State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0290	A. BUILDING: _____ B. WING _____	06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT SQUARE	501 OAK AVENUE 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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 06/04/19 through 06/05/19. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey. The census in this 18 bed facility was 18 at the time of the survey. The survey sample consisted of 8 current resident reviews and two closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Regulations for the Licensure of Nursing Facilities: 12 VAC 5-371-250 (A.) Resident Assessment and Care Planning Cross Reference to F-641 12 VAC 5-371-250 (F.) (G.) Resident Assessment and Care Planning Cross Reference to F-744	F 001	Plan of Correction for F641 1. Residents of Summit Square were not directly affected. 2. Residents of Summit Square did not suffer a negative outcome. 3. A. The Social Worker received additional training regarding accurately completing assessments. B. The MDS Coordinator will review all assessments for correlation/accuracy based on resident's condition. 4. The Clinical Coordinator and the Director of Nursing will provide quarterly oversight of the MDS's for the next twelve months to assure accuracy. 5. The Director of Nursing will forward results of compliance to the Administrator and the QA Committee will monitor quarterly for one year. Plan of Correction for F744	6/20/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/20/19

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F 001	Continued From page 1	F 001	1. Residents of Summit Square were not directly affected. 2. Residents of Summit Square did not suffer a negative outcome. 3. The MDS Coordinator will conduct a care plan audit and develop the care plan to address the dementia diagnosis. 4. The Clinical Coordinator and the Director of Nursing will provide quarterly oversight of the MDS's for the next twelve months to assure accuracy. 5. The Director of Nursing will forward results of compliance to the Administrator and the QA Committee will monitor quarterly for one year.	