	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		VA0017	B. WING		C 12/01/2021
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST/	ATE, ZIP CODE	
		2081 LA	NGHORNE ROA		
HOICE H	EALTHCARE AT LYNCH	BURG	URG, VA 24501		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	(X5) E COMPLE
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 000	Initial Comments		F 000		
	12/1/2021. The facili	nnial State Licensure Icted 11/29/2021 through ty was not in compliance Ilations for the Licensure of			
	time of the survey. T	0 bed facility was 75 at the he survey sample consisted t reviews and three closed			
F 001	Non Compliance		F 001		1/4/22
	The facility was out of following state license	-			
	This RULE: is not me The facility was not in following Virginia Reg Nursing Facilities:	•		Choice Healthcare at Lynchburg (_Facility_) is filing this plan of correction for the purpose of regulatory compliance The Facility is submitting this plan of	
	12VAC5-371-180 (C.	3) Cross Reference to F-686 3) Cross Reference to F-880		correction to comply with the applicable law. The submission of this plan of correction does not represent an	
		Cross Reference to F-886		admission or statement of agreement w respect to the alleged deficiencies.	vith
	12VAC5-371-220 Nui 12VAC5-371-220 (B)	sing Services Cross Reference to F-684		12VAC5-371-180 Infection Control 12VAC5-371-180 (C.3) Cross Reference	e
	12VAC5-371- 250 Re Care Planning	sident Assessment and		to F-686 1. Resident # 30 has been under the	~
	12VAC5-371-250 (A)	Cross Reference to F-641 Cross Reference to F-657		services of the wound care medical doctor. RN#2 was educated on the procedures for changing wound dressir	ngs.
	12VAC5-371 160 Fina funds	ancial Controls and resident		No adverse effect noted.	
	12VAC5-371 160 (C.2 F-570	2.) Cross Reference to		2. All residents with pressure ulcer dressing changes could have the poter to be affected by deficient practice.	tial

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

TITLE

(X6) DATE

12/14/21

Electronically Signed

ZONE11

If continuation sheet 1 of 16

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		VA0017	B. WING		12/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
CHOICE H	HEALTHCARE AT LYNCH	IBURG	NGHORNE ROA BURG, VA 24501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLET
F 001	Continued From page	e 1	F 001		
	12VAC5-371-140 (A) 12VAC5-371-140 (A) 12VAC5-371 Physica 12VAC5-371 (C.4) Cr 12VAC5-371 Pharma 12VAC5-371 (B) Cros 12VAC5-371 Director	Cross Reference to F607 Cross Reference to F609 Cross Reference to F610 In services ross Reference to F-684 Inceutical services ss Reference to F-761		 Re-education was provided to a wound care nurse RN#2 regarding a proper wound changing procedures. Survey exit. The Director of Nursing have oversight of the skin manager program. Director of Nursing/ or designed audit the Pressure Ulcer changing procedure of 2 residents weekly timmonth then monthly for 2 months. Findings will be reported to the Nurs Home Administrator (NHA) immedia when policy is not adhered to. Failure to adhere to facility policy with considered a violation. Violations we result in disciplinary action in accord with the facility progressive disciplinary of the fact of the fact	the before gwill nent e will les 1 sing ately lill be /ill dance lary le for cility months e for gg

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		VA0017	B. WING		C 12/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
	EALTHCARE AT LYNCH	2081 LA	NGHORNE ROA	ND	
		LYNCHE	BURG, VA 2450	I	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
F 001	Continued From page	e 2	F 001		
				3. Nursing staff and nursing agence will be in-serviced in the Hand Hygie policy by 12/16/2021.	-
				All new hires and new agency nursir will be trained in proper hand washir techniques.	
				LPN#1 and RN#2 will be tracked and trended for compliance.	d
				4. Director of nursing or designee a audit 5 Nursing staff members comp hand washing/sanitizing procedures weekly for one month and then 5 mc for two months.	lete
				Findings will be reported to the Nurs Home Administrator (NHA) immediat when policy is not adhered to.	
				Failure to adhere to facility policy wil considered a violation. Violations wi result in disciplinary action in accord with the facility progressive disciplina policy	ill ance
				The Administrator will be responsible overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the fac QAPI Committee monthly for three n to review the need for continued intervention or amendment of plan.	cility
				12VAC5-371-180 (B) Cross Referen F-886 1. COVID-19 testing will be conduc per CMS guideline. No resident was	cted

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		VA0017	B. WING		C 12/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
CHOICE F	EALTHCARE AT LYNCH	IRURG	NGHORNE ROA		
		LYNCHE	BURG, VA 24501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET
F 001	Continued From page	e 3	F 001		
				affected due to testing requirement is unvaccinated employees.	for
				2. All residents had the potential to affected by deficient practice.	be
				All unvaccinated employees will test t according to CMS QSO-20-38 NH.	0
				3. Administrator, Director of Nursing were in-serviced by the Clinical Nurse Consultant in monitoring CMS COVID)-19
				Nursing Home Data webpage for test frequency updates.	ing
				 Administrator, Director of Nursing designee will monitor the COVID-19 Nursing Home Data webpage for test frequency updates weekly. 	
				Findings will be reported to the Nursir Home Administrator (NHA) immediate when policy is not adhered to.	•
				Failure to adhere to facility policy will considered a violation. Violations will result in disciplinary action in accorda with the facility progressive disciplinar policy	nce
				The Administrator will be responsible overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the faci QAPI Committee monthly for three monthly to review the need for continued	lity
				intervention or amendment of plan. 12VAC5-371-220 Nursing Services 12VAC5-371-220 (B) Cross Referenc	e to

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		VA0017	B. WING		C 12/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
	EALTHCARE AT LYNCH	IRURG	NGHORNE ROA		
		LYNCHE	BURG, VA 24501		I
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
F 001	Continued From page	e 4	F 001	 F-684 Resident # 72 the Nystatin powd was removed and discarded. No adve effect noted. All residents with discontinued Nystatin powder physician orders cou have the potential to be affected by deficient practice. An audit of all residents with rece discontinue orders for Nystatin powde be inspected for continued use. Director of Nursing/ or designee audit weekly times 2 months then mo for 1 month for recent discontinued Nystatin powder orders and the discontinued use of the powder. Find will be reported to the Nursing Home Administrator (NHA) immediately whe policy is not adhered to. Failure to adhere to facility policy will considered a violation. Violations wil result in disciplinary action in accorda with the facility progressive disciplina policy. The Administrator will be responsible overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the faci QAPI Committee monthly for three m to review the need for continued intervention or amendment of plan. 12VAC5-371-250 Resident Assessme and Care Planning 12VAC5-371-250 (A) Cross 	erse

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
		VA0017	B. WING		C 12/01/202	21
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
CHOICE I	IEALTHCARE AT LYNCH	IBURG	NGHORNE ROA BURG, VA 24501			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COI	MPLET DATE
F 001	Continued From page	e 5	F 001	Reference to F-641 1. Resident # 49 □ s MDS was appropriately to reflect indwelling removal and bladder incontinence Survey exit. 2. All residents newly admitted readmitted from the hospital coult the potential to be affected by de practice. 3. An assessment and audit of residents with indwelling catheter been conducted to assure that th recent MDS reflects their approp urinary elimination status. Inservit the Clinical Consultant Nurse to t Coordinator on correct coding of indwelling catheters on the MDS appropriate care planning of urin elimination status has been comp 4. All newly admitted/readmitter residents will be assessed for the presence of an indwelling catheter have their orders and Admission-Readmission/readmiss the presence/absence of orders indwelling catheters will be discu the weekly Risk meeting and an maintained by the MDS Coordina assure that the presence of said remains in place and/or that the I reflects the correct urinary elimin status. Failure to adhere to facility policy considered a violation. Violation result in disciplinary action in acc with the facility progressive discip	e catheter e before or d have ficient all current rs has eir most riate icing by the MDS and ary bleted. d e and ary bleted. d e and ary bleted. ary ary ary ary ary ary ary ary ary ary	

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		VA0017	B. WING		C 12/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
	IEALTHCARE AT LYNCH	IBURG	NGHORNE ROA		
	1	LYNCH	BURG, VA 24501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET
F 001	Continued From page	e 6	F 001		
F 001	Continued From page	e 6	F 001	The Administrator will be responsible overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the faci QAPI Committee monthly for three me to review the need for continued intervention or amendment of plan. 12VAC5-371-250 (F) Cross Reference F-657 1. Resident # 49 s Care Plan was revised appropriately to reflect indwel catheter removal and bladder incontin before Survey exit. Resident s 47 s Care Plan was revi appropriately to reflect current Code Status before Survey exit. 2. All residents newly admitted, or readmitted from the hospital, and cha to hospice could have the potential to affected by deficient practice. 3. An assessment and audit of all co residents with indwelling catheters ha been conducted to assure that their m recent MDS reflects their appropriate urinary elimination status. In-servicing the Clinical Consultant Nurse to the M Coordinator on correct coding of indwelling catheters on the MDS and appropriate care planning of urinary elimination status has been completer All residents Code Status has been completed and accuracy verified that	lity onths e to ling hence sed sed urrent s host J by IDS d.
				Code Status is addressed in the Care Plan. In-servicing to the SS by the MI Coordinator on timeliness and approp	os

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		VA0017	B. WING		C 12/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	•
		2081 4	NGHORNE ROA		
CHOICE F	IEALTHCARE AT LYNCH	IBURG LYNCHE	BURG, VA 2450 ²	I	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
F 001	Continued From page	e 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 the weekly Risk meeting and an audit maintained by the MDS Coordinator to assure that the presence of said cather remains in place and/or that the MDS reflects the correct urinary elimination status. Any resident newly admitted to Hospic will have their Code Status verified at time of the Hospice admission and appropriately reviewed and revised in care plan. MD orders will be reviewed daily for Code Status changes by Soci Worker and any changes will be made the care plan. An audit will be conduct by the SW weekly to assure the change in Code Status are reflected appropriating the Care Plan	or at o eter the the the ial e in ted ges ately
				considered a violation. Violations will result in disciplinary action in accordar with the facility progressive disciplinary policy. The Administrator will be responsible f	nce y
				overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facili	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		VA0017	B. WING		12/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
	IEALTHCARE AT LYNCH	IBURG			
			BURG, VA 24501		01
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE
F 001	Continued From page	e 8	F 001		
				QAPI Committee monthly for three m to review the need for continued intervention or amendment of plan. 12VAC5-371 160 Financial Controls a resident funds	
				12VAC5-371 160 (C.2.) Cross Refer to F-570The facility did not have a suret	
				in an amount to cover resident fund balance.	
				2. All residents with a trust fund a could have the potential to be affected deficient practice.	
				3. The Business Office Manager w in-serviced on the policy and proced Surety Bond Requirements by 12/08	lure for
				4. Business Office Manager will au monthly the Surety Bond amount wi the trust fund balance. Findings will reported to the Nursing Home Administrator (NHA) immediately wh policy is not adhered to.	ll cover be
				Failure to adhere to facility policy wi considered a violation. Violations w result in disciplinary action in accord with the facility progressive disciplina policy.	ill lance
				The Administrator will be responsible overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the fac QAPI Committee monthly for three r to review the need for continued	cility

STATEMEN	/irginia OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		VA0017	B. WING		C 12/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST/	ATE, ZIP CODE	
CHOICE H	EALTHCARE AT LYNCH	IRURG	NGHORNE ROA BURG, VA 24501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
F 001	Continued From page	e 9	F 001		
				intervention or amendment of plan.	
				12VAC5-371-140 Policies and proce 12VAC5-371-140 (A) Cross Reference F607	
				1. Resident # 67 is no longer a res No adverse effect noted in the medic record.	
				2. All residents have the potential t affected by this deficient practice.	o be
				3. All staff will be in-serviced on se assault and reporting.	xual
				4. All incidents, accidents, and allegations of abuse will be immediat reported to the Corporate Clinical Consultant to ensure that all are report and thoroughly investigated to report the appropriate agencies per guideling	orted to
				Findings will be reported to the Nursi Home Administrator (NHA) immediat when policy is not adhered to.	ng
				Failure to adhere to facility policy will considered a violation. Violations wi result in disciplinary action in accords with the facility progressive disciplina policy	ll ance
				Report of findings and subsequent disciplinary action, if applicable, will I reported to the facility QAPI Commit consisting of DON, Medical Director, NHA, MDS, Safety Officer, Social Services Director, Infection Control	ee

	/irginia OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		VA0017			12/01/2021
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST		
	IEALTHCARE AT LYNCH	IBURG	NGHORNE ROA BURG, VA 24501		
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN OF CORRECTIO	DN (X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
F 001	Continued From page	e 10	F 001		
				continued intervention or amendmen plan.	it of
				12VAC5-371-140 (A) Cross Reference F609	ce to
				1. In-service Administrator/Director Nursing on Reporting abuse to State Agencies and Other Entities/ Individu policy and Abuse Investigation policy	Jals
				2. All residents with incidents, acci and allegations of abuse have the potential to be affected by deficient practice.	dents,
				3. Corporate Clinical Consultant in-serviced Administrator/ Director of Nursing on Virginia Department of H Reporting of Incidences and facility p on Abuse Prohibition.	ealth
				4. All incidents, accidents, and allegations of abuse will be immediat reported to the Corporate Clinical Consultant to ensure that all are report and thoroughly investigated to report the appropriate agencies per guideling	orted t to
				Findings will be reported to the Nurse Home Administrator (NHA) immediat when policy is not adhered to.	
				Failure to adhere to facility policy will considered a violation. Violations wi result in disciplinary action in accorda with the facility progressive disciplina policy	ll ance
				The Administrator will be responsible	for

tate of Virginia TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0017	B. WING		C 12/01/2021
AME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
HOICE HEALTHCARE AT LYN	CHBURG	ANGHORNE ROA BURG, VA 24501		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLET
F 001 Continued From particular of the second secon	ge 11	F 001	 overseeing all abuse/neglect alleg investigations and ascertaining that facility policy for Abuse Preventior Investigation and Reporting is follow including reporting requirements. Administrator will contact the Corp Director of Clinical Services within hours of being informed of an abu allegation to review the allegations abuse, review the investigation point the reporting requirements, and the compliance with the facility policy abuse reporting and investigation as the Elder Justice Act. 12VAC5-371-140 (A) Cross Refere F610 In-service Administrator/Direct Nursing on Reporting abuse to Stat Agencies and Other Entities/ Indiv policy and Abuse Investigation policy and Abuse Investigation policy and allegations of abuse have the potential to be affected by deficier practice. Corporate Clinical Consultant in-serviced Administrator/ Director Nursing on Virginia Department of Reporting of Incidences and facility on Abuse Prohibition. All incidents, accidents, and allegations of abuse will be immed reported and thoroughly investigation guidelines. 	at the in, in powed in the powed is the powed is the power of the powe

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		VA0017	B. WING		C 12/01/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
CHOICE F	EALTHCARE AT LYNCH	IBURG	NGHORNE ROA			
	1	LYNCH	BURG, VA 24501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET	
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 allegati investigations and ascertaining that t facility policy for Abuse Prevention, Investigation and Reporting is follow including reporting requirements. The Administrator will contact the Corpor- Director of Clinical Services within ei hours of being informed of an abuse allegation to review the allegations o abuse, review the investigation proce the reporting requirements, and the o compliance with the facility policy for abuse reporting and investigation as as the Elder Justice Act.	he ed ate ght f ess, overall	
				12VAC5-371 Physician services 12VAC5-371 (C.4) Cross Reference F684	to	
				1. Resident # 72 the Nystatin power was removed and discarded. No adv effect noted.		
				2. All residents with discontinued Nystatin powder physician orders con have the potential to be affected by deficient practice.	uld	
				3. An audit of all residents with rec discontinue orders for Nystatin powd be inspected for continued use.		

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		VA0017	B. WING		C 12/01/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE		
	EALTHCARE AT LYNCH	BURG 2081 LA	NGHORNE ROA	D		
	1	LYNCHE	BURG, VA 24501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLET	
F 001	Continued From page 13		F 001			
				 Director of Nursing/ or designee audit weekly times 2 months then more for 1 month for recent discontinued Nystatin powder orders and the discontinued use of the powder. Find will be reported to the Nursing Home Administrator (NHA) immediately whe policy is not adhered to. Failure to adhere to facility policy will considered a violation. Violations will result in disciplinary action in accorda with the facility progressive disciplinal policy. The Administrator will be responsible overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the fac QAPI Committee monthly for three m to review the need for continued intervention or amendment of plan. 12VAC5-371 Pharmaceutical service 12VAC5-371 (B) Cross Reference to Resident # 28 and Resident #72 medication that was left in the resider room was removed. No adverse effect noted. All residents could has the potent be affected by deficient practice. All residents rooms will be audite ensure medications have not left in th room. 	onthly dings en be l ance ry for ility ionths s F761 nt ct t to ed to	
				The current nursing staff and agency		

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		VA0017			C 12/01/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
CHOICE H	EALTHCARE AT LYNCH	IBURG	ANGHORNE ROA BURG, VA 24501			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	DN (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET	
F 001	Continued From page 14		F 001			
				nursing staff will be in-serviced on th proper medication distribution. All ne 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 considered a violation. Violations wi result in disciplinary action in accords with the facility progressive disciplina policy.	ll ance	
				The Administrator will be responsible overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the fac QAPI Committee monthly for three m to review the need for continued intervention or amendment of plan.	ility	
				12VAC5-371 Director of nursing 12VAC5-371 (B.1) Cross Reference F-695	to	
				1. Resident # 44 oxygen tubing an humidifier bottle was changed. No ac effect noted.		
				2. All residents using oxygen concentrators could has the potentia affected by deficient practice.	l to be	

State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP AND PLAN OF CORRECTION IDENTIFICATION		P.		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
VA0017		B. WING		C 12/01/2021	
/IDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
	HBURG				
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(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	CTION SHOULD BE COMPL O THE APPROPRIATE DAT	
Continued From page 15		F 001			
			 tubing and humidifier bottles has changed per policy. The current staff and agency stiin-serviced on the Oxygen Comusage policy. All new hires and agency will be in-serviced on C Concentrator Usage policy. 4. Director of Nursing/ or des audit 5 oxygen concentrator resweekly for 1 month then month months for tubing and humidified date per policy. Findings will be to the Nursing Home Administrimmediately when policy is not Failure to adhere to facility policonsidered a violation. Violation result in disciplinary action in a with the facility progressive disciplicy. The Administrator will be responded by the respondence of the result of findings subsequent disciplinary action, applicable, will be reported to the result of the result of findings for the result of the respondence of the respondence. 	ave been taff will be centrator d starting bxygen ignee will sidents ly for 2 er bottles in e reported ator (NHA) adhered to. cy will be ons will ccordance ciplinary nsible for and if he facility mee months d	
	/IDER OR SUPPLIER ILTHCARE AT LYNC SUMMARY S (EACH DEFICIEN REGULATORY OF	VA0017 VIDER OR SUPPLIER STREET A LTHCARE AT LYNCHBURG 2081 LA LYNCHE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	VA0017 A. BUILDING: VIDER OR SUPPLIER STREET ADDRESS, CITY, ST ALTHCARE AT LYNCHBURG 2081 LANGHORNE ROA LYNCHBURG, VA 24501 UNCHBURG, VA 24501 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG	VA0017 B. WING ADER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LTHCARE AT LYNCHBURG 2081 LANGHORNE ROAD LYNCHBURG, VA 24501 SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF COR CROSS-REFERENCED TO THE A DEFICIENCY Ontinued From page 15 F 001 3. All residents with oxygen concentrators will be audited to tubing and humidifier bottles he changed per policy. The current staff and agency si in-serviced on the Oxygen Con Usage policy. The current staff and agency si in-serviced on the Oxygen Con Usage policy. 4. Director of Nursing/ or des audit 5 oxygen concentrator re weekly for 1 month them months for tubing and humidifier date per policy. Findings will be to the Nursing Home Administri immediately when policy is not with the facility progressive dis policy. Failure to adhere to facility policy overseeing all audit of findings subsequent disciplinary action in a with the facility progressive dis policy.	VA0017 B. WING 12/1 ADER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2081 LANGHORNE ROAD LTHCARE AT LYNCHBURG 2081 LANGHORNE ROAD PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PROCEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ontinued 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. V/Otaltons will result in disciplinary action in accordance with the facility progressive disciplinary