

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

PRINTED: 01/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/08/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>LYNCHBURG HLTH &amp; REHAB CNTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5615 SEMINOLE AVENUE LYNCHBURG, VA 24502</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			
F 000	<p>An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted on 12/8/2020. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long Term Care Facilities.</p> <p>INITIAL COMMENTS</p> <p>An unannounced COVID-19 Focused Infection Control Survey was conducted on 12/8/2020. The facility was in substantial compliance with 42 CFR Part 483.80 infection control regulations, and had implemented the CMS and Centers for Disease Control (CDC) recommended practices to prepare for COVID-19</p> <p>On 12/8/2020, the census in this 180 certified bed facility was 114. The survey sample consisted of five current resident record reviews.</p> <p>There were 27 positive COVID-19 cases in the facility at the time of the survey. The facility has been in Outbreak Testing since 10/21/2020. On 11/30/2020, testing was conducted on 71 residents; 54 tested negative and 17 tested positive. On 12/7/2020, testing was conducted on 69 residents; the results are pending. During the week of 11/27/2020 through 12/3/2020, testing was conducted on 114 staff; 108 tested negative and 6 tested positive.</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

12/15/2020

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.