

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/07/2019
NAME OF PROVIDER OR SUPPLIER LANCASHIRE CONVALESCENT AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 287 SCHOOL STREET KILMARNOCK, VA 22482		
(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) COMPLETION DATE	
{E 000}	Initial Comments	{E 000}			
{F 000}	<p>INITIAL COMMENTS</p> <p>An unannounced Medicare/Medicaid revisit to the standard survey conducted 1/23/2019 through 1/25/2019 was conducted 3/6/2019 through 3/7/2019. The facility was in compliance with 42 CFR Part 483 Federal Long Term Care Requirements.</p> <p>The census in this 120 certified bed facility was 64 at the time of the survey. The survey sample consisted of 7 resident reviews.</p>	{F 000}			

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

TITLE

(X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.