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

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| MANIE OF PROVIDER OR SUPPLIER COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER STREET ADDRESS, CITY, STATE, ZP CODE 83* ELLERSULE AVE CONCENTRATION CONCENTRATIO | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|--|--|---|--|-------------------------------|------------|
| NAME OF PROVIDER OR SUPPLIER COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER (A41) B SUMMARY STATEMENT OF DEFICIENCIES (SEACH DEFICIENCY MUST ES PRECEDED BY PILLIF (IAC) B SEACH DEFICIENCY MUST ES PRECEDED BY PILLIF (IAC) B SEACH DEFICIENCY MUST ES PRECEDED BY PILLIF (IAC) B SEACH DEFICIENCY MUST ES PRECEDED BY PILLIF (IAC) B SEACH DEFICIENCY MUST ES PRECEDED BY PILLIF (IAC) B SEACH DEFICIENCY MUST ES PRECEDED BY PILLIF (IAC) B SEACH DEFICIENCY MUST ES PRECEDED BY PILLIF (IAC) B SEACH DEFICIENCY MUST ES PRECEDED BY PILLIF (IAC) B SEACH DEFICIENCY MUST ES PRECEDED BY PILLIF (IAC) B SEACH DEFICIENCY MUST ES PRECEDED BY PILLIF (IAC) B SEACH DEFICIENCY MUST ES PRECEDED BY PILLIF (IAC) B SEACH DEFICIENCY MUST ES PRECEDED BY PILLIF (IAC) B SEACH DEFICIENCY MUST ES PRECEDED BY PILLIF (IAC) B SEACH DEFICIENCY MUST ESPECIE MUST MUST MUST MUST MUST MUST MUST MUST | | | 495115 | B. WING | | | 1 | |
| PREFIX (EACH DEPICIENCY AUST BE PRECOCED BY FULL TAG CROSS-REPERBACED TO THE APPROPRIATE DIGITS OF THE APPROPRIATE DIGITS | NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 831 ELLERSLIE AVE | | | |
| An offsite paper revisit survey was conducted on 06/22/2023 for all previous deficiencies cited on 05/12/2023. All deficiencies have been corrected as of 06/20/2023. The facility is in compliance with all regulations surveyed. | PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREF | PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR | | | COMPLETION |
| LADODATORY DIRECTOR'S OR PROVIDER/SURBLIED REDRESENTATIVE'S SIGNATURE | {F 000} | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An offsite paper revisit survey was conducted on 06/22/2023 for all previous deficiencies cited on 05/12/2023. All deficiencies have been corrected as of 06/20/2023. The facility is in compliance | | {F C | DEFICIENCY) | | | |
| TARRESTED TO THE CONTROL OF THE CONT | LARGE TEST | DIRECTORIO CO DE COMPANIO | | | | | | (VC) DATE |

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.