

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

PRINTED: 02/01/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/19/2023
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NAME OF PROVIDER OR SUPPLIER JAMES RIVER NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 540 ABERTHAW AVENUE NEWPORT NEWS, VA 23601
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(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
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{E 000}	Initial Comments An unannounced Emergency Preparedness revisit to the Emergency Preparedness survey conducted 11/29/22 through 12/1/22 was conducted on 1/18/23 through 1/19/23. The facility was in compliance with the 42 CFR Part 483.73 Requirements for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard unannounced Medicare/Medicaid survey conducted 11/29/22 through 12/01/22, was conducted 1/18/23 through 1/19/23. The facility was in compliance with 42 CFR Part 483 of the Federal Long-Term Care regulations. No complaints were investigated during the survey. The census in this 154 certified bed facilities was 142 at the time of the survey. The survey sample consisted of 10 current Resident reviews. Residents 101 through 110.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 01/30/2023
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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.