #8 had been in 14-day quarantine (7/3/20) ignated unit with designated PPE based on his exposure.  The facility staff failed to nediately implement as on an observation unit and full PPE for 14 days for was revealed that DSP #1 his individual direct care and ive for COVID-19 on 7/3/20.	W 45	5			

AND PLAN OF CORRECTION DENTIFICATION NUMBER		(X2) MULTIP	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		49G013	B. WING_			07/17/2020
	ROVIDER OR SUPPLIER	THINC		STREET ADDRESS, CITY, STATE, ZIP CO 4211 COUNTY STREET PORTSMOUTH, VA 23707	DE	
(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 C (EACH CORRECTIVE ACTIVE) (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 455	The facility staff dete Individual #9 on 6/24 for the COVID-19 vir day was 6/26/20 due the virus and to date Random review of Individual 7/5/20 at 7:13 pspent time in the recremovies and listened to peers. On 7/8/20 at 11:58 a front porch with staff at Individual #9 had an I (ISP) dated 8/31/19 the note to the individual indicated due to the pmaintaining health an revised to include tem daily, monitoring for a respiratory illness 2 ti observed with a healt every 2 hours.  Another ISP change reindicated missed rout would be resumed, but into the community, eand face covering when Plan of Care dated 3/20 interventions.  There was no ISP change reindicated In immediately placed of observation on a designation of the constant of	rmined DSP#1, assigned to 1/20-6/26/20, tested positive us on 7/3/20. DSP #1's last to presenting symptoms of has not returned for work.  dividual #9's progress noted o.m., indicated the individual eation room, watched o music with staff and 1:14 p.m., the individual at one kitchen independently.  a.m., he played with toys on and peers.  Individualized Support Plan prough 8/30/20. A change is ISP dated 3/12/20 andemic, COVID-19, ind hygiene goals were inperature checks 2 times any signs and symptoms of mes daily and being the status focal assessment in the was not able to go out insure good hand hygiene en tolerated. The Nursing 16/20 indicated the same	W 45	55		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G013	B. WING			07/17/2020	
	ROVIDER OR SUPPLIER HOUSE OF PORTSMO	OUTH INC		STREET ADDRESS, CITY, STATE, ZIP COD 4211 COUNTY STREET PORTSMOUTH, VA 23707	Ε		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 455	On 7/14/20 at 10:15 conducted with the Administrator, Direct Licensed Practical and Social Worker. They implemented so (based on those than ursing assessments, O2 so individuals. The Adhad one COVID cas was tested on 7/4/2 exposure to Direct so who tested positive facility went into Sh 7/4/20 Individual #1 Wing COVID-19 are transmission precauthere was no mention individuals that DSF transmitted COVID-care and service than 17 individuals from 26, 2020 was DSP COVID-19 symptom this surveyor to prothe individuals DSP services. These nation 7/15/20 at 2:32 processistant Administrations observed on the Right Parket	views were conducted from 17/20:  5 am, an entry interview was Administrator, Assistant ctor of Nursing (DON), Nurse (LPN) Charge Nurse They stated in March 2020 social distancing, masks at would wear them) and focal its (VS, respiratory aturation-checks for all the ministrator stated the facility se, Individual #1 and that he 20 for COVID-19 due to his Support Professional (DSP) #1 on 7/3/20. He stated the letter in Place on 7/3/20. On I was re-assigned to the Right ea and placed on droplet utions. During the interview on of testing the other 17 P #1 may have possibly -19 due to her assignment to em. DSP#1 worked with the 6/24/20 through 6/26/20. June #1's last day of work due to ins. A request was made by vide the additional names of #1 provided care and mes were provided via email	W 45				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A, BUILDING			(X3) DATE SURVEY COMPLETED			
		49G013	B, WING _		0	7/17/2020
	ROVIDER OR SUPPLIER	TH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 COUNTY STREET PORTSMOUTH, VA 23707		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC 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
W 455	areas in order to provious ased precautions for observed cared for by individuals tolerated to very well.  On 7/15/20 at 4:00 put conducted with the Depractical Nurse (LPN) their quarantine procesuspected and confirm for 3 days. They refer Airborne Infection Iso 3/27/20 and the Pandindicated Confirmed of COVID-19 would utilized and plan indicated policy and the individual to find purpose to the service of the serv	ea were re-located to other ide droplet transmission Individual #1 who was DSP #2. She stated the he temporary re-assignment m., a phone interview was ON and the Licensed Ocharge Nurse. They stated edures for unknown, med COVID status would be enced a policy titled lation Room (AIIR) dated emic Plan dated 7/5/20 or Suspected cases of the 3-day room as a step of individuals. The same ted that individuals returning al, this same room would be dual would remain for a total before returning to the med the interview at 4:15 current Leave of Absence 15/20 due to COVID-19 unde a plan for quarantine to and symptoms of here a policy with a nage new admissions, post	W 4	55		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49G013	B. WING			07/17/2020	
	ROVIDER OR SUPPLIER HOUSE OF PORTSMOU	JTH INC		STREET ADDRESS, CITY, STATE, ZIP COD 4211 COUNTY STREET PORTSMOUTH, VA 23707	E		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION E DATE	
W 455	None of the aforeme addressed a 14-day dedicated staff, area admitted, re-admitted COVID-19 should be the virus for 14-days recommended COV individuals that were DSP#1 were not mo COVID-19 for at least exposure and DSP#COVID-19 on 7/3/20 date would be 7/17/2 use dedicated staff in placed the individual COVID-19.  According to CDC gone created for managin readmissions or post COVID-19 status is area with staff donner (or facemask if N95 (i.e., goggles or displand gown. (http://www.cdc.gov/Chcare-facilities.html). The Volume (VDH) referenced to aforementioned CDC CON 7/16/20 at 3:32 powith the Administrate Social Worker, the Amitigation plan dated preparation for the rethe individuals on 7/16/20 at 3:32 power control of the rethe individuals on 7/16/20 at 3:32 power control of the rethe individuals on 7/16/20 at 3:32 power control of the rethe individuals on 7/16/20 at 3:32 power control of the rethe individuals on 7/16/20 at 3:32 power control of the rethe individuals on 7/16/20 at 3:32 power control of the rethe individuals on 7/16/20 at 3:32 power control of the rethe individuals on 7/16/20 at 3:32 power control of the rethe individuals on 7/16/20 at 3:32 power control of the rethe individuals on 7/16/20 at 3:32 power control of the rethe individuals on 7/16/20 at 3:32 power control of the rether c	entioned policies or interviews quarantine plan with a or COVID-19 PPE. Newly of or residents exposed to a monitored for evidence of and cared for using the ID-19 PPE. The 17 exposed to the virus from nitored for evidence of at 14-days. Based on their 11 testing positive for 14, their quarantine cessation 160. Failure to quarantine and 161 and staff for the spread of 161 and staff for the spread of 162 and staff for the spread of 163 and staff for the spread of 164 and staff for the spread of 165 and staff for the spread of 166 and 166	W 4	455			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		49G013	B. WING_			07/17/2020	
	ROVIDER OR SUPPLIER	THINC		STREET ADDRESS, CITY, STATE, ZIP COD 4211 COUNTY STREET PORTSMOUTH, VA 23707	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
W 455	individuals and/or syrindividuals with designated for negation recovered from COV was designated for all individuals. When assunknown asymptomatic denoted to the without symptomatic denoted but without symptomatic denoted that those of the treated with contact at cleared to enter the guimeframe's were not in the yellow zone. All yellow zone repeated symptomatic individual would cohort COVID-unknown status individually would cohort covidually would function the above intestated, "I probably ne yellow unit would function the asymptomatic individual would cohort covidually would function the above intestated, "I probably ne yellow unit would function the asymptomatic indicated, "REThe mitigation plan at Virginia Department of the properties of the control of the c	upied by confirmed positive inptomatic suspected nated staff assigned to their ne green zone to be we individuals or those that ID-19. The yellow space I "unknown asymptomatic" ked by the survey team how tic individuals could be ney did not know at a known positive status, is. The mitigation plan on the yellow unit would be and droplet precautions until reen zone, but no need for monitoring individuals I procedures for utilizing the ally referred to unknown als, which denoted they 19 positive individuals with duals.  Inview the Administrator need to readdress how the cition and should probably it of verbiage out so there was means we knew they are not show symptoms?" With the Red, Green and Yellow FER TO CDC GUIDANCE." so indicated it was based on	W	<b>1</b> 55			

	NT OF DEFICIENCIES N OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49G013	B. WING		07	/17/2020
	ROVIDER OR SUPPLIER	THINC		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 COUNTY STREET PORTSMOUTH, VA 23707		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 455	individual 'infected' widoes not exhibit symmathe infection and are infection as a symptom symptoms) individual (https://www.cdc.gov/planning-scenarios.hsymptoms can range include fever or chills or difficulty breathing aches, headache, neathroat, congestion or vomiting and diarrhea (https://www.cdc.gov/ptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing/symptoms-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-testing-test	ymptomatic cases as an with COVID-19 virus who ptoms during the course of just as likely to transmit omatic (presents with legacian coronavirus/2019-ncov/hcp/tml). Symptomatic case a from mild to severe to a cough, shortness of breath a fatigue, muscle or body aw loss of taste or smell, sore trunny nose nausea or a coronavirus/2019-ncov/symboms.html).  Perview there was nowed in the fire ow zone on 7/3/20 to monitor at were exposed to the local hospital on mptoms and tested positive contracted the virus from cond DSP's last day of work wited a headache tested the third DSP's last day of stated positive on 7/8/20.  The fire were three contracted the virus from cond DSP's last day of work wited a headache tested the third DSP's last day of stated positive on 7/8/20.  The fire were three contracted the virus from cond DSP's last day of work wited a headache tested the third DSP's last day of stated positive on 7/8/20.  The fire were three contracted the virus from cond DSP's last day of work wited a headache tested the third DSP's last day of stated positive on 7/8/20.  The fire were three contracted the virus from cond DSP's last day of work wited a headache tested the third DSP's last day of stated positive on 7/8/20.  The fire were three contracted the virus from cond DSP's last day of work wited a headache tested the third DSP's last day of work wited and the final diministrator, DON and stated they will take a look at dures they are currently of their mitigation were revised and addressed	W 4	55		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		ATE SURVEY OMPLETED
		49G013	B. WING			07/17/2020
	ROVIDER OR SUPPLIER	DUTH INC		STREET ADDRESS, CITY, STATE, ZIP CO 4211 COUNTY STREET PORTSMOUTH, VA 23707		
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HEAPPROPRIATE	(X5) COMPLETION DATE
W 455	Direct Support (state Housekeeper #1 fastore their Personato include the use of the COVID-19 area Administrator, both were observed westheir N95. DSP#2' visible with the N95 #2 stated, "I have a have been assigned Housekeeper said same way since we well. This surveyor Administrator and a defeated the purpodirectly against the DSP #2 and House with how they store she was instructed plastic zip lock bag between uses. The cleaned her N95 we plastic zip lock bag uses.  The aforementioned the Administrator, I Charge nurse on 7.	ation of the COVID-19 area, the off) Professional (DSP) #2 and off) Professional (DSP) #2 and off) Professional (PSP) #3 and off) Professional (PPE) off the N95 respirator.  p.m. during observations of an escorted by the Assistant off) Professional Pro	W 48			
	validated how the s wore their N95. Th all staff on how to v	staff on the COVID-19 area te DON stated she educated vear the N95 and told them if from under the mask to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		G	(X3) DATE SURVEY COMPLETED	
		49G013	B, WING			07/17/2020	
NAME OF PROVIDER OR SUPPLIER  HOLIDAY HOUSE OF PORTSMOUTH INC				STREET ADDRESS, CITY, STATE, ZIP COI 4211 COUNTY STREET PORTSMOUTH, VA 23707	DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATI	(X5) COMPLETION E DATE	
W 455	seeping from under the know the staff were in and the Charge Nurse DON stated she instruction. N95 in a plastic zip lower monitors or rounds or procedures were in playing proper use of PPE, the Assistant Administrate person."  On 7/16/20 at 2:30 p. 1 conducted with the Did Health Department. Staff was observed implied to the N95, she was observed in the N95, she was observed in the N95 and Charge Nurnobservations were she stated she did not fitted ucated on how to use to inquire about N95 fup more training.  The education sign in identified that both DS Housekeeper (7/8/20) "Face Shield and N95 Education," based on Control and Prevention which indicated "the face piece respirator to be fitted to the nose, respectively."	to their face until no air was ne N95. She said she did not aproperly wearing the N95s a made no comment. The acted the staff to store the ck bag. When asked who in the area to ensure ace on the unit to include a Administrator said, "The or is the responsible  m., a phone interview was rector of the area's Local the stated based on how the aproperly wearing and would set up more training.  a.m., a debriefing was with the Administrator, the se. The aforementioned ared with them. The DON test the staff, but they were se an N95, but would have it-testing the staff and set	W	455			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49G013	B. WING_			07/17/2020	
NAME OF PROVIDER OR SUPPLIER  HOLIDAY HOUSE OF PORTSMOUTH INC				STREET ADDRESS, CITY, STATE, ZIP C 4211 COUNTY STREET PORTSMOUTH, VA 23707	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 455	The N95 Reduces we including small particl droplets (only non-oil Fit-Tight-fitting. User a requirement-yes. Filte airborne particles incl particles. When prope an effective seal is for leakage occurs aroun when user inhales (https://www.cdc.gov/r. DifferenceInfographic Hang used respirators area or keep them in container such as a pminimize potential crorespirators so that the and the person using identified	earer's exposure to particles e aerosols and large aerosols). Face Seal seal required-yes. Fit-testing ers out at least 95% of uding large and small erly donned (placed on face) rmed to the face, minimal d edges of the respirator hiosh/npptl/pdfs/Understand c-508.pdf).  s in a designated storage a clean, breathable aper bag between uses. To bes-contamination, store ey do not touch each other the respirator is clearly	W 4	9.55			