

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0199	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/22/2019
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NAME OF PROVIDER OR SUPPLIER RIVERSIDE REHABILITATION CENTER AT HAMPTON	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ALGONQUIN RD HAMPTON, VA 23661
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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 3/20/19 through 3/22/19. Three complaints were investigated during the survey. Corrections are required for compliance with Rules and Regulations for the Licensure of Nursing Facilities.</p> <p>The census in this 130 certified bed facility was 98 at the time of the survey. The survey sample consisted of 38 residents: 33 current resident reviews and 5 closed record reviews.</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 found to be out of compliance with the following regulations for the Licensure of nursing facilities:</p> <p>12VAC5-371-140 (E) Policies and Procedures. Cross reference to F607, F609, F622, F623 and F625.</p> <p>12VAC5-371-150 (C) Resident Rights. Cross reference F575.</p> <p>12VAC5-371-160 (B) Financial Controls and Resident Funds. Cross reference to F567.</p> <p>12VAC-371-180 (C) Infection Control. Cross Reference F880.</p> <p>12VAC-371-220 (D) Nursing services. Cross reference F687.</p> <p>12VAC5-371-250 (F) Resident Assessment and</p>	F 001	<p>12VAC5-371-140 (E) Policies and Procedures. Please cross reference to F607, F609, F622, F623 and F625 plan of correction</p> <p>12VAC5-371-150 (C) Resident Rights. Please cross reference to F575 plan of correction</p> <p>12VAC5-371-160 (B) Financial Controls and Resident Funds. Please cross reference to F567 plan of correction</p> <p>12VAC-371-180 (C) Infection Control. Please cross reference F880 plan of correction</p> <p>12VAC-371-220 (D) Nursing services. Please cross reference F687 plan of correction</p>	4/26/19

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

Electronically Signed

TITLE

(X6) DATE

04/11/19

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F 001	Continued From page 1 Care Planning. Cross references to F657. (A) Cross reference F641. 12VAC5-371-340 (A) Dietary and Food Service Program cross references to F814.	F 001	12VAC5-371-250 (F) Resident Assessment and Care Planning. Please cross reference to F657. (A)Cross reference F641 plan of correction 12VAC5-371-340 (A) Dietary and Food Service Program cross reference to F814 plan of correction	