

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

PRINTED: 05/13/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495426</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/03/2020</b>	
NAME OF PROVIDER OR SUPPLIER  <b>MULBERRY CREEK NURSING AND REHAB CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 BLUE RIDGE STREET MARTINSVILLE, VA 24112</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments  An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 12/01/2020 and offsite 12/01-12/03/2020.  The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.			E 000			
F 000	INITIAL COMMENTS  An unannounced COVID-19 Focused Survey was conducted onsite 12/01/2020 and continued with offsite review through 12/03/2020. The facility was in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19.  The census in this 300 certified bed facility was 180 at the time of survey. At the time of the onsite survey 17 residents and 8 staff were positive for COVID-19.			F 000			

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

TITLE

(X6) DATE

Electronically Signed

12/25/2020

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.