STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495399	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM HEALTH & REHABILITATION CENTER	100 RORER STREET CHATHAM, VA 24531

(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 An unannounced Emergency Preparedness (EP) COVID-19 Focused Survey was conducted onsite on 6/16/2020. Emergency Preparedness information was reviewed off site on 6/16/2020 through 6/18/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. On 6/16/2020, the census in the 85 certified bed facility was 76. As of 6/16/2020, a 20% sample of residents had been tested for the COVID-19 virus. One (1) resident had tested positive but was asymptomatic. This resident was retested and the second test result was negative for the COVID-19 virus; the result of a third test is pending. If the third test is negative, the results from the first COVID-19 test will be considered a 'false positive'.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted onsite on 6/16/2020. Infection Control information was reviewed off-site on 6/16/2020 through 6/18/2020. Corrections are not required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). On 6/16/2020, the census in the 85 certified bed facility was 76. As of 6/16/2020, a 20% sample of residents had been tested for the COVID-19 virus. One (1) resident had tested positive but was asymptomatic. This resident was retested and the second test result was negative for the COVID-19 virus; the result of a third test is pending. If the third test is negative, the results from the first COVID-19 test will be considered a	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/25/2020

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.

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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) COMPLETION DATE
F 000	Continued From page 1 'false positive'.	F 000		