

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0235	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2019
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NAME OF PROVIDER OR SUPPLIER THE SPRINGS NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 167 SPRING STREET HOT SPRINGS, VA 24445
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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) COMPLETE DATE
F 000	<p>Initial Comments</p> <p>An unannounced biennial Licensure survey was conducted 09/10/19 through 09/11/19. No complaints were investigated. The facility was in compliance with the Virginia Regulations for the Licensure of Nursing Facilities.</p> <p>The census in this 60 bed facility was 49 at the time of the survey. The survey sample consisted of 15 Resident reviews.</p>	F 000		

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

TITLE

(X6) DATE

Electronically Signed

09/23/19