

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

PRINTED: 05/12/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495352</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/15/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEE HEALTH AND REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>208 HEALTH CARE DRIVE PENNINGTON GAP, VA 24277</b>		
(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	
E 000	Initial Comments  An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 07/15/2020. Emergency Preparedness information had also been reviewed off site on 07/15/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000			
F 000	INITIAL COMMENTS  An unannounced COVID-19 Focused Infection Control Survey was conducted on 07/15-16/2020. The onsite portion of the survey was completed on 7/15/20. Infection Control information was also reviewed off site on 07/15/2020. No corrections are required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s).  On 07/15/2020, the census in this 110 certified bed facility was 98, with all current residents negative for COVID-19.	F 000			

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

TITLE

(X6) DATE

Electronically Signed

09/04/2020

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