

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

PRINTED: 05/20/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/28/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>RICHFIELD: HEALTH CENTER - SALEM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3719 KNOLLRIDGE ROAD SALEM, VA 24153</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	E 000			
	An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 12/22/20. Emergency Preparedness information was also reviewed off site on 12/22/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.				
F 000	INITIAL COMMENTS	F 000			
	An unannounced COVID-19 Focused Infection Control Survey was conducted on 12/22/2020. Infection Control information was reviewed offsite on 12/22-12/28/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.				
	On 12/22/20, the census in this 280 certified bed facility was 142. Of the 153 residents, there were 4 residents that had tested positive for the COVID-19 virus.				

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

TITLE

(X6) DATE

Electronically Signed

01/13/2021

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.