

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2023
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NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF ALTAVISTA	STREET ADDRESS, CITY, STATE, ZIP CODE 1317 LOLA AVE ALTAVISTA, VA 24517
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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 unannounced biennial State Licensure Inspection was conducted 5/22/2023 through 5/24/2023. The facility was not in compliance with the Virginia Regulations for the Licensure of Nursing Facilities.</p> <p>The census in this 111 bed facility was 104 at the time of the survey. The survey sample consisted of 21 current Resident reviews and three closed record reviews.</p>	F 000		
F 001	<p>Non Compliance</p> <p>The facility was out of compliance with the following state licensure requirements:</p> <p>This RULE: is not met as evidenced by: 12VAC5-371-220 A, B, C - cross reference to F684, F688, F689</p> <p>12VAC5-371-360 E - cross reference to F842</p>	F 001	<p>The statements on this plan of correction are not an admission to, do not constitute an agreement with the alleged deficiencies stated. The plan of correction constitutes the facilities allegation of compliance.</p> <p>The Plan of correction to the right of the individual citations above are the facilities attempt to correct the allegation of non-compliance with each cross referenced Ftag.</p>	6/27/23

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

Electronically Signed

TITLE

(X6) DATE

06/07/23