State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0081	A. BUILDING: _____ B. WING _____	R 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT HEALTH & REHAB CENTER	300 HATCHER STREET ROCKY MOUNT, VA 24151

(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 Medicare/Medicaid first revisit survey was conducted 5/15/25 through 5/16/25 as the result of a standard survey conducted 3/24/25 through 3/27/25. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 145 certified bed facility was 127 at the time of the survey. The survey sample consisted of seven (14) current resident reviews	{F 000}		
{F 001}	Non Compliance The facility was out of compliance with the following state licensure requirements: This STANDARD is not met as evidenced by: Clinical Records 12 VAC 5-371-360 (E) (6) and (9) - cross reference to F842	{F 001}	Cross reference POC for F842 for 12 VAC-5-371-360 (E)	5/22/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/22/25