

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>VA0147</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/06/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LOUDOUN NURSING AND REHAB CNTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176</b>
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(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}	<p>Initial Comments</p> <p>An offsite paper revisit survey was conducted on 06/06/2022 for all previous deficiencies cited on 04/26/2022. All deficiencies have been corrected. The facility is in compliance with all regulations surveyed.</p>	{F 000}		

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

TITLE

(X6) DATE