PRINTED: 01/20/2022 FORM APPROVED

State of Virginia
STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY						
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED						
		VA0004	B. WING		07/29/20:	21					
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE							
APPOMATTOX HEALTH & REHABILITATON CENTER  235 EVERGREEN AVE											
APPOMATTOX, VA 24522											
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	LD BE COMPLETE						
F 000	00 Initial Comments		F 000								
	Inspection was cond 7/29/2021. The facil with the Virginia Reg Nursing Facilities.  The census in this 60	nnial State Licensure ucted 7/27/2021 through ity was not in compliance ulations for the Licensure of 0 bed facility was 55 at the									
	_	The survey sample consisted nt reviews and three closed									
F 001	Non Compliance		F 001		9/10	)/21					
	The facility was out of following state licens	of compliance with the ure requirements:									
This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Regulations for the Licens Nursing Facilities.		n compliance with the		F001  The facility was not in compliance with	n the						
	12VAC5-371-180 Infection Control 12VAC5-371-180 (A) Cross Reference to F-880			following Virginia Regulations for the Licensure of Nursing Facilities.  12VAC5-371-180 Infection Control							
	12VAC5-371-210 Nu 12VAC5-371-210 (B)	rse Staffing Cross Reference to F-725		12VAC5-371-180 (A) Cross Reference F-880	e to						
	, ,	rsing Services Cross Reference to F-684 Cross Reference to F-686		12VAC5-371-210 Nurse Staffing 12VAC5-371-210 (B) Cross Reference F-725	e to						
	Planning 12VAC5-371-250 (A)	cross Reference to F-641 Cross Reference to F-656		12VAC5-371-220 Nursing Services 12VAC5-371-220 (B) Cross Reference F-684 12VAC5-371-220 (C) Cross Reference F-686							
		armaceutical Services ) Cross Reference to F-759		12VAC5-371-250 Resident Assessme and Care Planning	nt						

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

TITLE (X6) DATE 08/16/21

Electronically Signed

STATE FORM 5899 5NLI11 If continuation sheet 1 of 2

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		VA0004	B. WING		07/29/2021						
NAME OF PROVIDER OR SUPPLIER  APPOMATTOX HEALTH & REHABILITATON CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  235 EVERGREEN AVE  APPOMATTOX, VA 24522											
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE						
F 001	Continued From page	÷ 1	F 001	12VAC5-371-250 (A) Cross Reference F-641 12VAC5-371-250 (G) Cross Reference F-656 12VAC5-371-300 Pharmaceutical Services 12VAC5-371-300 (H) Cross Reference F-759	ce to						