| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **495363** | A. BUILDING _____ B. WING _____ | **06/16/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **FAIRMONT CROSSING HEALTH AND REHABILITATION** | **173 BROCKMAN PARK DRIVE AMHERST, VA 24521** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide and implement an infection prevention and control program.**<br><br>Based on observation, staff interview and facility document review, the facility staff failed to maintain social distancing for three of three residents on the Fox Ridge Unit, Resident #1, #2, and #3. Findings were: On 6/15/2020 at approximately 12:25 p.m., on the Fox Run unit of the facility three residents were observed sitting side by side in a row. They were not six feet apart. Resident #1 was in a wheelchair, Resident #2 was in a stationary chair, and Resident #3 was in a wheelchair. The residents were spaced approximately one foot apart. Each of the three residents had a bedside table in front of them and were eating their lunch. The unit manager, LPN (licensed practical nurse) #1 was interviewed about the seating of the residents. She stated, The dining room is closed. We have several residents who need assistance .the residents move around themselves .we try to keep them distanced to the best of our ability. The unit manager was asked if the three residents in question had moved their chairs and their bedside tables with the trays on it. She did not answer. She was asked if the three residents in question could move around on their own. She stated, (Name of Resident #1) moves around in her wheelchair a little bit, she backs herself up against the wall .she doesn't really self propel .(Name of Resident #2) can self propel around the unit .(Name of Resident #3) she is able to walk around the unit A CNA (certified nursing assistant) heard the conversation and moved Resident #2's wheelchair forward, creating the required six feet of social distancing between the three residents. At approximately 12:45 p.m., the administrator was interviewed regarding the observations on the Fox Ridge unit. She stated, Those are three very strong-willed ladies. She was asked if the three residents were care planned as being noncompliant with social distancing. She stated she didn't know. The care plans for the three residents were reviewed. There were no entries regarding social distancing. The MDS (minimum data set) for each of the three residents was reviewed. A quarterly MDS with an ARD (assessment reference date) of 05/12/2020, assessed Resident #1 as severely impaired with a cognitive summary score of 05. Resident #2's quarterly MDS with an ARD of 05/06/2020 assessed her as severely impaired with a cognitive summary score of 04. Resident #3's annual MDS assessment with an ARD of 04/09/2020 assessed her as severely impaired with a cognitive summary score of 06. The facility policy, Senior Care Services Response to COVID-19' contained the following information: Staff Support: .Implement social distancing-maintain six feet between staff members, between staff and residents (except in the provision of care) and between residents . At approximately 1:20 p.m., during an exit interview with the administrator, she was informed of the above information. No further information was obtained. |

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