State of Virginia

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | , , | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|--|---------------------|--|-------------------------------|--------------------------|
| | | | | _ | | c | |
| | | VA0024 | | B. WING | | 1 | 1/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| BAYSIDE | OF POQUOSON HEALTH | I AND REHAB | 1 VANTAGE | | | | |
| | Г | | | N, VA 23662 | | . | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B .SC IDENTIFYING INFORM | Y FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| F 000 | Initial Comments | | | F 000 | | | |
| | An unannounced bier Inspection was conductorrections are required following with the Virgifor the Licensure of North Consultation of the survival of the survival of the consisted of and 7 closed record of the survival of t | red 5/4/21 through red for compliance v jinia Rules and Reg ursing Facilities. certified bed facility rey. The standard s 27 current resident | n 5/11/21. with the ulations v was 43 survey | | | | |
| F 001 | | oviews. | | F 001 | | | 6/14/21 |
| | The facility was out of following state licensu | - | e | | | | |
| | This RULE: is not me In the area of Pharma | • | | | The statements made on this plan of correction are not an admission to and | d do | |
| | 12-VAC 5-371-300-A 12 VAC 5-371-370 (A Housekeeping. Refer | , | | | not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is | | |
| | 12 VAC 5-371-150 (A COV 32.1-138.01 (A) | | ghts and | | planning to take the actions set forth in following plan of correction. The follow plan of correction constitutes the center | /ing | |
| | 12 VAC 5-371-110 (B 32.1-126.01 (A). Refe | | OV | | allegation of compliance. All alleged deficiencies cited have been or are to corrected by the date or dates indicate | I | |
| | 12 VAC 5-371-250 (A Care Planning. Refer | , | ment and | | 2525.00 by the date of dates indicate | | |
| | 12 VAC 5-371-220 (D to F687. |). Nursing Services. | . Refer | | | | |
| | 12 VAC 5-371-260 (A Inservice Training. Re | • | nt and | | | | |
| | 12 VAC 5-371-300 (A |) (B). Pharmaceutic | al | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

06/04/21

State of Virginia

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | |
|---|--|--|---------------------|--|-----------------------------------|--------------------------|
| | | VA0024 | B. WING | | 0.5 | C / 11/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | • | ADDRESS, CITY, STAT | FE, ZIP CODE | , 55 | |
| BAVSIDE | OF POQUOSON HEALTH | 1 VANTA | AGE DRIVE | | | |
| BATSIDE | TOQUUSUN HEALT | POQUO | SON, VA 23662 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED TO DEFICIENCED TO DEFICIENCED TO DEFICIENCED TO TO THE PROVIDER OF T | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| F 001 | Continued From page 1 | | F 001 | | | |
| | Services. Refer to F7 | 55 and F761. | | | | |
| | 12 VAC 5-371-220 (B). Nursing Services. Refer to F760.12 VAC 5-371-340 (A) (L). Dietary and Food Service Program. Refer to F804 and F806. | | | | | |
| | | | | | | |
| | 12 VAC 5-371-180 (A Refer to F880. | a) (B). Infection Control. | | | | |
| | Provided for Depende (F). Each resident sh | ent Residents Under Section nall receive tub or shower eded, but not less than twice | | | | |
| | F-555 Please Cross F 5-371-150 (A). F-582 Please Cross F 5-371-150 (A). F657 Please Cross R 5-371-250 (I). | Reference to 12 VAC | | | | |
| | references to F558. 12 VAC 5-371-110.B. Administration) cross | references to F577. .2 (Policies and Procedures) | | | | |
| | 12 VAC 5-371-140 (E | E) (3) (A) | | | | |
| | F-658 12 VAC 5-371- | ·200 (B)(1)(ii) | | | | |

State of Virginia

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---|---|--------------------------------------|--------------------------|
| | | VA0024 | B. WING | | 05 | C 5/ 11/2021 |
| | PROVIDER OR SUPPLIER | 1 VANT | ADDRESS, CITY, STATE AGE DRIVE DSON, VA 23662 | , ZIP CODE | · | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETE DATE |
| F 001 | Continued From page 2 F-881 12VAC5-371-300 (C) F-882 12VAC5-90-103. (1) (30 (B) (C) | | F 001 | | | |
| | 1-002 12 VACS-90-10 | .б. (1) (50 (B) (С) | | | | |
| | 12 VAC5-371-250 (C) and (F) and (H) and (I). Resident Assessment and Care Planning cross references to F657 | | | | | |
| | 12 VAC5-371-220 (C) (1). Nursing Services cross references to F686 | | | | | |
| | 12 VAC5-371-300 (A cross references to F |). Pharmaceutical Services 756 | | | | |
| | 12 VAC5-371-300 (H cross references to F |). Pharmaceutical Services 758 | | | | |
| | 12 VAC 5-371-150 (E Cross-Reference to F | 3.1). Resident Rights. F-622 & F-625 | | | | |
| | 12VAC 5-371-220 (E Please cross referen | 8). Nursing Services. ce to F-684 and F-686. | | | | |
| | 12VAC 5-371-240 (C Please cross referen | .10). Physician Services. ce to F-578. | | | | |
| | 12 VAC 5-371-150 (E and F-600. | 3) Cross-Reference to F-583 | | | | |
| | 12 VAC 5-371-220 (0 F-684 and F-689. | C). Cross-Reference to | | | | |
| | 12 VAC 5-371-340 (A F-804, F-806 and F-8 | A). Cross-Reference to | | | | |

State of Virginia

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| | | | | | С | |
| | | VA0024 | B. WING | | 05/11/2021 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | DDRESS, CITY, STA | TE, ZIP CODE | | |
| BAYSIDE | OF POQUOSON HEALTI | H AND REHAB | GE DRIVE ON, VA 23662 | | | |
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| F 001 | Continued From page 3 | | F 001 | | | |
| | | Cross-Reference to F-880 | | | | |
| | | | | | | |