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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	C 04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 04/05/2022 through 04/06/2022. One complaint was investigated during the survey. Complaint #VA00054750 was unsubstantiated with no deficient practice. The facility was in substantial compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The census in this 109 certified bed facility was 82 at the time of the survey. The survey sample consisted of three current resident reviews and one closed record review.	F 000		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 4/12/22

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.