

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/23/2023
NAME OF PROVIDER OR SUPPLIER SNYDER NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 11 NORTH BROAD ST SALEM, VA 24153		
(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 An unannounced biennial State Licensure Inspection was conducted 8/21/23 through 8/23/23. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 45 bed facility was 29 at the time of the survey. The survey sample consisted of 13 current Resident reviews.	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: Infection Control 12 VAC 5-371-180 (A) and (C)(1) cross reference to F880 Nursing Services 12 VAC 5-371-220 cross reference to F684 Resident Assessment and Care Planning 12 VAC 5-371-250 (G) cross reference to F657	F 001	please see above, thank you	10/1/23

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

TITLE

(X6) DATE

Electronically Signed

09/12/23