PRINTED: 05/05/2022 FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:							
VA0256		VA0256	B. WING		02/27/2020				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
THE VIRGINIAN 9229 ARLINGTON BLVD FAIRFAX, VA 22031									
(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		F 000						
		ucted 2/25/20 through are required for compliance s and Regulations for the							
		bed facility was 77 at the he survey sample consisted s.							
F 001	Non Compliance		F 001			4/17/20			
	The facility was out o following state license								
	This RULE: is not me 12VAC5-371-220(A). F561.	et as evidenced by: Please cross reference to		Please see POC for F561. Please see POC for F656. Please see POC for F657.					
	12VAC5-371-250(G). F656.	Please cross reference to		Please see POC for F679. Please see POC for F689.					
	12VAC5-371-140(C). Please cross reference to F657.			Please see POC for F695. Please see POC for F744. Please see POC for F808.					
	12VAC5-371-280(A). F679.	Please cross reference to		Please see POC for F812.					
	12VAC5-371-220(A). F689.	Please cross reference to							
	12VAC5-371-220(D). F695.	Please cross reference to							
	12VAC5-371-220(A). F744.	Please cross reference to							
	12VAC5-371-340(D)(to F808.	1). Please cross reference							

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

TITLE (X6) DATE

Electronically Signed

03/19/20

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State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		VA0256	B. WING		02/27/2020						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
THE VIRGINIAN 9229 ARLINGTON BLVD FAIRFAX, VA 22031											
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE						
F 001 (Continued From page 1		F 001								
	12VAC5-371-340(A). F812.	Please cross reference to									