| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495363 | A. Building<br>B. Wing | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Fairmont Crossing Health and Rehab Center | 173 Brockman Park Drive<br>Amherst, VA 24521 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on observation, staff interviews, and facility documentation review, the facility staff failed to ensure a clean and sanitary environment in one of two dining rooms within the facility. The findings included:The facility staff failed to ensure a clean environment on the first-floor dining room area.On 4/20/26 at 12:00 pm an observation was conducted in the dining room area on the first floor of the facility. During the observation, there was a light fixture with a bug light underneath, and it was observed that there were cobwebs all over the bottom of the light fixture and top of the bug light. Also, observed were dead bugs on the top and sides of the bug light. There was a resident observed at a table right under the bug light.An interview was conducted with a certified nursing assistant, CNA#1 (CNA1). CNA1 showed the light fixture and bug light, and she said, that looks like it has been there for a while. CNA1 was observed making a disappointed facial expression. CNA1 looked on top of the bug light and said, yeah, it's full of bugs.On 4/21/26 at 2:06 pm an interview was conducted with the housekeeping staff, other staff #3 (OS3). She said, the dining room is deep cleaned by the dietary staff not housekeeping staff.On 4/21/26 at 2:30 pm an interview was conducted with a dietary aide, other staff #1 (OS1). OS1 provided dietary's monthly cleaning list for review and she stated, dietary deep cleans the kitchenette area not the actual dining area, that is done by housekeeping.On 4/21/26 at approximately 2:45 pm an interview was conducted with the housekeeping supervisor, other staff #2 (OS2). OS2 stated that deep cleaning of the dining room is done twice a month by housekeeping but was unable to provide evidence of when it was last completed. He stated he has no record of when it was done last or by who. OS2 stated that he doesn't keep a schedule of who or when the deep cleaning was completed. On 4/21/26 at 3:30 pm, a review of facility documentation was conducted. The facility policy titled, Cleaning and Disinfecting Environmental Surfaces, read in part, . Environmental surfaces will be cleaned and disinfected according to current CDC [Centers for disease Control] recommendations for disinfection of healthcare facilities and the OSHA [Occupational Safety and Health Administration] bloodborne pathogens standard. 9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visible soiled. 10. Environmental surfaces will be disinfected, (or cleaned) on a regular basis(e.g., daily, three times per week) and when surfaces are visibly soiled.On 4/21/26 at 5:00 pm, an end of day meeting was conducted, and the above concerns were discussed with the regional nurse consultant, director of nursing and the administrator. The administrator said, I am aware of how it looked, I have pictures of it. No additional information was provided prior to exit conference. |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility document review, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for six of fifteen residents in the survey sample (Residents #106, #109, #111, #113, #114 and #115). The findings include:1. Resident #109's plan of care was not revised regarding Covid-19 infection and discontinued use of enhanced droplet precautions.<br><br>Resident #109 (R109) was admitted to the facility with diagnoses that included multiple sclerosis, insomnia, hypothyroidism, major depressive disorder and dysphagia. The minimum data set (MDS) dated [DATE] assessed R109 as cognitively intact.<br><br>Review of R109's clinical record revealed a physician's order dated 2/26/26 for enhanced droplet precautions for seven days due to the resident testing positive for Covid-19. The clinical record documented the order for enhanced droplet precautions was discontinued on 3/5/26.<br><br>Resident #109's current plan of care (revised 3/2/26) documented the resident had tested positive for Covid-19 and required droplet precautions. Interventions to prevent complications from Covid-19 included, administer oxygen as ordered, use of appropriate personal protective equipment per policy, check oxygen saturation levels as needed, notification to physician of changes in condition, observe for signs/symptoms of respiratory complications related to Covid-19 infection and vital signs as needed.<br><br>On 4/21/26 at 9:10 a.m., the licensed practical nurse unit manager (LPN #1) caring for R109 was interviewed about the care plan. LPN #1 stated the resident had Covid-19 and was placed on droplet precautions for seven days per the physician. LPN #1 stated the droplet precautions had been discontinued and were no longer in use. LPN #1 stated the Covid-19 droplet precautions should have been removed from the care plan when the precautions were discontinued (3/5/26).<br><br>On 4/21/26 at 10:35 a.m., LPN #2 responsible for MDS assessments and care planning was interviewed about R109's plan. LPN #2 stated MDS usually completed the initial care plan and that unit managers were typically responsible for updates as needed. LPN #2 stated R109's care plan should have been revised when the droplet precautions for Covid-19 were discontinued. LPN #2 stated that the unit manager would typically update the care plan for discontinued care interventions.<br><br>The facility's policy titled Care Planning - Comprehensive Person-Centered (undated) documented, .The facility will develop and implement a comprehensive person-centered care plan for each resident , that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs .The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans .When there has been a significant change in the resident's condition .When goals, needs, and preferences change .<br><br>This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 4/21/26 at 4:45 p.m. with no further information presented prior to the end of the survey.<br><br>2. Resident #114's plan of care was not revised regarding discontinued contact precautions.<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #114 (R114) was admitted to the facility with diagnoses that include major depressive disorder, hypertension, atrial fibrillation, liver cirrhosis, diabetes, pediculosis (head lice) and anxiety. The minimum data set (MDS) dated [DATE] assessed R114 as cognitively intact.<br><br>R114's clinical record documented the resident had been treated prior to admission for head lice. The record documented a physician's order dated 3/17/26 for contact precautions due to head lice. Another treatment was administered on 3/17/26 and the contact precautions were discontinued on 3/20/26.<br><br>R114's plan of care (revised 4/3/26) documented the resident was on contact isolation due to head lice. Interventions to prevent complications and resolve infestation included personal protective equipment per policy, isolation precautions per order, observation for complications and vital signs as needed.<br><br>On 4/21/26 at 9:10 a.m., the licensed practical nurse unit manager (LPN #1) caring for R114 was interviewed about the care plan. LPN #1 stated the resident had been treated prior to admission for head lice, received an additional treatment upon admission and that contact precautions were discontinued after the resident had received two showers in the facility. LPN #1 stated R114 was no longer on contact precautions and that the contact precautions should have been removed from the care plan when discontinued.<br><br>On 4/21/26 at 10:35 a.m., LPN #2 responsible for MDS assessments and care planning was interviewed about R114's plan. LPN #2 stated MDS usually completed the initial care plan and that unit managers were typically responsible for updates as needed. LPN #2 stated R114's care plan should have been revised when the contact precautions were discontinued.<br><br>The facility's policy titled Care Planning - Comprehensive Person-Centered (undated) documented, .The facility will develop and implement a comprehensive person-centered care plan for each resident , that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs .The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans .When there has been a significant change in the resident's condition .When goals, needs, and preferences change .<br><br>This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 4/21/26 at 4:45 p.m. with no further information presented prior to the end of the survey.<br><br>3. Resident #115's plan of care was not revised to include interventions in place for appointment/transportation validation prior to outside appointments.<br><br>Resident #115 (R115) was admitted to the facility with diagnoses that included schizophrenia, paranoia, osteoarthritis, anemia, hypertension, atrial fibrillation and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed R115 as cognitively intact.<br><br>R115's clinical record documented on 3/18/26 that the resident left the facility for an audiology appointment, asked to instead be transported to a lawyer's office and then ended up at the social services office before being returned to the facility. On 4/21/26 at 9:55 a.m., the director of nursing (DON) was interviewed about the incident. The DON stated social services accompanied the resident back to the facility. The DON stated she was aware the resident left the facility for an appointment, (continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | but the resident had not mentioned that she was going to a lawyer's office instead of the appointment. The DON stated that following this incident, staff were now validating all appointments made by the resident and the resident's Medicaid transport service account was modified with instructions to verify with facility staff prior to confirming any transport arrangements for the resident, including the destination.<br><br>R115's plan of care was revised 4/9/26 regarding the resident making arrangements for an appointment she did not have/attend. The care pan had not been revised to include interventions of validating appointments made by the resident and the modified Medicaid transport service account limiting the resident's ability to make transportation arrangements.<br><br>On 4/21/26 at 10:00 a.m., the DON was interviewed about R115's plan of care. The DON stated she added the problem of the resident reporting an appointment that she did not have but did not include interventions of validating appointments and the modified Medicaid transportation account instructions to not allow transport services until verified with the facility. The DON stated the interventions should have been added to the care plan.<br><br>The facility's policy titled Care Planning - Comprehensive Person-Centered (undated) documented, .The facility will develop and implement a comprehensive person-centered care plan for each resident , that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs .The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans .When there has been a significant change in the resident's condition .When goals, needs, and preferences change .<br><br>This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 4/21/26 at 4:45 p.m. with no further information presented prior to the end of the survey.<br><br>4. Resident # 111's (R11) care plan was not revised regarding the use of heels up and heel protectors.<br><br>On 4/21/26 at 10:40 am, an observation was conducted of R111's room. There were no heels up or heel protectors visible in the room or on the bed at the time of observation.<br><br>On 4/21/26 at 10:47 am, an interview was conducted with a certified nursing assistant, CNA#2 (CNA2). During the interview, CNA2 stated this was the first time taking care of R111. She stated that there were no heels up on his bed or heel protectors on his heels this morning upon her arrival to take care of him today.<br><br>On 4/21/26 at 10:50 am, an interview was conducted with a licensed practical nurse, LPN#3 (LPN3). LPN3 stated that his heels up and heel protectors was as tolerated. LPN3 was unable to find any heels up or protectors in his room. She stated she didn't know what happened to the devices. LPN3 stated that R111 refuses the heels up and protectors and provider should be notified when he refuses and maybe something else can be initiated.<br><br>On 4/21/26 an interview was conducted with the licensed practical nurse, LPN#2 (LPN2), who was one of the MDS (Minimum Data Set) coordinators. She stated that a care plan was updated quarterly, for a decline or changes in resident care. LPN2 stated that the MDS coordinator was responsible to do the initial care plan and the unit managers on the units were responsible to do the updates on the care plans.<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of R11's clinical record was conducted. R11's care plan was revised on 3/30/26 and had to apply heel protectors as tolerated and float heels as tolerated. The care plan section of skin impairment had him with impaired skin integrity left heel, right heel, sacrum and left calf. R11's Quarterly Minimum Data Set (MDS) dated [DATE] was reviewed. Section M- Skin Conditions had him coded with a stage 4 pressure ulcer. R11's weekly wound evaluation dated 3/27/26 was reviewed. The wound evaluation had wound location was right heel, Stage 4, wound was unchanged, was to off-load heels and had specialty devices.<br><br>A review of facility documentation was conducted on 4/21/26. The policy titled, Care Planning-Comprehensive Person-Centered, read in part, 16. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a. When requested by the resident/resident representative b. When there has been a significant change in the resident's condition; c. When the desired outcome is not met; d. When goals, needs, and preferences change e. When the resident has been readmitted to the facility from a hospital stay; and f. At least quarterly and after each OBRA MDS assessment.<br><br>On 4/21/26 at 5:00 pm, an end of day meeting was conducted with the director of nursing, administrator and the regional nurse consultant and the above concerns were discussed.<br><br>No additional information was provided prior to the exit conference.<br><br>5. The facility staff failed to update and revise Resident #113's (R113) care plan as his overall health condition began to decline.<br><br>On 4-20-26 at 3:15 pm, a tour of the second-floor nursing units was conducted. During the tour, observations of R113 were made. The first observation was R113 lying in bed moving around, and the second observation was of him lying in bed with his eyes closed.<br><br>On 4/21/26 at 3:50 pm, a clinical record review was conducted. During the review, the Physician Assistant's (PA) progress note was reviewed. The progress note dated 4/14/26 read in part, .comfort focused interventions have been initiated including low dose of morphine and lorazepam for symptom management. The PA's progress noted dated 4/15/26 identified changes in R113's overall health condition. R113 was having increased abdominal pain, decreased food and fluid intake, altered level of consciousness, more assistance needed with activities of daily living, general weakness, and decreased mobility.<br><br>During the review, on 4/17/26 there was a progress note written by the medical doctor. The progress note read in part, .comfort-focused interventions were initiated on 4/14/26 including low-dose morphine concentrate and lorazepam for symptom management.<br><br>A nursing note by RN#3, dated 4/14/26, was reviewed and read in part, . discussed resident's change in condition with provider. Lack of interest in going to dining room for meals, decrease in appetite and fluid intake, decrease in mobility, and was complaining of chronic abdominal pain.<br><br>On 4/21/26 at 3:50 pm, an interview was conducted with a licensed practical nurse, LPN #2 (MDS). LPN#2 stated that care plans were updated quarterly when a resident has a decline or a change in status.<br><br>On 4/21/26 at 4:13 pm, an interview with a Registered Nurse, RN#3 who stated that resident was<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | started on comfort medications, but the facility staff was waiting for resident's representative (RR) to decide if she wanted to put resident on comfort care.<br><br>A review of facility documentation was conducted on 4/21/26. The policy titled, Care Planning-Comprehensive Person-Centered, read in part, 16. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a. When requested by the resident/resident representative b. When there has been a significant change in the resident's condition; c. When the desired outcome is not met, d. When goals, needs, and preferences change e. When the resident has been readmitted to the facility from a hospital stay, and f. At least quarterly and after each OBRA MDS assessment.<br><br>On 4/21/26 at approximately 5:00 pm, an end-of-day meeting was conducted with the administrator, the DON, and the regional nurse consultant and the above concerns were discussed. No additional information was provided at this time.<br><br>On 4/22/26 at 8:33 am, an interview with the Director of Nursing (DON) was conducted. During the interview, the DON stated that the care plan for R113 was not updated for decline in his overall condition, which included his decrease in appetite, decrease in fluid intake, increase in abdominal pain, decrease mobility, and decrease in socialization.<br><br>On 4/22/26 at 8:45 am, an interview was conducted with the director of nursing, the regional nurse consultant, and the physician assistant. The regional nurse consultant stated that she understood that the care plan was not updated by the facility staff with R113's overall health decline. The regional nurse consultant said, this was a learning curve for us. The PA, the director of nursing, and the regional nurse consultant, all three acknowledged that R113's care plan was not updated with his overall decline in his health condition for the facility staff to be able to provide care for him daily.<br><br>No additional information was provided prior to exit conference.<br><br>6. Resident #106's care plan had not been revised regarding interventions for pressure ulcer prevention that were no longer in use.<br><br>Resident #106 (R106) was admitted with diagnoses that included Metabolic Encephalopathy (broad term for brain dysfunction), Type 2 Diabetes Mellitus w/ foot ulcer on left heel, Dementia and Immunodeficiency. Resident #106's Minimum Data Set (MDS), an assessment protocol, dated 4/1/2026 showed Resident #106 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated severe cognitive impairment and required extensive assistance on staff for Activities of Daily Living and care.<br><br>On 4/21/26 a review of Resident 106's care plan, revised 4/3/2026, revealed the resident had pressure ulcers on the buttock and left heel and was at risk or pressure ulcer development due to Type 2 Diabetes Mellitus. Interventions for pressure ulcer treatment/prevention included applying heel protectors while the resident was in bed and the use of a heels up cushion while in bed, alternating air mattress and pressure reducing mattress.<br><br>On 4/21/26 at 9:20 AM accompanied by licensed practical nurse (LPN #1), Resident 106 was observed sleeping in bed and a heels up cushion was in place. There were no heel protectors on Resident 106 or visible in the resident's room. A pressure reducing mattress was in use.<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/21/26 at 9:40 AM an interview was conducted with Unit Manager LPN #1 regarding Resident 106's heel ulcer interventions in the care plan. LPN #1 stated that the heel protectors were no longer in use. LPN #1 said that Resident 106's heel ulcer was healing, and staff only used the heels off cushion. LPN #1 stated the care plan should have been revised to remove the heel protectors and alternating air mattress, as they were no longer in use.<br><br>On 4/21/2026 at 10:10 AM the Director of Nursing (DON) was interviewed regarding Resident 106's care plan. The DON stated that Resident 106 only used the heels up cushion and required a pressure-reducing mattress.<br><br>On 4/21/2026 at 10:49 AM an interview with LPN #2, responsible for MDS and care planning, was conducted. LPN #2 reviewed Resident 106's care plan for skin interventions. LPN #2 acknowledged the interventions needed to be clarified. At 11:36 AM LPN #2 confirmed that the current care plan for Resident 106 had not been updated and the resident no longer required heel protectors or alternating air pressure mattress.<br><br>A review of a facility policy titled, Care Planning-Comprehensive Person-Centered, read in part that the Care Planning/Interdisciplinary team was responsible for the review and updating of care plans. The policy provided examples of when a resident's care plan should be reviewed and updated, which included when there has been a significant change in the resident, when goals, needs and preferences change and when the resident has been readmitted to the facility from a hospital.<br><br>On 4/21/26 at 4:45 PM an end-of-day meeting with the Administrator, DON and the Regional Nurse Consultant was conducted and the failure to review and revise care plans was discussed with no further information provided prior to the end of the survey. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, resident interviews, and clinical record reviews, the facility staff failed to implement measures to promote healing to pressure ulcers for one resident, Resident #111 (R111) out of a survey sample of 15 residents. The findings included:The heels up and heel protectors (pressure relieving devices) were not available in R111's room to be offered/used for use to promote wound healing.On 4/21/26 at 10:40 am, an observation was conducted of R111's room. There were no heels up or heel protectors visible in the room or on the bed at the time of observation.On 4/21/26 at 10:47 am, an interview was conducted with a certified nursing assistant, CNA#2 (CNA2). During the interview, CNA2 stated this was the first time taking care of R111. She stated that there were no heels up on his bed or heel protectors on his heels this morning upon her arrival to take care of him today.On 4/21/26 at 10:50 am, an interview was conducted with a licensed practical nurse, LPN#3 (LPN3). LPN3 stated that he had heels up and booties LPN3 was unable to find any heels up or protectors in his room. She stated she didn't know what happened to the devices. LPN3 stated that R111 refuses the heels up and protectors and that the providers should be notified when he refuses and maybe something else can be initiated.On 4/21/26 at 10:50 am, While the nurse was looking through R111's room for the heels up and heel booties she asked him where they were and R111 said, you won't find them anywhere in here y'all took them out a long time ago to give to someone else.A review of R111's clinical record was conducted. R111's care plan section of skin impairment had him with impaired skin integrity to left heel, right heel, sacrum and left calf. R11's Quarterly Minimum Data Set (MDS) dated [DATE] was reviewed. Section M- Skin Conditions had him coded with a stage 4 pressure ulcer. R111's weekly wound evaluation dated 3/27/26 was reviewed. The wound evaluation had wound location was right heel, Stage 4, wound was unchanged, and he was to off-load heels and had specialty devices. On 4/21/26 at 5:00 pm, an end of day meeting was conducted with the director of nursing, administrator and the regional nurse consultant and the above concerns were discussed.No additional information was provided prior to the exit conference. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation, staff interviews, and facility document review the facility staff failed to ensure that meals were served at palatable temperatures for one of two kitchenettes within the facility. The findings included:The facility staff served residents on the first-floor nursing units (two units) lunch meals at temperatures that were not palatable.On 4/20/26 at 11:45 pm, an observation was made of the kitchenette on the first floor preparing to plate and serve the lunch meal to the residents.The dietary aide, other staff #7 (OS7) was observed obtaining the temperatures of the food from the steam table and the temperatures were as follows:Ham - 100 Puree ham- 90 Sweet potatoes- 110 Grilled chicken- 95 Noodles- 100 Chopped ham - 100 Puree broccoli- 95 Pork chops- 95 Broccoli- 100 Puree bread- 100OS7 was observed shaking her head while obtaining temperatures. OS7 said, it is not reaching the right temperature. OS7 continued to plate the food and was served to the residents on the first-floor of the facility with unsafe temperatures.On 4/20/26 at 2:42 pm, the dietary manager was interviewed. During the interview the dietary manager said, she knew she should have brought the food down to get it to temperature, and I even told her that earlier.On 4/21/26 a review of the facility documentation was conducted. The policy titled, Food temperature control, read in part, .All foods shall be cooked, held, and served at safe temperatures to prevent foodborne illness. Hot foods >135 [degrees Fahrenheit]. Corrective action will be taken immediately for any unsafe reading.A review of the facility documentation titled, Service Line Meal Temperature Monitoring, read in part, .All food temperatures shall be monitored, recorded, and maintained within safe ranges during cooking, holding, and service. Corrective action (reheat, cool, or discard) taken if unsafe range is found.A review of the facility documentation titled, Hot holding temperatures, read in part, All cooked food shall be maintained at proper hot-holding temperatures until service. If food drops below 135 [degrees Fahrenheit], it must be reheated to 165 [degrees Fahrenheit[ for 15 seconds, within 2 hours or discarded.On 4/21/26 at approximately 5:00 pm, an end of day meeting was held with the administrator, the director of nursing, and the regional nurse consultant. During the meeting, the above concerns were discussed. The administrator said, they know what to do, in reference to the dietary staff's actions when unsafe food temperatures were identified during food temperature monitoring. No additional information was provided prior to exit conference. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495363 | A. Building<br>B. Wing | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fairmont Crossing Health and Rehab Center | 173 Brockman Park Drive<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, staff interviews, and facility documentation review the facility staff failed to ensure food items in the walk-in freezer were within expiration dates in the main kitchen. The findings included:The facility staff failed to remove expired yogurt stored in the walk-in freezer.On 4/20/26 at 2:30 pm, an observation of the kitchen was conducted. During the observation, the dietary manager was present. In the walk-in freezer, a case of Dannon yogurt labeled with an expiration date of 4/17/26 was observed stored for use after its expiration date. On 4/20/26 at 2:32 pm, an interview was conducted with the dietary manager. During the interview, the dietary manager picked up the case, reviewed the date, and said, yes, it is expired, then shook his head and stated he does not know how the case was missed. He then reviewed the date on the case beside Dannon yogurt.On 4/21/26 a review of facility policy was conducted. The policy titled, Food storage and labeling, read in part, .All food shall be stored, labeled, and dated to prevent contamination and ensure freshness. Purpose: to maintain safe food storage conditions that comply with CMS [ Centers for Medicare & Medicaid Services] F812 requirements. The Dietary manager will ensure weekly storage inspections.On 4/21/26 at approximately 5:00 pm, an end of the day meeting was conducted with the administrator, the director of nursing, and the administrator. During the meeting, the above concerns were discussed.No additional information was provided prior to exit conference. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495363 | A. Building<br>B. Wing | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fairmont Crossing Health and Rehab Center | 173 Brockman Park Drive<br>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 interviews, and facility documentation the facility staff failed to ensure appropriate infection control practices for one resident, Resident #111 (R111) out of a survey sample of 15 residents. The findings included:Facility staff failed to ensure R111's nasal cannula tubing and CPAP (continue positive airway pressure) mask were stored appropriately to prevent infection and maintained infection control practices.On 4/20/26 at 2:45 pm, an observation was conducted in R111's room of his nasal cannula tubing and CPAP mask lying on the floor in his room.On 4/20/26 at 2:50 pm, an interview was conducted with the unit manager, registered nurse, RN#2 (RN2). During the interview, RN2 said, I will get another nasal cannula tubing for him, and it should be stored in a bag when not in use.On 4/21/26 at 10:30 am, a second observation was made of R11's room and the nasal cannula tubing and CPAP mask were on the floor. On 4/21/26 at 10:47 am, an interview was conducted with certified nursing assistant, CNA#2, (CNA2). During the interview, CNA2 stated that this was the first time she was R111's caregiver. She stated that the nasal cannula (NC) tubing and CPAP mask were on the floor when she arrived this morning for her shift. CNA2 stated that she had notified the charge nurse and had been asking for a table to place equipment on and for a bag for the NC tubing and CPAP mask to be stored. CNA2 stated she wanted the bag for storage and to keep the NC tubing and CPAP clean.On 4/21/26 at 10:50 am. an interview was conducted with a licensed practical nurse, LPN#3 (LPN3). LPN3 was the charge nurse on the unit that R111 resided. LPN3 observed the NC tubing and CPAP mask was on the floor. She said, it should not be placed on the floor, it should be put in bags that are properly labeled to keep the tubing and mask clean.On 4/21/26 at approximately 3:30 pm, the director of nursing was providing information concerning R111's oxygen nasal cannula tubing that was observed on the floor in his room two times. The DON stated that R111 was known to remove his oxygen and could have thrown the tubing on the floor. The DON was not aware that he was wearing his oxygen nasal cannula using an E cylinder (E-tank) and that the tubing on the floor was attached to his oxygen concentrator, which staff indicated was used at bedtime. The DON said, oh he had his oxygen on. No additional information was provided.On 4/21/26 a review of facility policy was conducted. The policy titled, Prevention of Infection While Providing Respiratory Care, read in part, .The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. 1. Respiratory equipment, when not in use by the assigned resident, will be stored in a safe manner to prevent injury and/or contamination. 3. a. oxygen cannulas and tubing will be changed weekly and when soiled; oxygen cannulas and masks will be kept covered when not in use. 5. CPAP/BiPAP or other Mechanical Respiratory Support Devices c. equipment will be cleaned and disinfected between resident use and will be stored in a clean environment. 7. a. When respiratory therapy equipment is cleaned/disinfected between resident use, the equipment will have a label indicating that the machine was cleaned/disinfected and the date. b. when respiratory supplies are changed, the facility will maintain a system for identifying the date that the equipment/supplies were changed and/or the date that the equipment/supplies are to be changed.On 4/21/26 at approximately 5:00 pm an end of date meeting was held to discuss the concerns above with the administrator, the director of nursing, and the regional nurse consultant.No additional information was provided prior to the exit conference. |