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 07/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANCASHIRE CONVALESCENT AND REHABILITATION CENTER	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		
	A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 7/21/2020 and continued with offsite review through 7/22/2020. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19.			
	The census in this 120 certified bed facility was 79 at the time of the survey.			
F 000	INITIAL COMMENTS	F 000		
	A COVID-19 Focused Infection Control Survey was conducted onsite 7/21/2020 and continued with offsite review through 7/22/2020. The facility was in substantial compliance with 42 CFR Part 483.80 infection control regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19.			
	The census in this 120 certified bed facility was 79 at the time of the survey.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/05/2020