

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>VA0176</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/10/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VMRC, COMPLETE LIVING CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1475 VIRGINIA AVENUE HARRISONBURG, VA 22802</b>
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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 Inspection was conducted 08/08/17 through 08/10/17. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated. The Life Safety Code survey/report will follow.</p> <p>The census in this 120 certified bed facility was 114 at the the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through 20) and three closed record review (Resident #21 through 23).</p>	F 000		
F 001	<p>Non Compliance</p> <p>The facility was out of compliance with the following state licensure requirements:</p> <p>This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.</p> <p>12VAC 5-371-180(B) and 12VAC 5-371-370(G). Please cross reference to F-253.</p> <p>12VAC5-371-250(F). Please cross reference to F-279</p> <p>12VAC5-371-210(A)(3). Please cross reference to F-280</p> <p>12VAC 5-371-220(A). Please cross reference to F-309</p>	F 001	<p>Plan of Correction Submitted for:</p> <p>F253 F279 F280 F309</p>	9/29/17

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

Electronically Signed

TITLE

(X6) DATE

08/26/17