

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49E084	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/29/2018
--	--	--	--

NAME OF PROVIDER OR SUPPLIER VIRGINIA HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HAMPTON ST RICHMOND, VA 23220
--	--

(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	Initial Comments An unannounced biennial State Licensure Inspection was conducted 11/27/18 through 11/29/18. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 130 bed certified bed facility was 127 at the time of the survey. The survey sample consisted of 31 current Resident record reviews and two closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-140. Policies and Procedures. Cross reference to F550 12VAC5-371-150. Resident Rights. Cross reference to F550. 12VAC5-371-360. Clinical Records cross reference to F842. 12VAC5-371-340 Dietary and Food Services Program 12VAC5-371-340 (A) cross reference to F812 12VAC5-371-140.D.2 Policies and Procedures Cross reference to F622 and F623 12 VAC 5-371-220 (D) cross references with Federal deficiency 695	F 001	<p style="text-align: center;">RECEIVED DEC 14 2018 VDH/OLC</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------