STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNCHBURG HLTH & REHAB CNTR	5615 SEMINOLE AVENUE LYNCHBURG, VA 24502

(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
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted 06/09/2020 and 06/25/2020. The facility was in substantial compliance with 42 CFR Part 483.80 infection control regulations, and has implemented the CMS and Centers for Disease Control (CDC) recommended practices to prepare for COVID-19. On 06/09/2020 the census in this 180 certified bed facility was 137. The facility had tested 17 residents and had one test pending. There was one positive COVID case in the facility. On 06/25/2020, the census was 147. The facility reported that they had tested one resident on 05/27/2020 due to an upcoming appointment. The test was reported as COVID positive on 05/28/2020. They retested her on 05/28/2020 and 05/29/2020 and both of those tests were negative. The resident was retested on 06/08/2020 and was positive. The Regional Epidemiologist was contacted and she advised that the resident was an "asymptomatic carrier of COVID-19" and should be isolated for five additional days. She did not recommend that the resident be retested before being removed from isolation. Twenty-nine employees were tested, all with negative results. At the time of the onsite survey, the facility reported that no additional residents had been tested, but the national guard was onsite (06/25/2020) to test 100 percent of residents and staff for COVID-19.	F 000		

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

Electronically Signed | 06/26/2020

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.