PRINTED: 10/10/2017 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION 15 - ED DEV CNT 1581	(X3) DATE COMP	SURVEY
		49G002	B. WING			i .	R 26/2017
	ROVIDER OR SUPPLIER VIRGINIA TRAINING CE	:NT			STREET ADDRESS, CITY, STATE, ZIP CODE 521 COLONY RD MADISON HEIGHTS, VA 24572		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION OATE
{K 000}	story masonry structure pitched roof. The roo structure by a rated corrected by a dry spin occupy the ground flobuilding was constructed. Construction Type: II. Sprinkler status: Part Dry System in the Attit elevator shafts, Wet Stand lobby storage roof. An unannounced Life standard survey condithrough 08/09/2017 with 08/26/2017, in accord Federal Regulation, Pfor Long Term Care Fisurveyed for compliant Health Existing regulation, howed Care requirements. The	ure: Building 15 is a two re with a wood framed, f area is separated from the oncrete slab and is inkler system. Patients or of this building. The ted in 1958. (222) ially Sprinklered building, c, Pre-action System in the system in building lobbies ims on both levels. Safety Code revisit to the ucted on 08/04/2017 ras conducted on ance with 42 Code of eart 483: Requirements for acilities. The facility was one using the LSC 2012 actions. This facility houses ever chooses to meet Health one facility was in compliance as for Participation Medicare	{K (000			

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.

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

TITLE

(X6) DATE

PRINTED: 10/10/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION 7 - ED DEV CNT 1781		SURVEY
		49G002	B. WING				R
NAME OF P	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	09/	/26/2017
CENTRAL	VIDCINIA TO AINING OF	-NI#			1 COLONY RD		
CENTRAL	. VIRGINIA TRAINING CE	IN I		M	ADISON HEIGHTS, VA 24572		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPRDPRI DEFICIENCY)		(X5) COMPLETION OATE
{K 000}	INITIAL COMMENTS	;	{K (000}			
	story masonry structu. The building has a wo The roof area is sepa rated concrete slab a sprinkler system. The any patients at this tir for occupancy. The building has a work of the system of the standard survey conductive to the standard survey conductive through 08/09/2017 work of the standard survey conductive through 08/09/2017 in according to the standard survey conductive through 08/09/2017 work of the standard survey conductive through 08/09/2017 in according the standard survey conductive through 08/09/2017 in according the standard survey conductive through 08/09/2017 work of the standard survey conductive through 08/09/2017 in according the standard survey conductive through 08/09/2017 in according the standard survey conductive through 08/09/2017 in according to the standard survey conductive through 08/09/2017 work of the standard survey conductive through 08/09/2017 with the standard survey conductive through 08/09/2017 work of the standard survey conductive through 08/09/20	tially Sprinklered building, ic, Pre-action System in the System in building lobbies oms on both levels. Safety Code revisit to the lucted on 08/04/2017					
LABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>		TITLE	_	(X6) 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.

(X6) DATE

PRINTED: t0/10/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 23 - BUILOING 8 RENOVATED 2012	(X3) DATE COMP	SURVEY PLETED
		49G002	B. WING_				R 26/2017
NAME OF P	ROVIDER OR SUPPLIER		·	:	STREET ADDRESS, CITY, STATE, ZIP CODE	00/	20/2011
CENTRAL	VIRGINIA TRAINING CE	NT			521 COLONY RD		
		<u></u>		L'	MADISON HEIGHTS, VA 24572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS		{K 0	00]			
	story masonry structu	ure: Building 8 is a one re. The building was in 1951 and completely					
	Construction Type: II	(000)					
	Sprinkler status: Fully Sprinklered NFPA 13 System with quick response heads. An unannounced Life Safety Code revisit to the standard survey conducted on 08/04/2017 through 08/09/2017 was conducted on 08/26/2017, in accordance with 42 Code of Federal Regulation, Part 483: Requirements for for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Health Existing regulations. This facility houses ICFID residents, however chooses to meet Health Care requirements. The facility was in compliance with the Requirements for Participation Medicare and Medicaid. Corrected deficiencies are identified on the CMS-2567B.						
LABORATORY D	DIRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) 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.

PRINTED: 10/10/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(Xt) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION NG 2 4 - BUILDING 12 RENOVATED 20 1	2	(X3) DATE SURVEY COMPLETED
	·	49G002	B. WING_			R 09/26/2017
	ROMDER OR SUPPLIER VIRGINIA TRAINING CE	NT		STREET ADDRESS, CITY, STATE, ZIP 521 COLONY RD MADISON HEIGHTS, VA 24572		33.20.23.11
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	
{K 000}	story masonry structuoriginally constructed remodeled in 2012. Construction Type: II Sprinkler status: Fully System with quick resumption of the standard survey conductor of the standard survey of the sta	ure: Building 12 is a one re. The building was in 1951 and completely (000) y Sprinklered NFPA 13 ponse heads. Safety Code revisit to the ucted on 08/04/2017 ras conducted on ance with 42 Code of rart 483: Requirements for acilities. The facility was no cusing the LSC 2012 rations. This facility houses ever chooses to meet Health the facility was in compliance is for Participation Medicare	{K 0	DEFICIEN		

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.

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

TITLE

(X6) OATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/10/2017 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (Xt) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 40 - BUILDING 10 49G002 09/26/2017 NAME OF PROVIOER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP CODE 521 COLONY RD CENTRAL VIRGINIA TRAINING CENT MADISON HEIGHTS, VA 24572 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {K 000} | INITIAL COMMENTS {K 000} Description of Structure: Building 10 is a one story masonry structure. The building was originally constructed in 1951 and completely remodeled in 2015. Construction Type: II (000) Sprinkler status: Fully Sprinklered NFPA 13 System with quick response heads. An unannounced Life Safety Code revisit to the standard survey conducted on 08/04/2017 through 08/09/2017 was conducted on 08/26/2017, in accordance with 42 Code of Federal Regulation, Part 483: Requirements for for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Health Existing regulations. This facility houses ICFID residents, however chooses to meet Health Care requirements. The facility was in compliance with the Requirements for Participation Medicare and Medicaid. Corrected deficiencies are identified on the CMS-2567B.

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

TITLE

(X6) DATE

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PRINTED: 10/10/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION 77 - BUILDING 9	(X3) DATE COMP	SURVEY LETED
		49G002	B. WING		107	1	R 26/20 1 7
	ROVIDER OR SUPPLIER VIRGINIA TRAINING CE	NT			STREET ADDRESS, CITY, STATE, ZIP COOE 521 COLONY RD MADISON HEIGHTS, VA 24572		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	story masonry structu The building was origi and completely remod Construction Type: II	ure: Building 9 is a one re with a partial basement. inally constructed in 1951 deled in 2013. (000) y Sprinklered NFPA 13	{K C	000	}		
	standard survey cond through 08/09/2017 w 08/26/2017, in accord Federal Regulation, P for Long Term Care F surveyed for compliar Health Existing regula ICFID residents, howe Care requirements. The	ras conducted on ance with 42 Code of lart 483: Requirements for acilities. The facility was not using the LSC 2012 lations. This facility houses ever chooses to meet Health the facility was in compliance as for Participation Medicare					

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.

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

(X6) OATE

PRINTED: 10/10/2017 FORM APPROVED

FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION 11 - BUILDING ELEVEN	(X3) DATE COMP	SURVEY LETED
		49G002	B. WING			l	₹ 26/2017
	ROVIDER OR SUPPLIER VIRGINIA TRAINING CE	NT		5	TREET ADDRESS, CITY, STATE, ZIP CODE 21 COLONY RD MADISON HEIGHTS, VA 24572	1 037	20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION OATE
{K 000}	INITIAL COMMENTS		{K 0	000}		. "	
	story masonry structure constructed in 1951 at Construction Type: II Sprinkler status: Fully An unannounced Life standard survey condithrough 08/09/2017 w 08/26/2017, in according Term Care Fourveyed for compliant Health Existing regulation, howed Care requirements. The Construction of	y Sprinklered. Safety Code revisit to the ucted on 08/04/2017					
į	Corrected deficiencies CMS-2567B.	s are identified on the					
ABORATORY D	IRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) 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.

	POS1	T-CERTIFIC	ATION REV	VISIT RI	EPORT	•		
PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER						·	DATE OF REV	ISIT
49G002	A. Building 24 _{Y1} B. Wing	- BUILDING 12 REN	IOVATED 2012				9/26/2017	
NAME OF FACILITY		~	STREET	ADDRESS, CIT	Y. STATE, ZIF	P CODE	10.20.20.11	Y3
CENTRAL VIRGINIA TRA	INING CENT		521 COL		.,	0001		
			MADISO	N HEIGHTS, VA	24572			
This report is completed by a show those deficiencies prev date such corrective action v the identification prefix code	riously reported on the vas accomplished. Ea	CMS-2567, Stateme ch deficiency should	ent of Deficiencies at be fully identified us	nd Plan of Cor sing either the	rection, that regulation or	have been correct	ted and the umber and	
(TEM	DATE	ITEM		DATE	ITEM		DA*	TF.
Y4	Y5	Y4		Y5	Y4		Y	
ID Prefix	Correction	ID Prefix	-	Correction	ID Prefix	· ·	Corr	ection
NFPA 101	Completed	Reg. #	01	Completed	Reg.#	NFPA 10 t	Com	pleted
LSC K021t	09/26/2017	LSC K0353		09/26/2017	LSC	K0355	09/28	5/2017
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Corr	ection
NFPA 101 Reg. #	Completed	Reg. #	01	Completed	Reg. #	NFPA 101	Com	pleted
LSC K0902	09/26/2017	LSC K0904		09/26/20t7	LSC	K0914	09/26	5/2017
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Corr	ection
NFPA t01	Completed	Reg. #	_	Completed	Reg.#			pleted
LSC K0918	09/26/2017	LSC			LSC			
ID Prefix	Correction	ID Prefix		Correction	ID Prefix	***	Corr	ection
Reg. #	Completed	Reg. #		Completed	Reg. #		Com	pleted
LSC		LSC			LSC			
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Corr	ection
Reg. #	Completed	Reg. #		Completed	Reg.#			pleted
LSC		LSC			LSC			
	EVIEWED BY	DATE 09-26-17	SIGNATURE OF SUR	RVEYOR	JH L	20	DATE 09/26/2	2017
	EVIEWED BY NITIALS)	DATE	TITLE			<u>'</u>	DATE	·
FOLLOWUP TO SURVEY COMP 8/9/2017	PLETED ON	CHECK FOR A UNCORRECT	ANY UNCORRECTED ED DEFICIENCIES (C	DEFICIENCIES MS-2567) SEN	S. WAS A SUM	IMARY OF CILITY?		——] NO
	 .	<u> </u>						

		POST	-CERTIFICA	TION REVISIT	REPORT	
	R / SUPPLIER / C	ż ż				DATE OF REVISIT
49G002	CATION NUMBER	A. Building 15 B. Wing	- ED DEV CNT 1581			y ₂ 9/26/2017 y ₃
NAME OF	FACILITY			STREET ADDRESS	CITY, STATE, ZIP CODE	Y2 9/20/2017 Y3
CENTR	AL VIRGINIA T	RAINING CENT		521 COLONY RD		
				MADISON HEIGHTS	S, VA 24572	
show tho date sucl	se deficiencies p n corrective actio	reviously reported on the in was accomplished. Ea	CMS-2567, Statement ch deficiency should be	edicaid and/or Clinical Labor t of Deficiencies and Plan of e fully identified using either odes shown to the left of eac	Correction, that have been the regulation or LSC prov	n corrected and the vision number and
ITE	M	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	NFPA 101	Completed	Reg. #	Completed	NFPA 101	Completed
LSC	K0353	09/26/2017	LSC K0914	09/26/2017	LSC K0918	09/26/2017
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg.#		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	i Reg. #	Completed
LSC			LSC		LSC	
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LSC			LSC		LSC	
						_
REVIEWEI STATE AG		REVIEWED BY (INITIALS) COH	DATE S 9	IGNATURE OF SURVEYOR	L. 25	DATE 09/26/2017
REVIEWEI	рву 🔲	REVIEWED BY (INITIALS)	DATE T	ITLE		DATE
FOLLOWU 8/9/2017	IP TO SURVEY CO	MPLETED ON	CHECK FOR AN UNCORRECTED	Y UNCORRECTED DEFICIENC DEFICIENCIES (CMS-2567) S	CIES. WAS A SUMMARY OF SENT TO THE FACILITY?	☐ YES ☐ NO

Form CMS - 2567B (09/92) EF (11/06)

Page 1 of 1

EVENT ID:

JYZY22

			POST	-CERT	TIFICATIO I	N REVISIT RI	EPORT	•		
	R / SUPPLIER / C CATION NUMBER		MULTIPLE CDN: A. Building 17 B. Wing		NT 1781			Y2	DATE OF REVIS	
NAME OF	FACILITY		!		-	STREET ADDRESS, CIT	Y STATE ZIE		0.20.2011	Y3
CENTR	AL VIRGINIA T	RAINING	G CENT			521 CDLONY RD	1,0,7,0,2,211	0002		
						MADISON HEIGHTS, VA	24572		<u> </u>	
show tho date such	se deficiencies μ h coπective actio	previously on was ac	reported on the complished. Ea	CMS-2567, ch deficienc	Statement of Defic y should be fully ide	and/or Clinical Laborato ciencies and Plan of Cor entified using either the own to the left of each re	τection, that regulation or	have been correct. LSC provision no	cted and the umber and	
ITE	M		DATE	ITEM		DATE	ITEM		DATE	
Y4			Y5	Y4		Y5	Y4		. Y5	
						····				
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Сопе	ction
Reg.#	NFPA 101		Completed	Reg. #	NFPA 101	Completed	Reg.#	NFPA 101	Comp	leted
LSC	K0353		- 09/26/2017	LSC	K0914	09/26/2017				
	10000		- 03/20/2011	LSC	K0914	09/20/2017	LSC	K0918	09/26/2	:017
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Correc	ction
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LSC			=	LSC		•	LSC			0.50
				1200			LSC			
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LSC			-	LSC			LSC			
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LSC	-		-	LSC	 -		_			Cica
			- -	1.30			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Соптес	ction
Reg. #			Completed	Reg. #		Completed	Reg. #		Compl	leted
LSC			_	LSC			LSC			
			-						7	
REVIEWE STATE AG	AF I	REVIEW (INITIAL:	^ ^	DATE 09-26		RE OF SURVEYOR	从上	29-	DATE 09/26/2	<u> </u>
REVIEWE CMS RO	D BY	REVIEW (INITIAL:		DATE	TITLE				DATE	
FOLLOWU 8/9/2017	LLOWUP TO SURVEY COMPLETED ON				CK FOR ANY UNCO ORRECTED DEFICI	RRECTED DEFICIENCIES ENCIES (CMS-2567) SEN	S. WAS A SUM T TO THE FAC	IMARY OF CILITY?	YES	NO .

			POS1	-CERT	IFICATION	ON RE	VISIT RI	EPORT	•			
	R / SUPPLIER / C CATION NUMBER		MULTIPLE CON: A. Building 23 B. Wing		8 RENOVATED	2012			Y2	DATE 0	F REVISIT	Y3
NAME OF	FACILITY		I		-	STREE	ET ADDRESS, CIT	Y. STATE, ZI		1		13
CENTR	AL VIRGINIA T	RAINING	S CENT				OLONY RD	.,	-			
						MADIS	SON HEIGHTS, VA	24572				
show tho	se deficiencies p h corrective actic	oreviously on was ac	reported on the complished. Ea	CMS-2567, ch deficiency	Statement of De should be fully	eficiencies identified	and Plan of Cor using either the	rection, that	nent Amendments have been correct r LSC provision nu on the survey repo	ted and thumber and	ne	
ITE	M		DATE	ÎTEM	·····	<u>.</u>	DATE	ITEM		.	DATE	_
Y4			Y5	Y4			Y5	Y4			Y5	
				-				<u> </u>	**			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction	on
Reg. #	NFPA 101		Completed	Reg.#	NFPA 101		Completed	Reg. #	NFPA t01		Complet	ed
LSC	K0904		09/26/2017	LSC	K0914		- - 09/26/2017 -	LSC	K0918		09/26/201	17
ID Prefix			Correction	ID Prefix			Correction	ID Prefix	<u>-</u>		Correction	on
Reg.#			Completed	Reg. #			Completed	Reg.#			Complet	ed
LSC			-	LSC			_	LSC				
ID Prefix			Correction	ID Prefix		"-	Correction	ID Prefix	***	- <u>-</u>	Correction	 on
Reg.#			Completed	Reg. #	·-		Completed	Reg. #			Complet	ed
LSC			- -	LSC			_	LSC				
ID Prefix			Correction	ID Prefix			Correction	. ID Prefix		,	Correction	on .
Reg.#			Completed	Reg. #		•	Completed	Reg. #		, <u>,</u>	Complet	ed
LSC			-	LSC			_	LSC			•	
ID Prefix			Correction	ID Prefix	<u></u>		Correction	ID Prefix			Comedi	
Reg.#			Completed	Reg. #			_			 -	Correction	
LSC			- Completed	LSC			Completed	Reg. #			Complet	ed
		-	-				-					
REVIEWE STATE AG		REVIEW (INITIALS		DATE 09-26-		URE OF S	URVEYOR	JHL	129	DATE 09	/26/20	— 17
REVIEWE CMS RO	D BY	REVIEW (INITIAL)		DATE	TITLE					DATE		
FOLLOWI 8/9/2017	JP TO SURVEY CO	OMPLETED	OON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?								

		POST	-CERTIFICATI	ON REVISIT RE	EPORT	
	R / SUPPLIER / C					DATE OF REVISIT
49G002	CATION NUMBER	A. Building 77 Y1 B. Wing	- BUILDING 9			9/26/2017
NAME OF	FACILITY	_ <u> </u>		STREET ADDRESS, CIT	Y. STATE, ZIP CODE	Y2 9/20/2017 Y3
CENTR	AL VIRGINIA T	RAINING CENT	•	521 COLONY RD	7) = 11 W C Z 11 C C C C C C C C C C C C C C C C C	
	-		. 	MADISON HEIGHTS, VA	24572	
show the date suc	se deficiencies p h corrective actio	previously reported on the on was accomplished. Ear	CMS-2567, Statement of [ch deficiency should be full	raid and/or Clinical Laborato Deficiencies and Plan of Cor ly identified using either the s shown to the left of each re	rection, that have been or regulation or LSC provisi	corrected and the ion number and
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Y4		Y5	Y4	Y5	Y4	Y5
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LSC	K0914	09/26/2017	LSC K0918	09/26/2017	LSC	
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REVIEWE STATE AG	#	REVIEWED BY (INITIALS) COH	DATE SIGNA 09-26-17	ATURE OF SURVEYOR	Jt L. 20	DATE 09/26/2017
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FOLLOWU 8/9/2017	IP TO SURVEY CO	OMPLETED ON	CHECK FOR ANY UNCORRECTED DE	NCORRECTED DEFICIENCIES FICIENCIES (CMS-2567) SEN	S. WAS A SUMMARY OF T TO THE FACILITY?	YES NO

			POST	-CERT	IFICAT	ION R	EVISIT RI	EPORT		
PROVIDER / SUPPIDENTIFICATION N			MULTIPLE CONS A. Building 40 B. Wing	TRUCTION - BUILDING	10				DATE 9/26/2	OF REVISIT
NAME OF FACILITY CENTRAL VIRO		RAINING	CENT			52 t C	ET ADDRESS, CIT OLONY RD SON HEIGHTS, VA	Y, STATE, ZIP CODE	·- ·-	
show those defici- date such correcti	encies p ive actic	previously on was acc	reported on the complished. Ear	CMS-2567, ch deficiency	Statement of should be fu	Deficiencies	s and Plan of Cor using either the	ry Improvement Amend rection, that have been regulation or LSC provi equirement on the surve	corrected and sion number a	the nd
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REVIEWED BY STATE AGENCY	ď	REVIEWE (INITIALS	OBY OOH	DATE 09-26-		NATURE DF S	SURVEYOR X	HL. 29	DATE	09/26/2017
REVIEWED BY CMS RO		REVIEWE (INITIALS		DATE	TITL	.E			DATE	
FOLLOWUP TO SU	LLOWUP TO SURVEY COMPLETED ON 3/2017				CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY DF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					

			POST	Γ-CER1	IFICATION	ON R	EVISIT RI	EPORT	•			
PROVIDER / SUPPLIER / CLIA / MULTIPLE C			MULTIPLE CON A. Building A1	NSTRUCTION A1 - BUILDING ELEVEN			Y				DATE OF REVISIT 9/26/2017 y3	
NAME OF FACILITY CENTRAL VIRGINIA TRAINING CENT							STREET ADDRESS, CITY, STATE, ZIP CODE 521 COLONY RD MADISON HEIGHTS, VA 24572					
show tho	se deficiencies h corrective actio	previously on was ac	reported on the complished. Ea	CMS-2567, ch deficiency	Statement of Do should be fully	eficiencie identified	Clinical Laborato s and Plan of Co l using either the the left of each re	rection, that regulation or	have been corre	ected and th	ne	
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LSC	K0918		09/26/2017	LSC	-		 	LSC				
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STATE AG	AF	(INITIAL:	s) COH	09-26		. 51 (2. 0)		从L.	12	09/	26/20°	17
REVIEWED BY CMS RO (INITIALS)			DATE	DATE TITLE					DATE			
FOLLOW(8/9/2017	JP TO SURVEY C	OMPLETE	D ON	CHE UNC	CK FOR ANY UN ORRECTED DEF	CORRECT	TED DEFICIENCIES S (CMS-2567) SEN	S. WAS A SUN T TO THE FA	MARY OF CILITY7			'n

Form CMS - 2567B (09/92) EF (11/06)