

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>VA0230</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 07/03/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH ROANOKE NURSING AND REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>3823 FRANKLIN RD, SW ROANOKE, VA 24014</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) COMPLETE DATE
{F 000}	Initial Comments  An offsite revisit for the 4/24/25 survey was conducted on 7/1/25 to 7/3/25. Based on review of credible evidence, the facility is found to be in substantial compliance as of the AOC date 6/3/25.	{F 000}		

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

Electronically Signed

TITLE

(X6) DATE