

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

PRINTED: 01/28/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495194	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2020
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF PORTSMOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 3610 WINCHESTER DR PORTSMOUTH, VA 23707		
(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 7/29/20. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000			
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey was conducted onsite 7/29/20. The facility was in substantial compliance with 42 CFR Part 483.80 infection control regulations, and had implemented the CMS and Centers for Disease Control (CDC) recommended practices to prepare for COVID-19. The census in this 108 certified bed facility was 98 at the time of survey. A point prevalence survey (PPS) was conducted by the National Guard 7/8/20. A total of 86 residents were tested with one resident testing positive. A total of 73 staff were tested with two staff testing positive. Those staff were excluded from work until cleared. On 7/27/20 a total of 79 residents were tested. Twenty-two tests are pending, fifty-six were negative, and the previously positive resident continued to test positive and remains in isolation on droplet precaution. A total of 72 staff were tested, with twelve staff refusing. The staff test results are pending. There were four residents on an observation unit on droplet precautions.	F 000			

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

TITLE

(X6) DATE

Electronically Signed

07/31/2020

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.