

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

PRINTED: 05/04/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495099	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02 B. WING _____	(X3) DATE SURVEY COMPLETED R 08/16/2016
NAME OF PROVIDER OR SUPPLIER FAIRFAX REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10701 MAIN STREET FAIRFAX, VA 22030	
(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
{K 000}	INITIAL COMMENTS The facility consists of two 4 story buildings of Type II (222) construction and is fully sprinklered. Building 01 is an existing building and is separated from new Building 02 by a 2-hour construction with protected openings.. An unannounced 2nd revisit to a recertification Life Safety Code survey conducted on May 10, 2016 was conducted August 16, 2016 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Facilities. The facility was surveyed for compliance using the LSC 2000 Existing regulations. The facility was in compliance with the Requirements for Participation Medicare and Medicaid.	{K 000}		
{K 000}	INITIAL COMMENTS The facility consists of two 4 story buildings of Type II (222) construction and is fully sprinklered. Building 01 is an existing building and is separated from new Building 02 by a 2-hour construction with protected openings.. An unannounced 2nd revisit to a recertification Life Safety Code survey conducted on May 10, 2016 was conducted August 16, 2016 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Facilities. The facility was surveyed for compliance using the LSC 2000 New regulations. The facility was in compliance with the Requirements for Participation Medicare and Medicaid.	{K 000}		

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.