

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>VA0037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>01/18/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GALAX HEALTH AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>836 GLENDALE RD</b> <b>GALAX, VA 24333</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 revisit survey was conducted on 1/18/24 for all previous deficiencies cited on 11/16/23. 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

12/15/23