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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X3) DATE SURVEY COMPLETED					
		VA0043	B WING_		C 04/16/2019				
NAME OF PROVIDER OR SUPPLIED STREET AD				DDRESS, CITY, STATE, ZIP CODE					
_	1017 GEORGE WASHINGTON HIGHWAY NORTH								
GREENE	GREENBRIER REGIONAL MEDICAL CENTER CHESAPEAKE, VA 23323 CORRECTED COPY								
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLET CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)					
F 000	VA0043 NAME OF PROVIDER OR SUPPLIER GREENBRIER REGIONAL MEDICAL CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 000		r				
	Inspection was conducted and 4/15/19 and 4/15/19 was not in complian Regulations for the Facilities. 4 complathe survey. The census in this 1 103 at the time of the consisted of 36 curr	ducted 04/10/19 through 19 through 4/16/19. The facility ace with the Virginia Rules and Licensure of Nursing ints were investigated during 20 licensed bed facility was a survey. The survey sample ent Resident reviews and 8		Reference to F-582.					
F 001	Non Compliance		F 001	12 VAC 5-371-250 B, C, D. Reside Assessment. Cross Reference to F	nt F640, F641.				
				COMPLETED C Q4/16/201! STATE, ZIP CODE HINGTON HIGHWAY NORTH 3323 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 12 VAC 5-371-150 (D). Resident Rights. Cross Reference to F-582. 12 VAC 5-371-150 (B)(1) Cross Reference To	ervices, Cross				
!	12 VAC 5-371-150 (D). Resident Rights. Cross			ices Cross				
F 001	12 VAC 5-371-250 B, C, D. Resident Assessment. Cross Reference to F640, F641.		- Control of the Cont		ervices, Cross				
					ced at F-tag				
	12 VAC 5-371-220 D Reference to F-687	Nursing Services Cross			ice. Cross				
	12 VAC 5-371-200 (/ Nursing, Cross Refe	A). Nursing/Director of erence to F-727.			cross				
	12 VAC 5-371-310 B Reference to F770.	, Diagnostic Services. Cross			es. Cross				

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

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If continuation sheet 1 of

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State of Virginia STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: B. WING	CONSTRUCTION	(X3) DATE SURVE COMPLETED C 04/16/201	
NAME OF PROVIDER OR SUPPLIER GREENBRIER REGIONAL MI	EDICAL CENTER 1017 GE	ADDRESS, CITY, S' EORGE WASHII PEAKE, VA 23:	NGTON HIGHWAY NORTH		
PREFIX (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE COME	X5) PLETE ATE
F 001 Continued From p	age 1	F 001		:	
12-VAC 5-371-300 755	A. cross referenced at F-tag	Angeles and the second			
12 VAC 5-371-220 Reference to F810	C. Nursing Service. Cross	· · · · · · · · · · · · · · · · · · ·		3 4	
12VAC5-371-180 I referenced to F-88	nfection Control cross 0.	The state of the s		1	
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