PRINTED: 04/28/2022 FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED					
		VA0414	B. WING		07/01/2021						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
RURAL RETREAT CARE CENTER 514 NORTH MAIN STREET											
RURAL RETREAT, VA 24368											
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE					
F 000	Initial Comments		F 000								
F 2024	survey and biennial S was conducted 6/29/2 Corrections are requirements and Virg for the Licensure of N Safety Code survey/r complaints were were survey. The census in this 12 109 at the time of the consisted of 25 currer closed record reviews	red for compliance with 42 all Long Term Care ginia Rules and Regulations lursing Facilities. The Life eport will follow. No exinvestigated during the 0 certified bed facility was survey. The survey sample and Resident reviews and 3	5.004								
F 001	Non Compliance The facility was out of	f compliance with the	F 001								
	following state licensu										
	This RULE: is not me The facility was not in following Virginia Rule Licensure of Nursing	compliance with the es and Regulations for									
	Management and Adr 12 VAC 5-371-110 (J)	ninistration) - cross reference to F883									
	Infection Control 12 VAC 5-371-180 (A) - cross reference to F880									
	F760) - cross reference to F684,									
	F686	(5) - cross reference to									

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

TITLE (X6) DATE

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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					
		VA0414	B. WING		07	/01/2021					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
RURAL RETREAT CARE CENTER 514 NORTH MAIN STREET RURAL RETREAT, VA 24368											
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE					
F 001	Continued From page	÷ 1	F 001								
	12 VAC 5-371-220 (H) - cross reference to F580									
	Pharmaceutical Servi 12 VAC 5-371-300 (A	ces) - cross reference to F755									
	Dietary and Food Ser 12 VAC 5-371-340 (A	vice Program) - cross reference to F812									
	Clinical Records 12 VAC 5-371-360 (B) - cross reference to F583									