

State of Virginia

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0290 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/18/2017 |
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| NAME OF PROVIDER OR SUPPLIER SUMMIT SQUARE | STREET ADDRESS, CITY, STATE, ZIP CODE 501 OAK AVENUE WAYNESBORO, VA 22980 |
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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) COMPLETE DATE |
|--------------------|---|---------------|---|--------------------|
| F 000 | <p>Initial Comments</p> <p>An unannounced biennial State Licensure survey was conducted 05/17/17 through 05/18/17. No complaints were investigated. The facility was in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.</p> <p>The census in this 18 bed facility was 16 at the time of the survey. The survey sample consisted of 7 current Resident reviews (Residents # 1 through # 7) and 1 closed record review (Resident # 8).</p> | F 000 | | |

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

TITLE

(X6) DATE

Electronically Signed

06/02/17