

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

PRINTED: 08/11/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495429</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/03/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVERSIDE LIFELONG HEALTH AND REHABILITATION – MAT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>603 MAIN STREET</b> <b>MATHEWS, VA 23109</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  An unannounced Emergency Preparedness survey was conducted 8/1/23 through 8/3/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000			
F 000	INITIAL COMMENTS  An unannounced Medicare/Medicaid standard survey was conducted 8/1/23 through 8/3/23. The facility was in substantial compliance with 42 CFR Part 483 Federal Long Term Care requirement(s). The Life Safety Code survey/report will follow. Two complaints were investigated during the survey.  VA00058386--Substantiated with no deficiency. VA00059375--Substantiated with no deficiency.  The census in this 60 certified bed facility was 57 at the time of the survey. The survey sample consisted of 20 resident reviews.	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.