STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/3/23 through 1/6/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No Emergency Preparedness complaints were investigated during the survey.	E 000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/3/23 through 1/6/23. Eight complaints were investigated during the survey: VA00056307 - substantiated without deficiency; VA00057143 - substantiated without deficiency; VA00056530 - substantiated with deficiency; VA00056292 - unsubstantiated; VA00056293 - unsubstantiated; VA00056672 - substantiated with deficiency; VA00057301 - substantiated without deficiency; and VA00057227 - substantiated with deficiency. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 87 at the time of the survey. The survey sample consisted of 37 current resident record reviews and seven closed resident record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Guerchonite Guillaume | TITLE: Administrator | (X6) DATE: 1/24/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined the facility staff failed to notify the responsible party of a change in condition for one of 44 residents in the survey sample, Resident #18 (R18). The findings include: For R18, the facility staff failed to notify the responsible party of a change in condition requiring a facility initiated transfer to the emergency room on 11/3/2022. On the most recent MDS (minimum data set) assessment, a five-day assessment with an ARD (assessment reference date) of 11/18/2022, the resident scored a six out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. The progress notes for R18 documented in part, - "11/3/2022 19:32 (7:32 p.m.) Note Text : Resident is having loss of fluid to mouth when fed. Will continue to encourage oral fluid. on call NP (nurse practitioner) [Name of NP] notified." - "11/3/2022 20:08 (8:08 p.m.) Note Text : New order received from on call NP [Name of NP] to send resident out for Lethargy, Weakness, And AMS (altered mental status). Picked up by EMT (emergency medical technician) @ 8.08pm (at 8:08 p.m.)."	F 580	F580: Failure to notify RP of COC 1. Resident #18 has returned to the facility. Resident #18 Responsible party was made aware of change in condition by night shift RN on 11/3/22 2. All residents are at risk of deficient practice. DON/Designee will review records for all hospital transfer over the last 30 days and ensure the proper RP notifications occurred. 3. DON/Designee will educate all licensed nurses on proper protocol for change in condition. Education will include placing call to update RP of any changes in condition and/or hospital transfers. 4. DON/Designee will audit 24/hour report during clinical meeting 5x a week for 4 weeks then weekly x 8 weeks to ensure that proper RP notification occurred for all change of conditions. Any issues identified will be addressed immediately by DON/Designee and appropriate actions will be taken. The DON/Designee will identify any trends or patterns and educate as needed. All findings will be discussed with QAPI committee monthly x 3 months for review and recommendations. 5. Date of Compliance: 2/20/2023	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3	F 580		

- "11/3/2022 23:30 (11:30 p.m.) Note Text : Resident's daughter wanted to speak with supervisor, I returned her call at 23:02 (11:02 p.m.) and spoke with resident's daughter for 25 minutes and addressed her concerns accordingly."
- "11/4/2022 06:54 (6:54 a.m.) Note Text : The resident was sent out by order of NP [Name of NP] because of Lethargy and altered mental status; notice of discharge form and bed hold form sent with resident, RP (responsible party) [Name of RP] notified."

The eInteract Change in Condition evaluation dated 11/04/2022 00:37 (12:37 a.m.) for R18 documented in part, "...The change in condition, symptoms or signs I am calling about is/are: Food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts), seems different than usual, tired, weak, confused or drowsy. This started on: 11/03/2022. Night...Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse)...Date and time of clinician notification: 11/03/2022 20:00 (8:00 p.m.) Recommendation of Primary Clinician(s): the resident to be sent out...Name of family/resident representative notified: [Name of responsible party] Date and time of family/resident representative notification: 11/03/2022 09:44 (9:44 a.m.)."

On 1/5/2023 at 11:44 a.m., an interview was conducted with LPN (licensed practical nurse) #5, unit manager. LPN #5 stated that the responsible party was notified of a resident going out to the hospital prior to them going out of the building. LPN #5 stated that the process was to call the physician, the responsible party and then 911 or the non-emergency number. LPN #5 stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4	F 580		

in an emergent situation they would call the responsible party as soon as the resident left the building by emergency services.

On 1/5/2023 at 2:32 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated that they were working as supervisor on 11/3/2022. RN #3 stated that R18 had already been sent to the emergency room when they arrived for their shift that night. RN #3 stated that they had a message to call R18's responsible party when they arrived at work that night. RN #3 stated that they spoke to R18's responsible party at length that night and they were upset about several issues. RN #3 stated that R18's responsible party was upset because they had not been notified by the facility that the resident was being sent to the emergency room. RN #3 stated that they had apologized to the responsible party to the best of their ability and followed up with the nurse. RN #3 stated that some of the transfer steps had been skipped and they had reviewed the process with the nurse as well as followed up with the emergency room to give a verbal report.

On 1/5/2023 at 3:31 p.m., an interview was conducted with LPN #2. LPN #2 stated that when they send a resident to the hospital they notified the responsible party prior to them leaving the facility because they would want to know what was going on with their family member. LPN #2 stated in an emergency transfer additional staff responded to assist and there was someone available to contact the responsible party prior to the resident leaving the building.

The facility policy, "Change in a residents condition", documented in part, "The facility will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 promptly notify the resident, his or her physician/practitioner, and the representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.)...Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: ...e. It is necessary to transfer the resident to a hospital/treatment center..." On 1/6/2023 at 10:17 a.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concern. No further information was obtained prior to exit. Complaint deficiency.	F 580		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered;	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 6 (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 7 section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility staff failed to evidence that all required documentation was provided to the receiving facility upon a hospital transfer for one of 44 residents in the survey sample; Resident #25. The findings include: For Resident #25, the facility staff failed to	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 8 evidence what documentation, if any, was sent to the hospital when the resident was transferred on 10/8/22. A review of the clinical record revealed the following: Nurse's note dated 10/8/22 had documented, "called hospital to get an update patient has a fracture and is being admitted." Nurse's note dated 10/9/22 had documented, "patient found on floor @7:20pm (at 7:20 PM), vital signs taken assessed, MD (medical doctor) and [family member] SENT TO HOSPITAL." There were no notes indicating what, if any, of the required documentation was provided to the hospital. A review of the facility's transfer packet was conducted. This packet consisted of a manila envelope with a "Check List for E.R. (Emergency Room) Transfer" form attached to the front for the facility staff to complete and put the required transfer documents in the envelope for the ambulance and hospital staff. The envelope was pre-filled with a Bed Hold notice and a Notice of Discharge or Transfer form for the resident's representative. The checklist attached to the front of the envelope included the following items: Discharge record, Notice of Discharge or Transfer, MD order, Nurses note, Most recent labs, Isolation status, MAR and TAR (Medication and Treatment Administration Records), Care Plan, Change in condition form, Bed Hold policy. Next to each above item listed was a box for the facility staff to initial next to each item that they provided in the	F 622	F622: Failure to evidence that all required documentation was provided to the receiving facility upon a hospital transfer. 1. Resident # 25 has already returned to the facility and therefore no corrective action can be taken with the resident at this time. It is the policy of Lynn Care Center to ensure that facility sends all required documentation to the hospital with the resident. 2. All residents have the potential to be affected by the alleged deficient practice. Residents that transferred to the emergency room or admitted to the hospital in the last 30 days and remain outside of this facility have been reviewed by DON to ensure that all required documentation was sent with the resident. Any Variances have been corrected. 3. DON/Designee will educate all license nurses on proper protocol for sending documentation to the hospital for all acute care transfers. The education will include documenting in the medical record that all documents were sent with resident. 4. DON/Designee will review all transfer/discharges for 12 weeks to ensure that all hospital transfer documentation was sent to the hospital with the resident. Any issues identified will be addressed immediately by DON/Designee and appropriate actions will be taken. The DON/Designee will identify any trends or patterns and educate as needed. All findings will be discussed with QAPI committee monthly x 3 months for review and recommendations. 5. Date of compliance: 2/20/2023	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 9 envelope. For Resident #25's hospital transfer of 10/8/22, the facility was unable to locate any evidence that this packet was completed, that the checklist was completed, or that any of the documents listed was provided to the hospital. On 1/5/23 at 3:34 PM an interview was conducted with LPN #5 (Licensed Practical Nurse) the unit manager. She stated that when a resident is sent to the hospital, the facility sends the facesheet, MAR (Medication Administration Record), care plan, bed hold, and transfer form. She stated that what was sent should be documented in the progress notes and the facility is supposed to keep a copy of the checklist to be scanned into the electronic health record. She was not able to locate a copy of this form for Resident #25's 10/8/22 hospital transfer. On 1/5/23 at approximately 5:00 PM, ASM #1 and ASM #2 (Administrative Staff Members) the Administrator and Director of Nursing, respectively, were made aware of the findings. ASM #2 stated that the facility did not have evidence that the checklist was completed. A hospital transfer policy was requested, however none was provided.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 10	F 623		

language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 11 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 12 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility staff failed to evidence that a written notice of a hospital transfer was provided to the resident's representative upon a hospital transfer for one of 44 residents in the survey sample; Resident #25. The findings include: For Resident #25, the facility staff failed to evidence that written notification of a hospital transfer was provided to the resident's representative when the resident was transferred to the hospital on 10/8/22. The most recent MDS (Minimum Data Set) a quarterly assessment with an ARD (Assessment Reference Date) of 10/20/22 coded the resident as being severely cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed the following: A nurse's note dated 10/9/22 that documented, "patient found on floor @7:20pm (at 7:20 PM), vital signs taken assessed, MD (medical doctor) and [family member] SENT TO HOSPITAL."	F 623	F623: Failure of Notice requirement before transfer, discharge. 1. Resident #25 returned from the hospital and therefore no corrective action can be taken with the resident at this time. It is the policy of Lynn Care Center to ensure that notice requirements before transfer are met. 2. All residents have the potential to be affected by the alleged deficient practice. Residents that transferred to the emergency room or admitted to the hospital in the last 30 days and remain outside of this facility have been reviewed by DON to ensure that evidence of written notification of transfer was provided to the responsible party. Any Variances have been corrected. 3. DON/Designee will educate social workers on proper protocol for notifying the responsible party in writing of all hospital discharge/transfers. 4. DON/Designee will review all transfers/discharges to the hospital for 12 weeks to ensure that the RP was notified in writing of the transfer. Any issues identified will be addressed immediately by DON/Designee and appropriate actions will be taken. The DON/Designee will identify any trends or patterns and educate as needed. All findings will be discussed with QAPI committee monthly x 3 months for review and recommendations. 5. Date of Compliance: 2/20/2023	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 13	F 623		

A physician progress note dated 10/18/22 that documented, "....Fell and suffered right femur fracture and was admitted 10/10/22 to hosp (hospital).

There were no notes indicating that a written notice was provided to the resident's representative.

A review of the facility's transfer packet was conducted. This packet consisted of a manila envelope with a "Check List for E.R. (Emergency Room) Transfer" form attached to the front for the facility staff to complete, and put the required transfer documents in the envelope for the ambulance and hospital staff. The envelope was pre-filled with a Bed Hold notice and a Notice of Discharge or Transfer form (the required written notice to the resident representative.)

The checklist attached to the front of the envelope included the following items: Discharge record, Notice of Discharge or Transfer, MD order, Nurses note, Most recent labs, Isolation status, MAR and TAR (Medication and Treatment Administration Records), Care Plan, Change in condition form, Bed Hold policy. Next to each above item listed was a box for the facility staff to initial next to each item that they provided in the envelope.

For Resident #25's hospital transfer of 10/8/22, the facility was unable to locate any evidence that this packet was completed, that the checklist was completed, and that the Notice of Discharge or Transfer that is included in the packet was provided to the resident's representative.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 14 On 1/5/23 at 3:34 PM an interview was conducted with LPN #5 (Licensed Practical Nurse) the unit manager. She stated that she is not aware of nursing ever providing written notices of hospital transfers to resident representatives. On 1/5/23 at approximately 5:00 PM, ASM #1 and ASM #2 (Administrative Staff Members) the Administrator and Director of Nursing, respectively, were made aware of the findings. A policy regarding hospital transfers was requested however none was provided.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to complete a significant change Minimum Data Set (MDS) assessment for one of 44 residents in the survey sample; Resident #25. The findings include:	F 637	F637: Comprehensive Assessment after significant change 1. At time of findings, resident #25 had returned to baseline and it was not within the 14-day timeframe to complete a significant change assessment. 2. All residents experiencing a significant change per RAI criteria have a potential to be affected. DON/Designee will review all residents in the last 14 days to ensure significant change assessment were completed for all appropriate residents on 1/23/2023. 3. Regional revenue integrity specialize/Designee will provide education to MDS coordinators on the requirements related to the completion of significant change MDS within RAI timeframes. 4. MDS/Designee will audit 24/hour report during clinical meeting 5x a week for 4 weeks then weekly for 8 weeks to ensure significant change MDS assessments were completed for all residents meeting RAI requirements. Any issues identified will be addressed immediately by MDS coordinator/Designee and appropriate actions will be taken. The MDS/Designee will identify any trends or patterns and educate as needed. All findings will be discussed with QAPI committee monthly x 3 months for review and recommendations. 5. Date of Compliance: 02/20/2023	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 15 For Resident #25 the facility staff failed to complete a significant change MDS after a hip fracture that resulted in significant decline in functioning. Resident #25 was most recently readmitted to the facility on 10/17/22 following a fall with a fracture that resulted in hospitalization. The most recent MDS (Minimum Data Set) a quarterly assessment with an ARD (Assessment Reference Date) of 10/20/22 coded the resident as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as not ambulating; as having lower limb limitations; as requiring the use of a wheelchair; as requiring extensive assistance for mobility, transfers, toileting; limited assistance for dressing, hygiene, and bathing; supervision for eating. A review of the clinical record revealed the following: A physician progress note dated 10/18/22 that documented, "....Fell and suffered right femur fracture and was admitted 10/10/22 to hosp (hospital). [Resident] had ORIF (1) on 10/13/22. Followed by [name of] ortho (orthopedics). [Resident] also was in complete heart block and underwent pacemaker placement on 10/11/22...." A review of the MDS completed prior to the above fracture was a quarterly assessment dated 8/12/22 and coded the resident as being ambulatory; not having any lower limb limitations; not requiring any assistive devices for ambulation/mobility; as being independent for mobility, transfers, ambulation; supervision only for dressing, eating, toileting, and hygiene; and	F 637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 16	F 637		

extensive assistance for bathing. The review of this MDS revealed the resident was in significantly better functional condition than the post-fracture MDS assessment.

On 1/5/23 at 9:50 AM an interview was conducted with RN (Registered Nurse) #1, the MDS coordinator and Licensed Practical Nurse (LPN) #6, MDS nurse. RN #1 stated that when completing the MDS, the facility follows the RAI manual (Resident Assessment Instrument). When asked what she considers a significant change, and if someone had a fracture due to a fall, would that be a significant change, she stated, "It would be if they did not return to baseline in 14 days." When the decline in Resident #25's functional status was reviewed by comparing the two above MDS's, she stated that it, "Sounds like in that situation it should have been a significant change."

On 1/5/23 at 11:39 AM, RN #1 and LPN #6 followed up and stated that after looking at the documentation. They stated that it was an oversight and that a significant change MDS should have been done for Resident #25.

A review of the RAI manual, Version 1.17.1, dated October 2019, documented the following:

Page 2-22: A "significant change" is a major decline or improvement in a resident's status that:
1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 17 revision of the care plan. Page 2-24 - 2-26: Some Guidelines to Assist in Deciding If a Change Is Significant or Not:.... Decline in two or more of the following:....Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individual's functioning...Examples....[A resident] required minimal assistance with ADLs. [The resident] fractured [their]hip and upon return to the facility requires extensive assistance with all ADLs..." On 1/5/23 at approximately 5:00 PM, ASM #1 and ASM #2 (Administrative Staff Members) the Administrator and Director of Nursing, respectively, were made aware of the findings. No further information was provided. References: 1. ORIF - Open Reduction Internal Fixation: is a surgery to fix severely broken bones. It's only used for serious fractures that cannot be treated with a cast or splint. Information obtained from https://www.healthline.com/health/orif-surgery	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 18 by: Based on observation, clinical record review, staff interview and facility document review, it was determined that the facility staff failed to accurately code the MDS (minimum data set) for two of 44 residents in the survey sample, Residents #15 (R15) and #79 (R79). The findings include: 1. For (R15), the facility staff failed to code the quarterly MDS (minimum data set) for the use of oxygen. Resident #15 was admitted to the facility with diagnoses that included but were not limited to: respiratory failure (1). On the most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 10/19/2022, the (R15) scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" failed to code (R15) for "Oxygen Therapy." On 01/04/2023 at approximately 8:44 a.m., (R15) was observed sitting in their room in a wheelchair receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between four and four-and-a-half liters per minute. The physician's order for (R15) dated 04/11/2022 documented, "Oxygen at 4 (four) liters per minute) via (by) NC (nasal cannula) verify O2 (oxygen) setting at eye level."	F 641	F641: Accuracy of Assessments 1. On 01/05/2023, MDS coordinator completed a modification for resident #15 to accurately code oxygen on the quarterly MDS assessment. On 1/12/23, a BIMs was completed for resident #79. 2. All residents have the potential to be affected. An audit of all current residents most re/cent MDS assessment was completed to ensure that a BIMs has been completed and entered for all residents. An audit of all residents who receive oxygen has been conducted to ensure that most recent MDS assessment has been accurately coded to include the use of oxygen. All variances have been corrected. 3. Regional MDS coordinator/Designee will re-educate MDS coordinators and social services on the proper protocol for accurately coding the use of oxygen on the MDS assessment and the proper protocol for completing a BIMs assessment. 4. MDS/Designee will audit 5 MDS assessments weekly x 12 weeks to ensure that oxygen has been accurately coded on the MDS assessment. Social services/designee will audit 5 MDS assessments weekly x 12 weeks to ensure that a BIMs assessment has been completed per RAI criteria. Any issues identified will be addressed immediately by the MDS coordinator/designee and appropriate actions will be taken. The MDS/Designee will identify any trends or patterns and educate as needed. All findings will be discussed with QAPI committee monthly x 3 months for review and recommendations. 5. Date of Compliance: 02/20/2023	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 19 On 01/05/23 at approximately 9:49 a.m., an interview was conducted with RN (registered nurse) #1, MDS coordinator regarding the coding for (R15's) oxygen use on the quarterly MDS assessment with the ARD of 10/19/2022. RN #1 stated that the assessment did not code (R15) for the use of oxygen and that it was an oversight. When asked to describe the procedure for completing the MDS RN #1 stated that they follow the RAI (resident assessment instrument) manual. On 01/05/2023 at approximately 4:40 p.m., ASM (administrative staff member) #1, administrator ASM #2, director of nursing, ASM #5, regional nurse consultant and ASM #6, maintenance director, were made aware of the above findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 2. For Resident #79 (R79), the facility staff failed to complete section C - Cognitive patterns on the MDS (minimum data set) assessment. On the most recent MDS assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/12/2022, R79 was coded in Section B - Hearing, Speech and Vision as understanding others and being understood. In Section C - Cognitive Patterns, the resident interview was not completed. On the quarterly assessment, with an ARD of	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 20	F 641		

8/16/2022, R79 was coded in Section B - Hearing, Speech and Vision as understanding others and being understood. In Section C - Cognitive Patterns, the resident interview was not completed. It was coded "Should brief interview for mental status be conducted?" A "No, resident is rarely/never understood."

On 1/4/2023 at 4:20 p.m., an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 stated that staff used the RAI (resident assessment instrument) manual as the guide when completing the MDS assessments. RN #1 stated that section B and C were completed by the social worker. RN #1 reviewed R79's MDS with the ARD of 10/12/2022 and stated that the cognitive assessment was not completed and they did not know why.

On 1/4/2023 at 4:24 p.m., an interview was conducted with OSM (other staff member) #3, social worker. OSM #3 stated that they completed Section B and C of the MDS assessments. OSM #3 stated that the cognitive assessment was completed on every resident unless it was determined that they were not understood. OSM #3 stated that they would review R79's MDS with the ARD of 10/12/2022.

On 1/4/2023 at 5:16 p.m., OSM #3 stated that they had reviewed R79's MDS with the ARD of 10/12/2022 and the cognitive status was not completed. OSM #3 stated that the assessment was missed.

On 1/5/2023 at 4:45 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the regional nurse consultant and ASM #6, the regional maintenance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 21 director were made aware of the concern. No further information was obtained prior to exit.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 22	F 655		

of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review, and clinical record, the facility staff failed to complete a baseline care plan for two of 44 residents in the survey sample, Residents #337 and #237.

The findings include:

1. For Resident #337 (R337), the facility staff failed to include the resident's non-weightbearing status on the baseline care plan.

R337 was admitted 12/28/22 with diagnoses of bilateral foot infections and bilateral toe amputations. R337 did not have a complete MDS (minimum data set) at the time of the survey. A review of the admission assessment dated 12/28/22 revealed the resident had no cognitive deficits, and required assistance with activities of daily living.

On 1/4/23 at 8:18 a.m., R337 was sitting up on the side of the bed. Both feet were wrapped completely in white gauze bandages. R337 stated they had been admitted to the facility after having surgery to amputate toes on both feet because of an infection in the bones of both feet. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 23 resident stated they could not transfer from bed to chair without a mechanical lift, and were not allowed to put any weight on either foot. A review of R337's baseline care plan dated 12/28/22 failed to reveal any information/instructions regarding R337's post-surgical status or transfer status. On 1/5/23 at 10:14 a.m., CNA (certified nursing assistant) #3 was interviewed. She stated if R337 needs toileting, the resident uses a bedpan. She stated the resident is non-weightbearing. She stated the resident has told her that the resident believes they can walk, despite the bandages on both feet. When asked how she knows about the resident's weightbearing status, she stated: "It's something somebody told me; I think it was a nurse." When asked if she has access to a resident's baseline care plan, she stated she did not think so. On 1/5/23 at 11:36 a.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. She stated when a resident is admitted, the transfer and weightbearing status is communicated from the hospital. She stated the weightbearing status should be a part of the baseline care plan, adding, "It's how we know how to take care of the resident." On 1/5/23 at 4:40 p.m., ASM (administrative staff member) #1, ASM #2, ASM #5, regional nurse consultant, and ASM #6, the regional maintenance director, were informed of these concerns. On 1/6/23 at 9:57 a.m., ASM (administrative staff member) #2 was interviewed. She stated a	F 655	F655: Baseline Care Plan 1. Resident #337 has a comprehensive care plan and it was updated on 1/19/2023 to include residents transfer status/ weight bearing status. Resident #237 has a comprehensive care plan in place and was updated to addresses dialysis care and treatment on 1/04/23. 2. All residents have the potential to be affected. Unit managers conducted an audit of all resident care plans to ensure that baseline care plans were completed timely. All variances have been corrected. 3. DON/Designee has educated all licensed nurses on the policy for entering baseline care plans within 48 hours of admission. The education includes updating current transfer status and dialysis care and treatment for all resident that receive dialysis. 4. DON/Designee will review all new admission for 12 weeks to ensure that a baseline care plan has been completed and include transfer status and dialysis care and treatment. DON/Designee will identify any trends and or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly x 3 months for review and recommedations. 5. Date of Compliance: 02/20/2023	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 24	F 655		

resident's baseline care plan should be completed within 24 hours of admission and should include a resident's non-weightbearing status.

A review of the facility policy, "Baseline Care Plans," revealed, in part: "A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight hours of admission...The Interdisciplinary Team will review the healthcare practitioner's orders and implement a baseline care plan to meet the resident's immediate care needs."

No further information was provided prior to exit.
2. For (R237) the facility staff failed to develop a baseline care plan to address dialysis (1) care and treatment.

(R237) was admitted to the facility with a diagnosis that included but not limited to: end stage renal failure (2).

The most recent MDS (minimum data set), an admission assessment was not due at the time of the survey.

The facility's admission assessment for (R237) dated 12/27/2022, documented that (R237) was oriented to person, place, time and situation.

On 01/04/2023 at approximately 10:00 a.m. a review of the physician's order sheet for (R237) failed to evidence an order for dialysis.

On 01/04/2023 at approximately 10:15 a.m. a review of (R237's) baseline care plan failed to evidence documentation for dialysis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 25	F 655		

On 01/04/2023 at approximately 10:24 a.m., an interview was conducted with (R237) regarding the last time they received dialysis services, (R237) stated that they went to dialysis on Monday 01/02/2023.

On 01/04/2023 at approximately 4:08 p.m. an interview was conducted with LPN (licensed practical nurse) #4. When asked about the missing documentation concerning (R237's) dialysis on the baseline care plan LPN # 4 stated that it was updated today and that it should have been updated sooner.

On 01/06/2023 at approximately 9:57 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. When asked who was responsible for completing a resident's baseline care plan and when it should be completed ASM # 2 stated that the baseline care plan is completed by the admitting nurse and should be completed within 24 hours of the resident's admission to the facility.

The facility's policy "Baseline Care Plans" documented in part, "SPECIFIC PROCEDURES / GUIDANCE: 1. To assure the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission."

On 01/04/2023 at approximately 4:36 p.m., ASM #1, administrator ASM #2, director of nursing, ASM #4, regional director of operations and ASM #5, regional nurse consultant, were made aware of the above findings.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 26 References: (1) It removes waste from your blood when your kidneys can no longer do their job. This information was obtained from the website: Dialysis - hemodialysis: MedlinePlus Medical Encyclopedia. (2) The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 27	F 656		

recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to implement the care plan for two of 44 residents in the survey sample, Resident #32 and Resident #15.

The findings include:

1. For Resident #32, the facility staff failed to implement the comprehensive care plan for two-person transfer.

Resident #32 was admitted to the facility on 4/13/2017 with diagnosis that included but not limited to: osteoporosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 28 The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/26/22, coded the resident as scoring a 08 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance of two persons for transfers. A review of the comprehensive care plan dated 2/15/22 revealed, "FOCUS: The resident has a potential for further falls due to history of falls, impaired mobility, cognitive deficits, poor balance, unsteady gait, generalized weakness, incontinence, visual deficits, and multiple chronic health conditions & medication use. INTERVENTIONS: Utilize 2-person transfer. If resident feels/appears weaker then may utilize Hoyer (1) lift." A review of the nursing progress note, dated 12/15/2022 at 9:11 PM, revealed, "Resident was being transferred to bed with mechanical lift by CNA's when she fell, when asked how she fell resident stated her arm was hurting and she couldn't hold on anymore, neuro checks and vitals taken by nurse, swelling noted on back of residents head, on call notified and resident sent out, RP (responsible party) and MD (medical doctor) aware." A review of the nursing progress note, dated 12/16/22 at 3:38 AM, revealed, "Resident returned from hospital at 01:40 on 12/16/22, report from hospital given by nurse stated resident had an CT (computerized tomography)	F 656	F656: Develop/Implement Comprehensive Care plan 1. CNA responsible for transferring resident # 32 on 12/15/2022 was immediately suspended pending investigation and terminated upon completion of investigation. On 1/4/2023, Unit managers immediately upon notification adjusted resident #15 oxygen to comply with care plan and physician order. 2. The DON/Designee has reviewed all current care plans to determine residents transfer status and oxygen requirements. The DON/Designee has observed all residents that are care planned for a two-person transfer to ensure that the care plan is being implemented and staff are utilizing a two-person transfer. DON/Designee has audited/observed all residents that require the use of oxygen to ensure that the nursing staff have implemented the care plan and the correct liters of oxygen are being maintained. 3. DON/Designee will educate all license staff on implementing the residents care plan when providing care to the residents. The education will include where to locate individualize care plan interventions, the requirement to utilize a two person transfer for all hoyer lift transfers and ensuring that the residents oxygen tank is set on the correct liter per the care plan. 4. DON/Designee will conduct 5 random Hoyer lift transfer observations a week x 4 weeks and then 2 a week x 8 weeks to ensure the staff members are implementing interventions that are documented in the care plans. DON/Designee will observe 2 residents a week x 12 weeks to ensure that the resident is receiving the correct liters of oxygen. The DON/Designee will identify any trends and or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly x 3 months for review and recommendations. 5. Date of Compliance: 02/20/2023	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 29	F 656		

scan to head, cervical spine, and arms, resident was found by CT scan to have broken right elbow. Resident is now sleeping in bed will continue to monitor."

A review of the facility investigation dated 12/20/22, revealed a statement from Resident #32 dated 12/16/22, "When asked what she thought happened during the transfer in the Hoyer lift, she stated, "I was not secure. I wiggled my body and fell out." A statement dated 12/17/22, from CNA #11, "Resident was my resident. She was ready for bed. I was told she was a Hoyer lift. I attempted to ask for help. Nobody was available. I grabbed the Hoyer lift. I put the Hoyer pad around her. She mentioned her right arm hurting prior from the lift. I double checked with her and she told me she hit something. I proceeded to tell her I was going to lift her up and put her I bed. She was okay with that. I begin to lift her up slowly. She said my arm and pulled her arm out. She hit her headfirst and upper back. She never hit her arm upon the fall." A statement dated 12/17/22, from CNA #12 revealed, "On Thursday 12/15/22. I was putting a resident to bed when I saw out of the corner of my eye, Resident #32 fall out of the sling. I hurried over to where the CNA was and mad sure there was no blood and asked the resident if she was okay. She said she was okay but her head and arm hurt. I went back to my resident and finished getting her to bed. The nurse and CNA were getting vitals on Resident #32. All seemed normal. The CNA and I lifted Resident #32 back into bed. I went back to check on her and to get her changed. She was coherent, just in pain."

An interview was conducted on 1/4/23 at 7:30 AM with CNA (certified nursing assistant) #1. When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 30	F 656		

asked what assistance Resident #32 requires when transferring from the bed to the recliner chair or wheelchair, CNA #1 stated, she needs a two person assist. When asked if a Hoyer lift is used, what assistance is required, CNA #1 stated, a resident using a Hoyer lift is always a two person assist.

An interview was conducted on 1/4/23 at 11:00 AM with LPN (licensed practical nurse) #1. When asked the purpose of the care plan, LPN #1 stated, the purpose is to provide a guide of the care the resident needs. When asked if the care plan is followed when it specifies a two person assist and only a one-person assist is used, LPN #1 stated, no, the care plan is not followed.

An interview was conducted on 1/4/23 at 1:00 PM with Resident #32. When asked to describe the events of the fall and injury to her right elbow, Resident #32 stated, the aide was moving me from the recliner back to bed and there was only one aide. Usually there are two aides. I slipped out of the sling and hit my head and arm. I went to the hospital and they put a sling on my arm. It feels much better now.

On 1/5/23 at approximately 4:45 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, regional vice president of operations and ASM #5, the regional nurse consultant was made aware of the findings.

A review of the facilities "Care Planning-Comprehensive Person-Centered" policy with no date, "Each resident's comprehensive care plan will describe the following: Services that are to be furnished to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 31 attain or maintain the resident's highest practicable physical, mental and psychosocial well-being." No further information was provided prior to exit. Reference obtained from https://www.fda.gov/medical-devices/general-hospital-devices-and-supplies/patient-lifts: (1) Patient lifts are designed to lift and transfer patients from one place to another (e.g., from bed to bath, chair to stretcher). These should not be confused with stairway chair lifts or elevators. Patient lifts may be operated using a power source or manually. The powered models generally require the use of a rechargeable battery and the manual models are operated using hydraulics. While the design of patient lifts will vary based on the manufacturer, basic components may include a mast (the vertical bar that fits into the base), a boom (a bar that extends over the patient), a spreader bar (which hangs from the boom), a sling (attached to the spreader bar, designed to hold the patient), and a number of clips or latches (which secure the sling). These medical devices provide many benefits, including reduced risk of injury to patients and caregivers when properly used. However, improper use of patient lifts can pose significant public health risks. Patient falls from these devices have resulted in severe patient injuries including head traumas, fractures, and deaths 2. For (R15), the facility staff failed to implement (R15's) comprehensive care plan for the administration of oxygen at four liters per minute.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 32	F 656		

Resident # 15 was admitted to the facility with diagnoses that included but were not limited to: respiratory failure (1).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/19/2022, the (R15) scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" failed to code (R15) for "Oxygen Therapy."

On 01/04/2023 at approximately 8:44 a.m., (R15) was observed sitting in their room in a wheelchair receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between four and four-and-a-half liters per minute.

On 01/04/2023 at approximately 10:19 a.m., (R15) was observed sitting in their room in a wheelchair receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between four and four-and-a-half liters per minute.

On 01/04/2023 approximately 2:45 p.m., (R15) was observed sitting in their room in a wheelchair receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between four and four-and-a-half liters per minute.

The physician's order for (R15) dated 04/11/2022 documented, "Oxygen at 4 (four) liters per minute) via (by) NC (nasal cannula) verify O2 (oxygen) setting at eye level."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 33 Review of the (R15's) comprehensive care plan dated 12/09/2022 documented in part, "The resident has altered respiratory status/difficulty breathing... Date Initiated: 12/09/2022." Under "Interventions" it documented in part, "Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Date Initiated: 12/09/2022." On 01/04/2023 at approximately 4:08 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked to describe the purpose of a care plan LPN #4 stated that it tell them how to take care of the resident. After informed of the above observations and review of (R15's) comprehensive care plan, LPN #4 was asked if the care plan was being followed for the administration of (R15's) oxygen. LPN #4 stated that the care plan was not implemented. On 01/04/2023 at approximately 4:36 p.m., ASM (administrative staff member) #1, administrator ASM #2, director of nursing, ASM #4, regional director of operations and ASM #5, regional `nurse consultant, were made aware of the above findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 34 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to review and revise the care plan for one of 44 residents in the survey sample, Resident #18 (R18). The findings include:	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 35 For R18, the facility staff failed to review and revised the comprehensive care plan after a pressure injury developed on the right heel. On the most recent MDS (minimum data set) assessment, a five-day assessment with an ARD (assessment reference date) of 11/18/2022, the resident scored a six out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section M documented R18 at risk of developing pressure injuries and not having any pressure injuries at the time of the assessment. Review of the facility wounds at the time of the survey documented R18 having a Stage 1 pressure injury (1) to the right heel identified on 12/7/2022. The comprehensive care plan for R18 dated 4/27/2022 documented in part, "[R18] has a S.T (skin tear) (L) forearm and hand and is at risk for further impairment to skin integrity r/t (related to) incontinence, cognitive deficits, impaired mobility, history of squamous cell carcinoma, polypharmacy, and other chronic conditions. She has a suspected cancerous lesion to her perineum (which family has declined to treat). Skin breakdown may be unavoidable r/t terminal prognosis. Date Initiated: 04/27/2022. Revision on: 10/26/2022." The comprehensive care plan failed to evidence a review or revision documenting the right heel pressure injury first observed on 12/7/2022. Review of the physician orders for R18 documented in part, "Skin prep right heel daily every shift. Order Date: 01/03/2023."	F 657	F657 Care Plan Timing and Revision 1. Resident # 18 is no longer residing at the facility therefore corrections could not be completed. 2. All residents with pressure injuries have the potential to be affected. DON/Designee will conduct an audit of all current residents with pressure injuries to ensure that the care plan has been updated/revised with current pressure injury status. A process has been developed and implemented to identify residents with new or changed pressure injuries during daily clinical meetings and update/revise the care plans to reflect the current wound status. 3. DON/Designee will educate all licensed nurses and interdisciplinary team members on the care plan process. The DON/Designee has educated the nursing leadership team and treatment nurse of the care plan process and updating care plans to reflect residents' current needs. 4. DON/Designee will conduct an audit of 10 resident care plans a week for 4 weeks and then 5 a week x 8 week to ensure that care plans have been revised to reflect the current pressure injury status. The DON/Designee will identify any trends and/or patterns and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee monthly x 3 months for review and recommendations. 5. Date of Compliance: 02/20/2023	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 36	F 657		

The wound notes for R18 documented in part,
- "12/07/2022 ...Wound #2 Right Heel is a Deep Tissue Pressure Injury...0.5cm (centimeter) length x 0.5cm width with no measurable depth, with an area of 0.25 sq cm (square centimeters)...Wound dressing Apply: Skin prep..."
- "12/14/2022 ...Wound #2 Right Heel is a Stage 1 Pressure Ulcer...0.7cm length x 0.79 cm width with no measurable depth, with an area of 0.553 sq cm...The wound is improving...Wound dressing Apply: Skin prep..."
- "12/28/2022 ...Wound #2 Right Heel is a Stage 1 Pressure Injury...0.7cm length x 0.79 cm width with no measurable depth, with an area of 0.553 sq cm...There is no change noted in the wound progression...Wound dressing Apply: Skin prep..."
- "1/3/2023 ...Wound #2 Right Heel is a Stage 1 Pressure Injury ...0.51cm length x 0.43cm width with no measurable depth, with an area of 0.219 sq cm...There is no change noted in the wound progression...Wound dressing Apply: Skin prep..."

On 1/6/2023 at 9:01 a.m., an interview was conducted with LPN (licensed practical nurse) #5, unit manager. LPN #5 stated that the comprehensive care plan was updated when there were new treatments and orders affecting the residents. LPN #5 stated that the nurses or the unit manager were responsible for updating the care plans. LPN #5 stated that they had multiple agency staff nurses who did not update the care plans so the responsibility was on the unit manager at the current time. LPN #5 stated that any new wounds were documented, the physician and the responsible party were notified, orders were obtained and the care plan was updated at that time. LPN #5 reviewed R18's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 37	F 657		

care plan and stated that the right heel wound was not addressed on the care plan and that it should have been updated when the wound was observed. LPN #5 stated that the purpose of the care plan was to show staff how to care for the resident.

On 1/6/2023 at 9:40 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that the nurses and unit managers were responsible for updating the care plans. ASM #2 stated that the wound nurse practitioner came in weekly and rounded with the unit manager. ASM #2 stated that the wound nurse practitioner sent their progress notes to them and they were currently responsible for overseeing the notes and entering new orders and updating the wound log. ASM #2 stated that the nurses were responsible for conducting weekly skin assessments and completing the treatments as ordered by the nurse practitioner and documenting them on the treatment administration record.

The facility policy, "Care Plans, Comprehensive Person-Centered," documented in part, "16. The care planning/Interdisciplinary Team is responsible for the review and updating of care plans: ...b. when there has been a significant change in the resident's condition..."

On 1/6/2023 at 10:17 a.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concern.

No further information was obtained prior to exit.

Complaint deficiency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 38 (1) Stage I pressure injury A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst.Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document interview, and clinical	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 39 record review, it was determined that the facility staff failed to obtain a physician's order for a newly-admitted resident's method of transfer from bed to chair for one of 44 residents in the survey sample, Resident #337. The findings include: For Resident #337 (R337), a new admission, the facility staff failed to obtain a physician's order for the resident's non-weightbearing status. R337 was admitted 12/28/22 with diagnoses of bilateral foot infections and bilateral toe amputations. R337 did not have a complete MDS (minimum data set) at the time of the survey. A review of the admission assessment dated 12/28/22 revealed the resident had no cognitive deficits, and required assistance with activities of daily living. On 1/4/23 at 8:18 a.m., R337 was sitting up on the side of the bed. Both feet were wrapped completely in white gauze bandages. R337 stated they had been admitted to the facility after having surgery to amputate toes on both feet because of an infection in the bones of both feet. The resident stated they could not transfer from bed to chair without a mechanical lift, and were not allowed to put any weight on either foot. A review of R337's physician's orders from the time of admission failed to reveal evidence of any order regarding the resident's transfer or non-weightbearing status. A review of R337's baseline care plan dated 12/28/22 failed to reveal any information/instructions regarding R337's transfer or non-weightbearing status.	F 684	F684 Quality of Care 1. Resident # 337 was assessed by nursing and medical record was reviewed. Unit manager obtained a physician's orders for resident #337's weight-bearing status and entered it into the chart on 1/5/2023. 2. All residents have the potential to be affected. An audit of current resident with modified weightbearing status has been completed to ensure that a physician's order has been obtained and entered into the medical record. DON/Designee has met with the therapy director to ensure that all residents with modified weightbearing status have been identified and physicians' orders have been obtained. 3. DON/Designee has educated all licensed nurses on obtaining physicians orders for residents with modified weight bearing transfer status and entering them into the medical record. All licensed nurses were educated on providing care per MD orders. The education included the importance of obtaining an order for modified weight bearing status. 4. DON/Designee will audit all new admissions and residents with changes to their weight bearing status x 12 weeks to ensure physicians orders are obtained to reflect weight bearing status. The DON/Designee will identify any trends and or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly x 3 months for review and recommendations 5. Date of Compliance: 02/20/2023	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 40	F 684		

A review of R337's physical therapy evaluation dated 12/29/22 revealed, in part: "Patient is s/p (status/post) ...partial amputation of toes ...MD (medical doctor) orders for NWB (non-weightbearing) bilaterally."

On 1/5/23 at 10:14 a.m., CNA (certified nursing assistant) #3 was interviewed. She stated if R337 needs toileting, the resident uses a bedpan. She stated the resident is non-weightbearing. She stated the resident has told her that R337 believes they can walk, despite the bandages on both feet. When asked how she knows about the resident's weightbearing status, she stated: "It's something somebody told me; I think it was a nurse."

On 1/5/23 at 11:36 a.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. She stated when a resident is admitted, the transfer and weightbearing status is communicated from the hospital. She stated the electronic medical record has a template which includes a space for entry of information regarding a resident's transfer/weightbearing status. She stated the admitting nurse is responsible for telling CNAs about a resident's needs, and the admitting nurse should make sure a physician's order is entered if a resident is not allowed to bear weight on any extremity for any reason.

On 1/5/23 at 4:40 p.m., ASM (administrative staff member) #1, ASM #2, ASM #5, regional nurse consultant, and ASM #6, the regional maintenance director, were informed of these concerns.

On 1/6/23 at 9:57 a.m., ASM (administrative staff member) #2 was interviewed. She stated a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 41 resident's baseline care plan should be completed within 24 hours of admission and should include a resident's non-weightbearing status. A review of the facility policy, "Medication and Treatment Orders," failed to reveal any information related to obtaining a physician's order regarding weightbearing status for a newly admitted resident. No further information was provided prior to exit.	F 684		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide toenail care to one of 44 residents in the survey sample, Resident #17. The findings include: For Resident #17, the facility failed to provide toenail care which resulted in thick, curved,	F 687		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 42 overgrown toenails. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12-22-22, Resident #17 (R17) was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS (brief interview for mental status). R17 was coded as being dependent on staff for bathing and personal hygiene. On 1/4/23 at 8:12 a.m., R17 was sitting up in bed with eyes closed. R17's feet were visible at the end of the bed. Toenails on both feet were yellow, with both great toenails thick, longer than the end of the toe, and cracked. The skin around the great toenails was dry and scaly. The right great toenail was long and curved over the top of the resident's toe. The toenails on the other toes were all between approximately two and four centimeters over the edge of the toes. On 1/4/23 at 4:12 p.m., R17's toenails were observed to be in the same condition as at the morning observation. On 1/5/23 at 10:14 a.m., CNA (certified nursing assistant) #3 was interviewed. She stated she checks residents' toenails if she gives the resident a bed bath or assists with a shower. She stated, "Most of our residents have long toenails. I know I'm not allowed to cut them or anything." She stated she did not regularly report a resident's toenail condition to anyone. She stated she had "just gotten used to them being how they are." On 1/5/23 at 11:32 a.m., RN (registered nurse) #2 looked at R17's toenails. When asked to describe	F 687	F687 Foot Care 1. Unit manger assessed resident #17 and reviewed medical records. After assessing, unit manager provided toenail care to resident #17 and referral was made to podiatry. 2. All residents have the potential to be affected. An audit on all current resident toenail care will be conducted to ensure all nails are trimmed and maintained. 3. All licensed staff were educated on proper nail care and the process of podiatry referrals. 4. DON/Designee will audit 10 residents weekly for 4 weeks and then 5 residents weekly x 8 weeks to ensure all nails are maintained and podiatry referrals are implemented. The DON/Designee will identify any trends and or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly x3 for review and recommendations. 5. Date of Compliance:02/20/2023	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 43	F 687		

them, she stated: "They need to be cut. Really bad." When asked who is responsible for toenail care, she stated the facility has a list of residents to be seen by the podiatrist. She stated she would add R17 to the podiatrist's list for the next visit.

On 1/5/23 at 11:36 a.m., LPN (licensed practical nurse) #5, the unit manager, was interviewed. She stated toenail care was ordinarily provided by the podiatrist.

On 1/5/23 at 4:40 p.m., ASM (administrative staff member) #1, ASM #2, ASM #5, regional nurse consultant, and ASM #6, the regional maintenance director, were informed of these concerns.

On 1/6/23 at 9:57 a.m., ASM #2, the director of nursing, was interviewed. She stated facility staff should observe residents' toenails during bathing and skin assessments. She stated if a CNA identifies a concern, the nurse should be notified, and the nurse should put the resident on the list to be seen by the podiatrist. She stated the facility currently has a podiatrist who comes regularly to the facility to see residents.

A review of the facility policy, "Fingernails/Toenails," revealed, in part: "Routine nail care may be performed by nursing staff and/or qualified activity team members...Nail care includes daily cleaning and regular trimming...Proper nail care can aid in the prevention of skin problems around the nail bed...Referrals may be made as ordered by the physician/practitioner for podiatry care...Trimmed and smooth nail beds prevent the resident from accidentally scratching and injuring his or her skin...Report to the nurse supervisor if...nails are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 44 too thick to cut with ease." No further information was provided prior to exit.	F 687		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide adequate supervision and monitoring during a transfer resulting in a fall and fracture which constitutes harm, for one of 44 residents in the survey sample; Resident #32. This was cited as past non-compliance. The findings include: The facility staff failed to provide adequate supervision and monitoring when transferring Resident #32 from the chair to the bed using a Hoyer (1) (mechanical) lift, resulting in a fall and fracture of the right elbow on 12/15/22. Resident #32 was admitted to the facility on 4/13/2017 with diagnosis that included but not limited to: osteoporosis. The most recent MDS (minimum data set)	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 45	F 689		

assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/26/22, coded the resident as scoring a 08 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance from two persons for transfers.

A review of the comprehensive care plan dated 2/15/22 revealed, "FOCUS: The resident has a potential for further falls due to history of falls, impaired mobility, cognitive deficits, poor balance, unsteady gait, generalized weakness, incontinence, visual deficits, and multiple chronic health conditions & medication use. INTERVENTIONS: Utilize 2-person transfer. If resident feels/appears weaker then may utilize Hoyer lift."

A review of the nursing progress note, dated 12/15/2022 at 9:11 PM, revealed, "Resident was being transferred to bed with mechanical lift by CNA's when she fell, when asked how she fell resident stated her arm was hurting and she couldn't hold on anymore, neuro checks and vitals taken by nurse, swelling noted on back of residents head, on call notified and resident sent out, RP (responsible party) and MD (medical doctor) aware."

A review of the nursing progress note, dated 12/16/22 at 3:38 AM, revealed, "Resident returned from hospital at 01:40 on 12/16/22, report from hospital given by nurse stated resident had an CT (computerized tomography) scan to head, cervical spine, and arms, resident was found by CT scan to have broken right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 46	F 689		

elbow. Resident is now sleeping in bed will continue to monitor."

A review of the facility investigation dated 12/20/22, revealed a statement from Resident #32 dated 12/16/22 which included: "When asked what she thought happened during the transfer in the Hoyer lift, she stated, "I was not secure. I wiggled my body and fell out." A statement dated 12/17/22, from CNA #11, "Resident was my resident. She was ready for bed. I was told she was a Hoyer lift. I attempted to ask for help. Nobody was available. I grabbed the Hoyer lift. I put the Hoyer pad around her. She mentioned her right arm hurting prior from the lift. I double checked with her and she told me she hit something. I proceeded to tell her I was going to lift her up and put her I bed. She was okay with that. I begin to lift her up slowly. She said my arm and pulled her arm out. She hit her headfirst and upper back. She never hit her arm upon the fall." A statement dated 12/17/22, from CNA #12 revealed, "On Thursday 12/15/22. I was putting a resident to bed when I saw out of the corner of my eye, Resident #32 fall out of the sling. I hurried over to where the CNA was and made sure there was no blood and asked the resident if she was okay. She said she was okay but her head and arm hurt. I went back to my resident and finished getting her to bed. The nurse and CNA were getting vitals on Resident #32. All seemed normal. The CNA and I lifted Resident #32 back into bed. I went back to check on her and to get her changed. She was coherent, just in pain."

An interview was conducted on 1/4/23 at 7:30 AM with CNA (certified nursing assistant) #1. When asked the number of staff used to transfer a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 47	F 689		

resident using a Hoyer lift, CNA #1 stated, "There are two CNAs to use a Hoyer lift." When asked what education is provided to staff who use a Hoyer lift, CNA #1 stated, "We have it in orientation and then there is a yearly competency."

An interview was conducted on 1/4/23 at 1:00 PM with Resident #32. When asked to describe the events of the fall and injury to her right elbow, Resident #32 stated, "The aide was moving me from the recliner back to bed and there was only one aide. Usually there are two aides. I slipped out of the sling and hit my head and arm. I went to the hospital and they put a sling on my arm. It feels much better now."

On 1/4/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, regional vice president of operations and ASM #5, the regional nurse consultant were asked to provide any action plans that had been developed from 9/5/22 to present.

On 1/5/23 at 10:00 AM, ASM #1 and ASM #2 provided the action plan for Resident #32's fall with injury. The action plan was dated 12/20/22. Education of staff was completed on 12/26/22 with audits beginning on 12/26/22.

The facility enacted a plan of correction which contained the following 5 points:
1. Root Cause Analysis: CNA did not use a 2-person transfer method when using the Hoyer lift. (12/20/22)
2. Goals/Objectives/Expected Outcome: Retrain all staff to sue (sic) a 2-person transfer method for all Hoyer lift transfers. No lift related incidents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 48 All staff will use the lift in the appropriate manner with 2 staff members present. (12/20/22) 3. Correction: Staff member was immediately suspended pending investigation. Following investigation-agency staff member was DNR'd (do not returned) from the facility. Agency was notified of incident and agency staff members involvement. Resident was sent to the emergency room for evaluation of elbow pain. All lifts were assessed by the maintenance director to ensure that they were in good working order. (12/20/22) 4. System Changes: Educate all licensed staff on proper Hoyer lift transfer techniques to include utilizing a two person assist for all Hoyer lift transfers. CNAs to give return demonstration prior to utilizing the Hoyer lift for transfers. Hoyer lift transfers will be reviewed at orientation for all new employees and for all new agency staff members. (12/16/22) 5. DON (director of nursing)/designee will conduct 2 random Hoyer lift transfer observations a week for 4 weeks to ensure that staff members are utilizing a two-person transfers. Any issues identified with transfers will be addressed immediately. The DON/designee will identify any trends and/or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI (quality assurance process improvement) monthly to review compliance. On 1/5/23 at 11:00 AM, after discussion with supervisor, ASM #1 and ASM #2 were made aware of harm for Resident #32 and with action plan initiated, this was past non-compliance. A review of the incident and grievance log from 12/15/22-1/3/23 evidenced no further injuries regarding transfers.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 49 On 1/5/23 at approximately 4:45 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, regional vice president of operations and ASM #5, the regional nurse consultant were made aware of the findings. A review of the facilities "Safe Lifting of Residents" policy with no date, "Floor based and overhead full-body sling lifts (i.e., Hoyer) require a minimum of 2 person assist." No further information was provided prior to exit. Reference obtained from https://www.fda.gov/medical-devices/general-hospital-devices-and-supplies/patient-lifts: (1) Patient lifts are designed to lift and transfer patients from one place to another (e.g., from bed to bath, chair to stretcher). These should not be confused with stairway chair lifts or elevators. Patient lifts may be operated using a power source or manually. The powered models generally require the use of a rechargeable battery and the manual models are operated using hydraulics. While the design of patient lifts will vary based on the manufacturer, basic components may include a mast (the vertical bar that fits into the base), a boom (a bar that extends over the patient), a spreader bar (which hangs from the boom), a sling (attached to the spreader bar, designed to hold the patient), and a number of clips or latches (which secure the sling). These medical devices provide many benefits, including reduced risk of injury to patients and	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 50 caregivers when properly used. However, improper use of patient lifts can pose significant public health risks. Patient falls from these devices have resulted in severe patient injuries including head traumas, fractures, and deaths	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide respiratory care and services for one of 44 residents in the survey sample, Resident #15 (R15). The findings include: For (R15), the facility staff failed to maintain (R15's) oxygen flow rate at four liters per minute according to the physician's orders. Resident #15 was admitted to the facility with diagnoses that included but were not limited to: respiratory failure (1). On 01/04/2023 at approximately 8:44 a.m., (R15) was observed sitting in their room in a wheelchair	F 695	F695 Respiratory/Tracheostomy Care and Suctioning 1. On 1/4/23, unit managers adjusted resident # 15 Oxygen rate to reflect MD order. 2. All residents that are currently on oxygen have the potential to be affected. DON/Designee observed all resident on oxygen to ensure that their oxygen was set on the correct rate. 3. All Licensed nurses were educated on the proper protocol of administering oxygen. Education included following physician orders and reading oxygen tanks at eye level to ensure they are accurately set. 4. DON/Designee will audit all residents on oxygen 3 x a week for 12 weeks to ensure all levels reflect MD orders. The DON/Designee will identify any trends and or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly x 3 for review and recommendations. 5. Date of Compliance: 02/20/2023	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 51	F 695		

receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between four and four-and-a-half liters per minute.

On 01/04/2023 at approximately 10:19 a.m., (R15) was observed sitting in their room in a wheelchair receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between four and four-and-a-half liters per minute.

On 01/04/2023 approximately 2:45 p.m., (R15) was observed sitting in their room in a wheelchair receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed a flow rate between four and four-and-a-half liters per minute.

The physician's order for (R15) dated 04/11/2022 documented, "Oxygen at 4 (four) liters per minute) via (by) NC (nasal cannula) verify O2 (oxygen) setting at eye level."

Review of the (R15's) comprehensive care plan dated 12/09/2022 documented in part, "The resident has altered respiratory status/difficulty breathing... Date Initiated: 12/09/2022." Under "Interventions" it documented in part, "Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Date Initiated: 12/09/2022."

On 01/04/2023 at approximately 3:28 a.m., an observation of (R15's) oxygen flow rate on the oxygen concentrator was conducted with LPN (licensed practical nurse) #3. After reading the flow meter LPN #3 stated that it was between four and four-and-a-half liters per minute. When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 52 asked what the flow rate should be LPN #3 stated that they needed to check the physician's orders. After looking up the physician's order in (R15's) EHR (electronic health record) LPN #3 stated that the flow rate was ordered for four liters per minute. When asked to describe how to read the oxygen flow rate on an oxygen concentrator and how often a resident's oxygen flow rate should be checked LPN #3 stated that the liter line should pass through the middle of the float ball inside the flow meter and the flow rate should be checked at the beginning of each shift and whenever the nurse goes into the room. The facility's policy "Oxygen Administration" documented in part, "Steps in the Procedure: 7. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being delivered." On 01/04/2023 at approximately 4:36 p.m., ASM (administrative staff member) #1, administrator ASM #2, director of nursing, ASM #4, regional director of operations and ASM #5, regional `nurse consultant, were made aware of the above findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 53 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide care and services for a complete dialysis (1) program for one of 44 residents in the survey sample, Resident #237 (R237). The findings include: For (R237) the facility staff failed to obtain a physician's order for dialysis care and treatment, and failed to provide a dialysis communication form for (R237's) dialysis visit on 01/02/2023. (R237) was admitted to the facility with diagnoses included but were not limited to: end stage renal failure (2). The facility's admission assessment for (R237) dated 12/27/2022 documented that (R237) was oriented to person, place, time and situation. On 01/04/2023 at approximately 10:00 a.m. a review of the physician's order sheet for (R237) failed to evidence an order for dialysis. On 01/04/2023 at approximately 10:05 a.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about a physician's order for (R237's) dialysis LPN #3 checked the physician's orders for (R237) and	F 698	F698 Dialysis 1. On 1/4/2023, unit manager assessed resident #237 and reviewed the medical record. Unit manager obtained an order from the physician for resident dialysis care and treatment and entered it into the medical record. Communication with the dialysis center has been established for resident #237 and a dialysis communication book is being utilized to facilitate communications. 2. All Residents with dialysis care and treatment have the potential to be affected. An audit on all residents with dialysis care and treatment was conducted to ensure MD orders are obtained and communication forms are sent and recived. 3. DON/Designee will educate the License nursing staff on the proper protocol for all residents obtaining Dialysis care and treatment. The education includes obtaining MD orders for all residents that are receiving dialysis to include date/time/place that the resident is receiving dialysis and the importance of sending and receiving resident information via the communication book. 4. DON/Designee will review residents receiving dialysis care and treatment weekly x 12 to ensure all MD orders are obtained and implemented and that communication book has been sent and received from dialysis center. The DON/Designee will identify any trends and/or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly x3 for review and recommendations. 5. Date of compliance: 02/20/2023	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 54	F 698		

stated that there were no orders for dialysis.

On 01/04/2023 at approximately 10:15 a.m. a review of (R237's) baseline care plan failed to evidence documentation for dialysis.

On 01/04/2023 at approximately 10:24 a.m., an interview was conducted with (R237) regarding the last time they received dialysis services, (R237) stated that they went to dialysis on Monday 01/02/2023.

On 01/04/2023 at approximately 4:08 p.m. a review of (R237's) dialysis communication book failed to evidence a communication sheet for 01/02/2023.

On 01/04/2023 at approximately 4:08 p.m. an interview was conducted with LPN (licensed practical nurse) #4. When asked about the lack of a physician's order for (R237's) dialysis, LPN #4 stated that the order was given verbally but there was no documentation of a physician's order for dialysis in the electronic health record for (R237). When asked to describe the procedure when a verbal order is received LPN #4 stated that when a verbal order is received it is to put into the resident's record. When asked who was responsible for putting the order in the resident's record LPN #4 stated that it was the responsibility of nursing. When asked to describe the purpose of the dialysis communication sheets LPN #4 stated that it informs the dialysis center of the resident's status. When asked about (R237's) dialysis communication sheet for 01/02/2023, LPN #4 reviewed (R237's) dialysis communication book and stated that it was not in the book and could not say that a communication sheet was completed for 01/02/2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 55	F 698		

On 01/05/2023 at approximately 9:00 a.m. a review of the physician's order sheet for (R237) documented in part, "Dialysis at (Name of Dialysis Center and Address) on Tues, Thurs, Sat (Tuesday, Thursday, Saturday). Chair time 10 AM (10:00 a.m.). Order Date: 1/4/2023. Created Date: 1/4/2023 19:20 (7:20 p.m.)."

The facility's policy "Hemodialysis Access Care" documented in part, "Policy: The facility is committed to following current CMS, state guidelines, and clinical standards of practice in provide care for residents with End Stage Renal Dialysis receiving hemodialysis at an outpatient dialysis facility."

The facility's policy "Medication and Treatment Orders" documented in part, "SPECIFIC PROCEDURES / GUIDANCE: 7. Verbal orders must be recorded immediately in the resident's medical record by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order."

On 01/04/2023 at approximately 4:36 p.m., ASM (administrative staff member) #1, administrator ASM #2, director of nursing, ASM #4, regional director of operations and ASM #5, regional `nurse consultant, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) It removes waste from your blood when your kidneys can no longer do their job. This information was obtained from the website: Dialysis - hemodialysis: MedlinePlus Medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 56 Encyclopedia. (2) The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record, the facility staff failed to assess a resident for the safe use of side rails for one of 44	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 57 residents in the survey sample, Resident #337. The findings include: For Resident #337 (R337), the facility staff failed to assess the resident for the safe use of side rails when the resident was admitted. R337 was admitted on 12/28/22. R337 did not have a complete MDS (minimum data set) at the time of the survey. A review of the admission assessment dated 12/28/22 revealed the resident had no cognitive deficits, and required assistance with activities of daily living. On 1/4/23 at 8:18 a.m. and 1/5/23 at 9:35 a.m., R337 was sitting up on the side of the bed. At both observations, quarter side rails were up on both sides at the head of the resident's bed. R337 stated they had been admitted to the facility after having surgery. The resident stated they could not transfer from bed to chair without a mechanical lift, and were not allowed to put any weight on either foot. On 1/4/23 at 8:18 a.m., when asked about the use of the quarter side rails, R337 stated they used the rails to help with positioning in bed. A review of R337's clinical record failed to reveal an assessment for the safe use of side rails prior to survey entrance on 1/3/23 at 6:00 p.m. On 1/5/23 at 12:34 p.m., LPN (licensed practical nurse) #5 provided a side rail safety assessment for R337 dated 1/4/23. When asked why the side rail assessment had been completed on 1/4/23, LPN #5 stated, "It just completely slipped my mind that it needed to be done." She stated ordinarily the admitting nurse is responsible for	F 700	F700 Bed Rails 1. Unit manager assessed resident #337 and reviewed the medical records. On 1/4/23, the unit manager, completed the side rail safety assessment for resident #337. 2. All residents with side rails have the potential to be affected. An audit of all residents who utilize side rails was completed to ensure that they have an updated side rail safety assessment completed. 3. DON/Designee will educate the License nursing staff on the proper protocol for all residents with side rails. The education included completing the side rail safety assessment on admission. 4. DON/Designee will audit all new admissions for 12 weeks to ensure all new admissions have the appropriate side rail safety assessment completed. The DON/Designee will identify any trends and or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly x 3 for review and recommendations. 5. Date of Compliance: 02/20/2023	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 58 completing the side rail assessment for resident safety. She stated it is important to make sure this assessment is done for each resident because "all beds have side rails, and we need to make sure the resident is safe." On 1/5/23 at 4:40 p.m., ASM (administrative staff member) #1, ASM #2, ASM #5, regional nurse consultant, and ASM #6, the regional maintenance director, were informed of these concerns. No further information was provided prior to exit.	F 700		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review it was determined that the facility staff failed to ensure three of five CNAs (certified nursing assistants) received annual performance reviews, CNA #4, #5, and #6. The findings include: On 01/05/2023 an employee record review was conducted to include the annual performance reviews of five CNAs. This review revealed the following: 1. CNA # 4 hired 12/17/2018, revealed no	F 730	F730 Nurse Aide Performance Review 1. No individual residents appear to have been affect as n resident were noted. CNA # 4, 6, 5 will have annual performance review completed by 1/27/23. 2. All residents have the potential to be affected. Administrator designee will perform an audit on all current employees to ensure annual performance review has been completed. All variances will be corrected. 3. Administrator will educate all department heads regarding the policy for required annual performance review # 4, 6, 5 had performance review completed their performance review 4. Administrator or designee will audit 10 employee files per week for four weeks, then five for eight weeks. The Administrator or Designee will identify any trends and or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly x 3 for review and recommendations. 5. Findings will be presented to QAPI monthly x 3 for review and recommendations.	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730	Continued From page 59 evidence of performance review between 12/17/2021 and 12/17/2022. 2. CNA # 5 hired 10/22/2018, revealed no evidence of performance review between 10/22/2021 and 10/22/2022. 3. CNA # 6 hired 03/09/2020, revealed no evidence of performance review between 03/09/2021 and 03/09/2022. On 01/05/2023 at approximately 4:40 p.m., ASM (administrative staff member) #1, administrator ASM #2, director of nursing, ASM #5, regional nurse consultant and ASM #6, maintenance director, were made aware of the above findings. On 01/06/2023 at approximately 9:57 a.m. an interview was conducted with ASM (administrative staff member) #1, administrator. When asked for the competency/performance reviews for the CNAs listed above, ASM #1 stated that they did not have the competency reviews and where unable to locate them. When asked to describe the procedure for the competency reviews, ASM #1 stated that the reviews were completed annually with the CNA's hire date as the anniversary date for completing the competency reviews. No further information was provided prior to exit.	F 730		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	F 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 60 §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and in the course of a complaint investigation, it was determined the facility staff failed to prepare and serve food at an appetizing temperature in one of three nursing units, Shenandoah Farms. The findings include: Observation was made of the tray line and food delivery on 1/4/2023 at 11:04 a.m. The temperatures were as followed: Ham slices - 151 degrees Cauliflower - 161 degrees Sweet potatoes - 63 degrees - removed from tray line by staff; new pan 158 degrees. White rice - 165 degrees Chopped ham - 160 degrees Chopped cauliflower - 165 Pureed sweet potatoes - 129 degrees - removed from tray line by staff, new pan 158 degrees. Pureed ham - 167 - degrees Mashed potatoes - 158 - degrees Pureed cauliflower - 179 - degrees Gravy - 167 - degrees Observation was made that the hot pellets were not being used under the plates. The plates did come from a warmer. The cart with the food trays left the kitchen at 1:10 p.m. Observation was made of the staff on Shenandoah unit passing the trays and assisting resident to eat.	F 804	F804 Nutritive Value/Appear, Palatable/Prefer Temp 1. No individual residents appear to have been affect as no resident were noted. 2. All residents who consume food at the facility have the potential to be affected. Administrator immediately met with the re-educated the dietary manager to ensure that the pellet warmer was to be used for all meals on 1/4/23. 3. The dietary manager will reeducate all staff the pellet will be used for all meal services. 4. The Administrator will audit five meals a week for four weeks, then three meals per week for eight weeks. 5. Findings will be presented to QAPI monthly x 3 for review and recommendations.	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 61 On 1/4/2023 at 1:47 p.m. OSM (other staff member) #15, the dietary manager, was asked why she didn't use the pellets under the plates. OSM #15 stated the pellet machine doesn't work. At 2:00 p.m., 50 minutes after leaving the kitchen, the last resident was served their lunch tray. The tray had been stored in a cart. The test tray was tasted by OSM #15 and the surveyor. The food temperatures were as followed: Pureed ham - 93.7 degrees, a difference of 73.3 degrees. Cauliflower - 95.5 degrees, a difference of 65.5 degrees. Ham - 91 degrees, a difference of 60 degrees. Sweet potatoes - 90.1 degrees, a difference of 67.9 degrees. Chopped ham - 88.3 degrees, a difference of 71.7 degrees. Rice - 102.5 degrees, a difference of 62.5 degrees. Mashed potatoes - 112.2 degrees, a difference of 45.8 degrees. Once tasted OSM #15 was asked if the food was palatable. OSM #15 stated the food was cold, but the flavor was good. The surveyor agreed with this statement. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 1/4/2023 at 3:58 p.m. When asked the status of the repair of the plate warming pellet machine, ASM #1 stated it works. A tour of the kitchen was conducted with ASM #1 and ASM # 7, the regional director of dining services. The pellet machine was heated up.	F 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 62 ASM #1 stated, the machine in the kitchen takes the black plates and the one that needs a new plug takes the blue pellet plates. There was a mix of blue and black plates on the machine available for use. The machine was tested by ASM #1 and ASM #7. The Three pellets were heated and were warm to hot to the touch. ASM #1 stated she has worked the tray line and there are plenty in the house to use. A policies on food temperatures, tray line, use and maintenance of the pellet plate warmer and palatable food temperatures were requested on 1/4/2023 at 3:31 p.m. from ASM #1. No policy on palatable food temperatures or maintenance of the pellet warmer was provided. ASM #1, ASM #2, the director of nursing, ASM #5, the regional nurse consultant, and ASM #4, the regional director of operations, were made aware of the above concerns on 1/4/2023 at 4:33 p.m. No further information was obtained prior to exit.	F 804		
F 811 SS=D	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law.	F 811		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 811	Continued From page 63 §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to ensure a staff member was a trained feeding assistant prior to allowing staff member (OSM #17) to feed one of 44 residents in the survey sample, Resident #26 (R26). The findings include: On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/21/2022, the resident scored a one out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired for making daily decisions. In Section G - Functional Status, R26 was coded as requiring supervision with one-person physical assistance for eating.	F 811	F811 Feeding Assistance/Training/Supervision/Resident 1. On 1/4/23 DON assessed resident #26 and no concerns were noted. On 1/4/23 Administrator immediately educated staff member #17 to non-longer assist with meals. 2. All residents who require assistance with meal have the potential to be affected. Administrator completed an audit of all residents who require assistance with their meals was conducted to ensure that only licensed or certified nursing staff (RNs, LPNs, CNAs) to provide assistance. 3. Administrator will provide education to all staff regarding on the required qualification for assisting residents with meals. 4. Administrator or design will conduct an audit for residents' assistance with their meals for five meals per week for four weeks, then three meals per weeks for eight weeks. 5. Findings will be presented to QAPI monthly x 3 for review and recommendations.	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 811	Continued From page 64 The comprehensive care plan dated, 10/5/2022, documented in part, "Focus: (R26) has an ADL (activities of daily living) self-care performance deficit AEB (as exhibited by) need for physical assist with ADL self-performance debility." The "Interventions" documented in part, "Physical assist as needed with ADL self-care. Provide supervision and cuing as needed to promote independence with ADL self-care." Observation was made of the Shenandoah Gardens unit during lunch time on 1/4/2023 between 1:10 p.m. through 2:00 p.m. OSM (other staff member) #17, an activity assistant, was observed feeding R26 at 1:15 p.m. OSM #17 was observed hand feeding R26 their lunch meal. OSM #17 finished feeding the resident at 1:43 p.m. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 1/4/2023 at 2:34 p.m. When asked if the facility had a feeding assistant program, ASM #1 stated they did. A request was made for the training documentation for OSM #17 from an approved state feeding assistance training program. ASM #1 presented a certificate from a training program, "Personal Care Aide Training Program" and another certificate, "Direct Care Aide Training Program." The "Direct Care Aide Training Program" curriculum was approved by the Commonwealth of Virginia Department of Social Services. On 1/4/2023 at 4:33 p.m. a request was made for further documentation related to the training that	F 811		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 811	Continued From page 65 meets the regulation. The facility policy, "Paid Feeding Assistants" documented in part, "Policy: Resident may be assessed for appropriateness for the feeding assistant program and receive services according to their plan of care. Paid feeding assistants are trained and supervised...4. Paid feeding assistants must successfully complete a state-approved training course taught by qualified professionals (as defined by state law) before being permitted to feed residents." ASM #1, ASM #2, the director of nursing, ASM #5, the regional nurse consultant, and ASM #4, the regional director of operations, were made aware of the above concerns on 1/4/2023 at 4:33 p.m. No further information was provided prior to exit.	F 811		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 66 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to store and prepare food in a sanitary manner in one of one kitchens. The findings include: Observation was made of the kitchen on 1/3/2023 at 6:19 p.m. A ice cream freezer was located just inside the kitchen. Inside the freezer was a fast-food large plastic cup with a straw, with ice in it. An interview was conducted with OSM (other staff member) #14, the cook, on 1/3/2023 at approximately 6:24 p.m. When asked if the fast-food cup in the freezer was resident related, OSM #14 stated, no. Three hard boiled eggs were on the counter. When asked how long the eggs had been out of the refrigerator, OSM #14 stated he believed an hour. Observation was made of a sink, with no tap for water and had a covering over it to cover the drain. Inside this sink were pieces of plastic, small pieces of uncooked spaghetti noodles, plastic closures from bread bags and crumbs. The "food sink" was observed with stagnant water in the bottom, when asked about the sink, OSM #14 stated the disposal doesn't work. At 6:32 p.m. OSM #15, the dietary manager came to the kitchen. A half pan was stacked in a pile on the rack of clean, ready to use dishes. When lifted the pan had a greasy film over the inside of	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1. No individual residents appear to have been affect as no resident were noted. 2. All residents who consume food from the facility have the potential to be affected. All identified items from the kitchen freezer were immediately discarded by Dietary Manager. The three identified hard boiled eggs were immediately discarded by the Dietary Manager. The identified sink was cleaned and sanitized, and the stagnant water was drained. The Dietary Manager immediately removed the half pan and made sure that it was properly cleaned and sanitized. The Dietary Manager immediately discarded the items that were observed sitting on the shelf in the refrigerator. The Dietary Manager immediately instructed the staff #16 to properly place hairnet to cover all of her hair. 3. The Dietary Manager will reeducate all dietary staff regarding: Proper storage and label and date of food items. Appropriate use of refrigerator and freezer for resident use only. To appropriately sanitation and storage of kitchen items. Personal hygiene and infection control. 4. Administrator will do kitchen walking rounds of the kitchen and observe for: Proper storage and label and date of food items. Appropriate use of refrigerator and freezer for resident use only. To appropriately sanitation and storage of kitchen items Personal hygiene and infection control. Walking rounds will be conducted by Administrator five times a week for four weeks, then three times a week for eight weeks. Findings will be presented to QAPI monthly x 3 for review and recommendations.	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 67	F 812		

the pan. When asked if the pan was clean, OSM #15 stated, no.

The refrigerator was observed. A plastic grocery bag contained two king size packs of Reese's cups. An energy drink can was observed sitting on the shelf in the refrigerator. A pitcher of what appeared to be lemonade was sitting on the shelf with no label or contents or date when made. Two metal pans of what looked to be eggs with other ingredients such as sausage and peppers was noted, no label of the contents and no date when made. A small package of American cheese was wrapped in plastic wrap and was not labeled or dated.

The freezer was observed. An open bag of green peppers was observed with no date. A bag of omelets was open with no date. A bag of sausage patties was observed to be open with no date. A box of fish patties was open, and the inside bag was open to air. A box of corn was open with the bag open to air. Rib shaped pork patties box was open, and the inner bag was open to air. A bag of frozen cookie dough was open to air.

An interview was conducted with OSM #15 on 1/3/2023 at approximately 7:00 p.m. When asked if hard boiled eggs can be left sitting on the table out of refrigeration, OSM #15 stated, no, they should only be out for when you are making something. When asked about the foods in the refrigerator and freezer, OSM #15 stated they should all have been labeled, dated, and covered.

Observation was made on 1/4/2023 at 12:27 p.m. of the tray line. OSM #15 and OSM #16, a cook, were serving the food from the tray line and preparing the trays. OSM #16 had a hair net on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 68 her head but her bangs, approximately two inches long were not in the hair net and were hanging over her forehead. When asked what the purpose of the hair net is, OSM #16 stated to keep my hair out of the food. When asked about the bangs hanging down, OSM #16 stated, "I can't keep them back." The facility policy, "Food Safety and Sanitation" documented in part, "When a food package is opened, the food item should be marked to indicate to indicate the open date. This date is used to determine when to discard the food." The facility policy, "Personal Hygiene and Health Reporting" documented in part, "5. Hair should be neat and clean. Hair restraints must be worn around exposed foods, in the kitchen or food service areas and dining areas." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #5, the regional nurse consultant, and ASM #4, the regional director of operations, were made aware of the above concerns on 1/4/2023 at 4:33 p.m. No further information was provided prior to exit.	F 812		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to maintain kitchen equipment in	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 69 operating condition in one of one kitchens. The three-compartment sink was not functional. The findings include: Observation was made of the kitchen on 1/3/2023 at 6:19 p.m. In the dish room the dishwasher was observed. On the opposite side of the room was the three-compartment sink. There were pans stacked in the middle sink in water. There was no water or chemicals in the two other sinks. An interview was conducted with OSM (other staff member) #15, the dietary manager, on 1/3/2023 at approximately 6:40 p.m. When asked what is wrong with the three-compartment sink, OSM #15 stated it's clogged up and it doesn't work and the grease trap is not working. A policy on the use and maintenance of the three-compartment sink was requested on 1/4/2023 at 3:31 p.m. from ASM #1. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 1/4/2023 at 3:58 p.m. When asked why the three-compartment sink is not functioning, ASM #1 stated they have treated the grease trap a few times and educated the staff on the use of it. A tour was conducted of the kitchen with ASM #1 and ASM #7, the regional director of dining services on 1/4/2023 at 4:22 p.m. The three-compartment sink was observed. OSM #16, the cook, turned the water on. It was observed the water flowed into a white drain but overflowed onto the drain on the floor that was approximately 12 inches by 12 inches. ASM #1	F 908	F908 Essential Equipment, Safe Operating Condition 1. No individual residents appear to have been affect as no resident were noted. The three-compartment sink was fixed and is now in working order. 2. All residents at the facility have the potential to be affected. Administrator and Dietary Manager audited kitchen equipment to make sure they were in working order. Any variances were corrected. 3. The Administrator re-educated the Dietary Manager on the following: • To immediately notify the Administrator and the Maintenance Supervisor of any kitchen equipment needing repair. • Proper usage and sanitation of the three-sink compartment. 4. The Administrator will conduct walking rounds to make sure that all kitchen equipment remains operational three times a week for four week, then one time a week for eight weeks. Findings will be presented to QAPI monthly x 3 for review and recommendations.	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 70 stated the three-compartment sink needed repair. ASM #1 stated she has had maintenance look at it before and it was treated before. The policy, "Cleaning Dishes - Manual Dishwashing" documented in part, "Policy: Dishes and cookware will be cleaned and sanitized after each meal. Procedure: 1. Scrape dishes into a clean waste basket and/or garbage disposal. 2. Rinse dishes off and stack them carefully. Pre-soak as needed. 3. Clean and sanitize sinks prior to beginning. Prepare sinks according to the chart below. Place a few dishes into the sink at a time. Clean thoroughly with clean cloth or sponge. Scrub items as needed using scouring pad. Rinse in Sink 2 and sanitize in skin 3 following the directions below. 4. After dishes are done, clean and sanitize sinks and faucets. 5. Check sanitation sink frequently using a test strip to assure the level of sanitization solution is appropriate. Follow chemical manufacturer's guidelines to prepare sanitizing solution." ASM #1, ASM #2, the director of nursing, ASM #5, the regional nurse consultant, and ASM #4, the regional director of operations, were made aware of the above concerns on 1/4/2023 at 4:33 p.m. No further information was provided prior to exit. \	F 908		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must-	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 71 §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review it was determined that the facility staff failed to ensure CNAs (certified nursing assistants) received required training as part of the annual performance reviews for three of five CNA records reviewed, CNA #4, #5, and #6. The findings include: On 01/05/2023 an employee record review was conducted of the annual retraining transcripts of five CNAs. This review failed to evidence the following required training for the CNAs: 1. CNA # 4, hired 12/17/2018, revealed no evidence of dementia, abuse/neglect, infection control and emergency preparedness training between 12/17/2021 and 12/17/2022. 2. CNA # 5, hired 10/22/2018, revealed no evidence of dementia, abuse/neglect, infection control and emergency preparedness training	F 947	F947 Required-Inservice training for Nurses Aides 1. No individual residents appear to have been affect as no residents were noted. CNA # 4, 6, 5 will have required annual training completed by 1/27/23. 2. All residents have the potential to be affected. Administrator designee will perform an audit on all current employees to ensure required annual training have been completed. All variances will be corrected. 3. Administrator will educate all department heads regarding the policy for required annual performance review. 4. Administrator or designee will audit 10 employee files per week for four weeks, then five for eight weeks. The Administrator or Designee will identify any trends and or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly x 3 for review and recommendations.	2/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN CARE CENTER	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 72 between 10/22/2021 and 10/22/2022. 3. CNA # 6, hired 03/09/2020, revealed no evidence of dementia, abuse/neglect and infection control training between 03/09/2021 and 03/09/2022. On 01/05/2023 at approximately 4:40 p.m., ASM (administrative staff member) #1, administrator ASM #2, director of nursing, ASM #5, regional nurse consultant and ASM #6, maintenance director, were made aware of the above findings. On 01/06/2023 at approximately 9:57 a.m. an interview was conducted with ASM (administrative staff member) #1, administrator. When asked for the competency reviews for the CNAs listed above ASM #1 stated that they were unable to locate documentation of the missing training stated above. No further information was provided prior to exit.	F 947		