State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0251	A. BUILDING: _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 A unannounced biennial State Licensure Inspection was conducted 06/08/21 through 06/10/21. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Corrections were required. The census in this 180 certified bed facility was 145 at the time of the survey. The survey sample consisted of 30 current resident reviews and 2 (two) closed record reviews. Three complaints were investigated during the course of the survey.	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: Policies and Procedures 12 VAC 5-371-140 - cross reference to F607 Nursing Services 12 VAC 5-371-220 B - cross reference to F684 Clinical Records 12 VAC 5-371-360 (E) - cross reference to F842	F 001		

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