STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. BUILDING _____ B. WING _____	C 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENRICO HEALTH & REHABILITATION CENTER	561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 7/24/23 through 7/25/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint (VA00059295 substantiated with deficiency) was investigated during the survey The census in this 120 certified bed facility was 114 at the time of the survey. The survey sample consisted of 3 resident reviews.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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.	F 657		8/15/23

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

Electronically Signed | 08/08/2023

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.

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F 657	Continued From page 1 (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 interview, clinical record review and facility documentation the facility staff failed to review and revise the care plan after assessment for 1 Resident (#1) in a survey sample of 3 Residents. The findings included: For Resident #1, the facility staff failed to review and revise the care plan after falls. On 7/24/23, a review of the clinical record revealed that Resident #1 had a fall on 6/23/23 and a fall on 7/13/23. On 7/24/23, a review of the clinical record revealed that Resident #1's care plan had not been updated after she fell. On 7/25/23, an interview was conducted with the DON who stated that care plans should be updated with any changes in patient conditions, medications and or treatments. When asked if this was done, she stated that it had not been. On 7/25/23, during the end of day meeting the Administrator was made aware of the concerns and no further information as provided.	F 657	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F657 Care Plan Timing and Revision 1. Resident care plan was reviewed and updated with intervention for post fall on 7/18/2023. 2. All residents have the potential to be affected. Current residents from July 1, 2023, will have an audit conducted to verify the care plan was updated timely post fall. Any findings will be corrected. 3. The licensed nurses and MDS staff will receive education by the staff development coordinator or designee on the completion of the fall process with initiating, revising /updating care plan with intervention after a fall to reduce/prevent further falls. 4. Audits of all falls will be conducted by the unit manager or designee weekly x 4 weeks to verify the care plan was initiated, revised/updated with interventions after a fall. Any findings will be corrected. Findings will be submitted to QAPI and revised until compliance is met and	

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F 657	Continued From page 2	F 657	deemed that deficient practices are no longer occurring. 5. Date of compliance: 8/15/2023	