State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0161	A. BUILDING: _____ B. WING _____	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RADFORD HEALTH AND REHAB CENTER	700 RANDOLPH STREET RADFORD, VA 24141

(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 State Licensure survey was conducted 4/17/18 through 4/19/18. One complaint was investigated. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 85 at the time of the survey. The survey sample consisted of 24 current Resident 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 Virginia Rules and Regulations for the Licensure of Nursing Facilities. 12VAC5-371-3140 E Cross Reference to F-607 12VAC5-371-250 G Cross reference to F-657 12 VAC 5-371-220 D Cross Reference to F-677, F684 12 VAC 5-371-360 E Cross reference to F-698	F 001	12VAC5-371-3140 E Cross reference to F-607 pages 7-10 12VAC5-371-250 G Cross reference to F-657 pages 16-18 12VAC5-371-220 D Cross reference to F-677, 684 pages 18-23 12VAC5-371-360 E Cross reference to F698, pages 23-25	5/15/18

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

Electronically Signed | 05/15/18