

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>49G005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R 06/26/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHEASTERN VIRGINIA TRAINING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320</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) COMPLETION DATE
{E 000}	Initial Comments	{E 000}		
{W 000}	INITIAL COMMENTS	{W 000}		
{W 122}	CLIENT PROTECTIONS CFR(s): 483.420(a)  The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by:	{W 122}		
{W 127}	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5)  The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by:	{W 127}		
{W 153}	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by:	{W 153}		
{W 154}	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)  The facility must have evidence that all alleged violations are thoroughly investigated.	{W 154}		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>49G005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R 06/26/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHEASTERN VIRGINIA TRAINING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2100 STEPPINGSTONE SQUARE CHESAPEAKE, VA 23320</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) COMPLETION DATE
{W 154}	Continued From page 1  This STANDARD is not met as evidenced by:	{W 154}		
{W 156}	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4)  The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.  This STANDARD is not met as evidenced by:	{W 156}		
{W 157}	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4)  If the alleged violation is verified, appropriate corrective action must be taken.  This STANDARD is not met as evidenced by:	{W 157}		