

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

PRINTED: 09/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49E131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/16/2022
NAME OF PROVIDER OR SUPPLIER SW VA M H INST GERI TRT CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 340 BAGLEY CIRCLE MARION, VA 24354		
(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 A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 9/6/22 through 9/7/22 and continued with offsite review occurring 9/14/22 through 9/16/22. The facility was in substantial compliance with 42 CFR Part 483.73(b)(6) emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 25 certified bed facility was 18 at the time of the survey.	E 000			
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated and COVID-19 Focus Infection Control survey was conducted onsite 9/6/22 through 9/7/22 and continued with offsite review occurring 9/14/22 through 9/16/22. The facility was in substantial compliance with 42 CFR Part 483 Federal Long Term Care requirement(s) and 42 CFR Part 483.80 infection control regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. During the survey one (1) complaint (VA00056142-unsubstantiated) was investigated. The census in this 25 certified bed facility was 18 at the time of the survey. The survey sample consisted of three (3) current resident reviews (Resident #1, Resident #2, and Resident #4) and one (1) closed record (Resident #4).	F 000			

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

TITLE

(X6) DATE

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.