STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CHOICE HEALTHCARE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 11/29/2021 through 12/1/2021. The facility was not in compliance with the Virginia Regulations for the Licensure of Nursing Facilities. The census in this 120 bed facility was 75 at the time of the survey. The survey sample consisted of 20 current Resident reviews and three closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Regulations for the Licensure of Nursing Facilities: 12VAC5-371-180 Infection Control 12VAC5-371-180 (C.3) Cross Reference to F-686 12VAC5-371-180 (C.3) Cross Reference to F-880 12VAC5-371-180 (B) Cross Reference to F-886 12VAC5-371-220 Nursing Services 12VAC5-371-220 (B) Cross Reference to F-684 12VAC5-371- 250 Resident Assessment and Care Planning 12VAC5-371-250 (A) Cross Reference to F-641 12VAC5-371-250 (F) Cross Reference to F-657 12VAC5-371 160 Financial Controls and resident funds 12VAC5-371 160 (C.2.) Cross Reference to F-570	F 001	Choice Healthcare at Lynchburg (_Facility_) is filing this plan of correction for the purpose of regulatory compliance. The Facility is submitting this plan of correction to comply with the applicable law. The submission of this plan of correction does not represent an admission or statement of agreement with respect to the alleged deficiencies. 12VAC5-371-180 Infection Control 12VAC5-371-180 (C.3) Cross Reference to F-686 1. Resident # 30 has been under the services of the wound care medical doctor. RN#2 was educated on the procedures for changing wound dressings. No adverse effect noted. 2. All residents with pressure ulcer dressing changes could have the potential to be affected by deficient practice.	1/4/22

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

Electronically Signed | 12/14/21

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F 001	Continued From page 1 12VAC5-371-140 Policies and procedures 12VAC5-371-140 (A) Cross Reference to F607 12VAC5-371-140 (A) Cross Reference to F609 12VAC5-371-140 (A) Cross Reference to F610 12VAC5-371 Physican services 12VAC5-371 (C.4) Cross Reference to F-684 12VAC5-371 Pharmaceutical services 12VAC5-371 (B) Cross Reference to F-761 12VAC5-371 Director of nursing 12VAC5-371 (B.1) Cross Reference to F-695	F 001	3. Re-education was provided to the wound care nurse RN#2 regarding the proper wound changing procedures before Survey exit. The Director of Nursing will have oversight of the skin management program. 4. Director of Nursing/ or designee will audit the Pressure Ulcer changing procedure of 2 residents weekly times 1 month then monthly for 2 months. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan. 12VAC5-371-180 (C.3) Cross Reference to F-880 1. RN#2 was educated in proper handwashing technic while providing wound care. LPN#1 was in-serviced in the handwashing policy. 2. All residents have the potential to be affected by deficient practice.	

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F 001	Continued From page 2	F 001	3. Nursing staff and nursing agency staff will be in-serviced in the Hand Hygiene policy by 12/16/2021. All new hires and new agency nursing staff will be trained in proper hand washing techniques. LPN#1 and RN#2 will be tracked and trended for compliance. 4. Director of nursing or designee will audit 5 Nursing staff members complete hand washing/sanitizing procedures weekly for one month and then 5 monthly for two months. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan. 12VAC5-371-180 (B) Cross Reference to F-886 1. COVID-19 testing will be conducted per CMS guideline. No resident was	

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F 001	Continued From page 3	F 001	affected due to testing requirement is for unvaccinated employees. 2. All residents had the potential to be affected by deficient practice. All unvaccinated employees will test to according to CMS QSO-20-38 NH. 3. Administrator, Director of Nursing were in-serviced by the Clinical Nurse Consultant in monitoring CMS COVID-19 Nursing Home Data webpage for testing frequency updates. 4. Administrator, Director of Nursing or designee will monitor the COVID-19 Nursing Home Data webpage for testing frequency updates weekly. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan. 12VAC5-371-220 Nursing Services 12VAC5-371-220 (B) Cross Reference to	

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F 001	Continued From page 4	F 001	F-684 1. Resident # 72 the Nystatin powder was removed and discarded. No adverse effect noted. 2. All residents with discontinued Nystatin powder physician orders could have the potential to be affected by deficient practice. 3. An audit of all residents with recent discontinue orders for Nystatin powder will be inspected for continued use. 4. Director of Nursing/ or designee will audit weekly times 2 months then monthly for 1 month for recent discontinued Nystatin powder orders and the discontinued use of the powder. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan. 12VAC5-371-250 Resident Assessment and Care Planning 12VAC5-371-250 (A) Cross	

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F 001	Continued From page 5	F 001	Reference to F-641 1. Resident # 49□s MDS was revised appropriately to reflect indwelling catheter removal and bladder incontinence before Survey exit. 2. All residents newly admitted or readmitted from the hospital could have the potential to be affected by deficient practice. 3. An assessment and audit of all current residents with indwelling catheters has been conducted to assure that their most recent MDS reflects their appropriate urinary elimination status. Inservicing by the Clinical Consultant Nurse to the MDS Coordinator on correct coding of indwelling catheters on the MDS and appropriate care planning of urinary elimination status has been completed. 4. All newly admitted/readmitted residents will be assessed for the presence of an indwelling catheter and have their orders and Admission-Readmission Screening reviewed at the next Clinical Meeting following the admission/readmission for the presence/absence of orders r/t an indwelling catheter. All residents with indwelling catheters will be discussed at the weekly Risk meeting and an audit maintained by the MDS Coordinator to assure that the presence of said catheter remains in place and/or that the MDS reflects the correct urinary elimination status. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy.	

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F 001	Continued From page 6	F 001	The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan. 12VAC5-371-250 (F) Cross Reference to F-657 1. Resident # 49□s Care Plan was revised appropriately to reflect indwelling catheter removal and bladder incontinence before Survey exit. Resident□s 47□s Care Plan was revised appropriately to reflect current Code Status before Survey exit. 2. All residents newly admitted, or readmitted from the hospital, and changed to hospice could have the potential to be affected by deficient practice. 3. An assessment and audit of all current residents with indwelling catheters has been conducted to assure that their most recent MDS reflects their appropriate urinary elimination status. In-servicing by the Clinical Consultant Nurse to the MDS Coordinator on correct coding of indwelling catheters on the MDS and appropriate care planning of urinary elimination status has been completed. All residents Code Status has been completed and accuracy verified that the Code Status is addressed in the Care Plan. In-servicing to the SS by the MDS Coordinator on timeliness and appropriate	

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F 001	Continued From page 7	F 001	Code Status was completed. 4. All newly admitted/readmitted residents will be assessed for the presence of an indwelling catheter and have their orders and Admission-Readmission Screening reviewed at the next Clinical Meeting following the admission/readmission for the presence/absence of orders r/t an indwelling catheter. All residents with indwelling catheters will be discussed at the weekly Risk meeting and an audit maintained by the MDS Coordinator to assure that the presence of said catheter remains in place and/or that the MDS reflects the correct urinary elimination status. Any resident newly admitted to Hospice will have their Code Status verified at the time of the Hospice admission and appropriately reviewed and revised in the care plan. MD orders will be reviewed daily for Code Status changes by Social Worker and any changes will be made in the care plan. An audit will be conducted by the SW weekly to assure the changes in Code Status are reflected appropriately in the Care Plan Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility	

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F 001	Continued From page 8	F 001	QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan. 12VAC5-371 160 Financial Controls and resident funds 12VAC5-371 160 (C.2.) Cross Reference to F-570 1. The facility did not have a surety bond in an amount to cover resident fund balance. 2. All residents with a trust fund account could have the potential to be affected by deficient practice. 3. The Business Office Manager will be in-serviced on the policy and procedure for Surety Bond Requirements by 12/08/2021. 4. Business Office Manager will audit monthly the Surety Bond amount will cover the trust fund balance. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued	

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F 001	Continued From page 9	F 001	intervention or amendment of plan. 12VAC5-371-140 Policies and procedures 12VAC5-371-140 (A) Cross Reference to F607 1. Resident # 67 is no longer a resident. No adverse effect noted in the medical record. 2. All residents have the potential to be affected by this deficient practice. 3. All staff will be in-serviced on sexual assault and reporting. 4. All incidents, accidents, and allegations of abuse will be immediately reported to the Corporate Clinical Consultant to ensure that all are reported and thoroughly investigated to report to the appropriate agencies per guidelines. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee consisting of DON, Medical Director, NHA, MDS, Safety Officer, Social Services Director, Infection Control Officer monthly to review the need for	

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F 001	Continued From page 10	F 001	continued intervention or amendment of plan. 12VAC5-371-140 (A) Cross Reference to F609 1. In-service Administrator/Director of Nursing on Reporting abuse to State Agencies and Other Entities/ Individuals policy and Abuse Investigation policy. 2. All residents with incidents, accidents, and allegations of abuse have the potential to be affected by deficient practice. 3. Corporate Clinical Consultant in-serviced Administrator/ Director of Nursing on Virginia Department of Health Reporting of Incidences and facility policy on Abuse Prohibition. 4. All incidents, accidents, and allegations of abuse will be immediately reported to the Corporate Clinical Consultant to ensure that all are reported and thoroughly investigated to report to the appropriate agencies per guidelines. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy The Administrator will be responsible for	

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F 001	Continued From page 11	F 001	overseeing all abuse/neglect allegation investigations and ascertaining that the facility policy for Abuse Prevention, Investigation and Reporting is followed including reporting requirements. The Administrator will contact the Corporate Director of Clinical Services within eight hours of being informed of an abuse allegation to review the allegations of abuse, review the investigation process, the reporting requirements, and the overall compliance with the facility policy for abuse reporting and investigation as well as the Elder Justice Act. 12VAC5-371-140 (A) Cross Reference to F610 1. In-service Administrator/Director of Nursing on Reporting abuse to State Agencies and Other Entities/ Individuals policy and Abuse Investigation policy. 2. All residents with incidents, accidents, and allegations of abuse have the potential to be affected by deficient practice. 3. Corporate Clinical Consultant in-serviced Administrator/ Director of Nursing on Virginia Department of Health Reporting of Incidences and facility policy on Abuse Prohibition. 4. All incidents, accidents, and allegations of abuse will be immediately reported and thoroughly investigated per guidelines. Findings will be reported to the Nursing Home Administrator (NHA) immediately	

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F 001	Continued From page 12	F 001	when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy The Administrator will be responsible for overseeing all abuse/neglect allegation investigations and ascertaining that the facility policy for Abuse Prevention, Investigation and Reporting is followed including reporting requirements. The Administrator will contact the Corporate Director of Clinical Services within eight hours of being informed of an abuse allegation to review the allegations of abuse, review the investigation process, the reporting requirements, and the overall compliance with the facility policy for abuse reporting and investigation as well as the Elder Justice Act. 12VAC5-371 Physician services 12VAC5-371 (C.4) Cross Reference to F684 1. Resident # 72 the Nystatin powder was removed and discarded. No adverse effect noted. 2. All residents with discontinued Nystatin powder physician orders could have the potential to be affected by deficient practice. 3. An audit of all residents with recent discontinue orders for Nystatin powder will be inspected for continued use.	

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F 001	Continued From page 13	F 001	4. Director of Nursing/ or designee will audit weekly times 2 months then monthly for 1 month for recent discontinued Nystatin powder orders and the discontinued use of the powder. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan. 12VAC5-371 Pharmaceutical services 12VAC5-371 (B) Cross Reference to F761 1. Resident # 28 and Resident #72 medication that was left in the resident room was removed. No adverse effect noted. 2. All residents could has the potential to be affected by deficient practice. 3. All residents rooms will be audited to ensure medications have not left in the room. The current nursing staff and agency	

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F 001	Continued From page 14	F 001	nursing staff will be in-serviced on the proper medication distribution. All new hires and starting agency will be in-serviced on proper medication distribution. 4. Director of Nursing/ or designee will audit 10 residents rooms weekly for 1 month then monthly for 2 months to ensure the medications are secure and not in the resident rooms. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan. 12VAC5-371 Director of nursing 12VAC5-371 (B.1) Cross Reference to F-695 1. Resident # 44 oxygen tubing and humidifier bottle was changed. No adverse effect noted. 2. All residents using oxygen concentrators could has the potential to be affected by deficient practice.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(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) COMPLETE DATE
F 001	Continued From page 15	F 001	3. All residents with oxygen concentrators will be audited to ensure the tubing and humidifier bottles have been changed per policy. The current staff and agency staff will be in-serviced on the Oxygen Concentrator Usage policy. All new hires and starting agency will be in-serviced on Oxygen Concentrator Usage policy. 4. Director of Nursing/ or designee will audit 5 oxygen concentrator residents weekly for 1 month then monthly for 2 months for tubing and humidifier bottles in date per policy. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan.	