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Sunrise at Reston Town Center
1778 Fountain Drive
Reston, VA 20190
(703) 956-8930

Current Inspector: Jacquelyn Kabiri (703) 397-3017

Inspection Date: Sept. 19, 2024 , Sept. 20, 2024 and Sept. 23, 2024

Complaint Related: No

Areas Reviewed:

2VAC40-73 GENERAL PROVISIONS
22VAC40-73 ADMINISTRATION AND ADMINISTRATIVE SERVICES
22VAC40-73 PERSONNEL
22VAC40-73 STAFFING AND SUPERVISION
22VAC40-73 ADMISSION, RETENTION AND DISCHARGE OF RESIDENTS
22VAC40-73 RESIDENT CARE AND RELATED SERVICES
22V AC40-73 RESIDENT ACCOMMODATIONS AND RELATED PROVISIONS
22VAC40-73 BUILDINGS AND GROUND
22VAC40-73 EMERGENCY PREPAREDNESS
22VAC40-73 ADDITIONAL REQUIREMENTS FOR FACULTIES TAHT CARE FOR Adults WITH SERIOUS COGNITIVE IMPAIRMENTS
63.2- (17) LICENSURE AND REGISTRATION PROCEDURES

63.2- (18) FACILITIES AND PROGRAMS
22VAC40-90 BACKGROUND CHECKS FOR ASSISTED LIVING FACILITIES 22VAC40-90 THE SWORN STATEMENT OR AFFIRMATION
22VAC40-90 THE CRIMINAL HISTORY RECORD REPORT
22VAC40-80 THE LICENSE

Comments:

Type of inspection: Renewal
Date of inspection and time the licensing inspector was on-site at the facility for each day of the inspection: 09/19/2024 11 :00am-2:40pm, 09/20/2024 9:40-3:15pm, 09/23/2024 8:45am-2:30pm.
The Acknowledgement of Inspection form was signed and left at the facility for each date of the inspection.

Violations:

Standard #: 22VAC40-73-1180-A

Description: Based on observation and staff interview, the facility failed to ensure when there are indications that ordinary materials or objects may be harmful to a resident, these materials or objects shall be inaccessible to the resident except under staff supervision.

Evidence:
1. During the inspection on 09/20/2024, 12:05 pm, of resident 5's secure memory room, the bathroom was open, and two blue shaving razors were observed.

2. One blue razor was observed in an open medicine cabinet.

3. A second blue shaving razor was observed on the bathroom floor.

4. During an interview with Staff 2, it was determined that the razors belonged to resident 4, the spouse of resident 5, in a shared bathroom.

5. Photos taken as evidence.

Plan of Correction: A. With respect to the specific resident/situation cited: Resident did not experience any negative outcomes from disposable safety razors being present and scattered but not secured in suite bathroom. Razors were immediately removed. B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: Resident Care Director (RCD) or designee conducted an audit of all resident?s rooms to confirm hazardous items are secured. Re- education was provided to all staff regarding environmental precautions regulation in assisted living facilities. C. With respect to what systemic measures have been put into place to address the stated concern: Neighborhood Coordinator or designee will conduct weekly room rounds for 1 month and then monthly for 3 months to confirm all hazardous items are inaccessible to residents in Memory Care. D. With respect to how the plan of correction will be monitored: The results of room rounds will be presented to the Quality Assurance and Performance Improvement Committee quarterly starting December 17th,2024 for two quarters. During and at the conclusion of one year, the QAPI

committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for implementation and ongoing compliance with all components of this Plan of Correction and address/resolve any variance that may occur. The Executive Director or designee will verify the status of this Plan of Correction is reviewed and discussed at Quality Assurance/Improvement Meetings and action initiated when/if necessary.

Standard #: 22VAC40-73-290-B

Description: Based on the Licensing inspector's (LI) direct observation and staff interview, the facility failed to develop and implement a procedure for posting the name of the current on-site person in charge, as provided for in this chapter, in a place in the facility that is conspicuous to the residents and the public

Evidence:
1. The name of the current person in charge was not present or in a conspicuous place for residents or the public to view.

2. During an interview on 09/19/2024, with Staff 2, it was stated that the "person in charge" sign was in a neighboring room that was covered up during the remodeling and redecoration project.

3.Photos taken as evidence.

Plan of Correction: A. With respect to the specific resident/situation cited:
Manager On Duty Sign was still hanging in its original spot on the wall but had just been covered by the construction crew the morning of the inspection. The Concierge had not yet moved it to a temporary, but visible place prior to the inspector walking in. Manager On Duty Sign was immediately made visible for all to see. B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: Concierge or designee will check daily that MOD sign is visible including during renovations when sign may be inadvertently covered by construction crew. C. With respect to what systemic measures have been put into place to address the stated concern: Concierge or designee will create checklist that includes checking that MOD sign is posted and visible daily. The results of new checklist will be presented to the next Quality Assurance and Performance Improvement Committee D. With respect to how the plan of correction will be monitored: During and at the conclusion the QAPI committee will re-evaluate and initiate necessary action or extend the review period.The Executive Director or designee is responsible for implementation and ongoing compliance with all components of this Plan of Correction and address/resolve any variance that may occur The Executive Director or designee will verify the status of this Plan of Correction is reviewed and discussed at Quality Assurance/Improvement Meetings and action initiated when/if necessary. Next QAPI meeting is scheduled for December 17th, 2024 and will also be reviewed during Quarter 1 QAPI on March 17th, 2025.

Standard #: 22VAC40-73-410-A

Description: Based on resident record review, the facility failed to ensure that upon admission, the assisted living facility provided an orientation for new residents and their legal representatives, including emergency response procedures, mealtimes, and use of the call system. Acknowledgment of having received the orientation shall be signed and dated by the resident and,

as appropriate, his legal representative, and such documentation shall be kept in the resident's record.

Evidence:

1. Resident #3 was admitted to the facility on 06/20/2020.

2. Resident #3 's record did not include an orientation form signed by the resident and legal representative.

3. On 9/20/2024, Staff# 1 confirmed the orientation form was not in the record.

Plan of Correction: A. With respect to the specific resident/situation cited: Resident admission record did not include orientation acknowledgement signed by both the resident AND responsible party. Business Office Coordinator and/or designee corrected the wording on the Orientation document to reflect requirement for both signatures. Resident orientation was signed by both RP and resident. B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: Business Office Coordinator and/or designee audited resident administrative files to check for compliance and obtained required signatures. C. With respect to what systemic measures have been put into place to address the stated concern: Business Office Coordinator and/or designee will add compliance of both signatures to the orientation to the New Move-In Debrief
D. With respect to how the plan of correction will be monitored: The Executive Director or designee is responsible for implementation and ongoing compliance with all components of this Plan of Correction and address/resolve any variance that may occur. The Executive Director or designee will verify the status of this Plan of Correction is reviewed and discussed at Quality Assurance/Improvement Meetings and action initiated when/if necessary. The results of new checklist will be presented to the next Quality Assurance and Performance Improvement Committee on December 17th 2024 and reviewed for 1 year. During and at the conclusion the QAPI committee will re-evaluate and initiate necessary action or extend the review period.

Standard #: 22VAC40-73-460-B

Description: Based on the record review and resident interviews, the facility failed to ensure care provision and service delivery shall be resident-centered to the maximum extent possible and include prompt response by staff to resident needs as reason to the circumstances.

Evidence:

1. Resident #3 was interviewed by the Licensing Inspector (LI) and mentioned their call bells are not answered quickly.

2. Record review of the call bells:

A. Resident #3 on 09/02/2024, 33minutes.
B. Resident #3 's call bell, on 09/06/2024, 1 hr 3minutes 18 seconds.
C. Resident #3 's call bell, on 09/10/2024, 1 hr 3minutes 1 seconds.

3. Resident #3 's Individualized service plan (ISP) documents resident's needs such as requiring human and mechanical aid for mobility, eating, and dressing.

Plan of Correction: A. With respect to the specific resident/situation cited: Residents did not experience any negative outcomes with regards to call bell response times by staff not prompt. Staff was immediately re-educated as to the importance of a prompt response and how to request assistance if they are occupied with another resident. B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: Neighborhood Coordinator or designee will conduct a daily audit of the previous 24 hrs. of call bell response times to determine if any do not qualify as prompt, and address as necessary. C. With respect to what systemic measures have been put into place to address the stated concern: Neighborhood Coordinator re-educated all frontline team members on the importance to answering call bells promptly. Neighborhood Coordinator or designee will check the daily audits for three months to note that call bell response times are trending in the right direction. D. With respect to how the plan of correction will be monitored: The results of audit will be presented to the next Quality Assurance Performance Improvement Committee meeting. During and at the conclusion of the QAPI meeting, the committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for implementation and ongoing compliance with all components of this Plan of Correction and address/resolve any variance that may occur The Executive Director or designee will verify the status of this Plan of Correction is reviewed and discussed at Quality Assurance/Improvement Meetings and action initiated when/if necessary.

Standard #: 22VAC40-73-570-B

Description: Based on Li's inspection and facility tour, the facility failed to ensure that all buildings shall be well-ventilated and free from foul, stale, and musty odors.

1. At 12:34 pm, LI detected a strong smell of urine around the bed area in Resident 3's room.

2. LI detected a strong smell of urine in Resident 7's room.

Plan of Correction: A. With respect to the specific resident/situation cited: Residents did not experience any negative outcomes from the room not being free from strong smell of urine. Residents? bedding was changed, and carpet shampooed. B. With res to how the facility will identify residents/situations with the potential for the identified concerns: Neighborhood Coordinator or Designee will conduct audit of resident rooms and commons areas to monitor for foul smells. Housekeeping and/or direct care staff will rectify any findings. C.With respect to what systemic measures have been put into place to address the stated concern: Re-education provided to team members on reporting foul smells to housekeeping staff so appropriate measures can be taken. Neighborhood Coordinator or Designee will conduct weekly room rounds for 1 month and monthly for 3 months to assess for foul smells in resident?s room. D. With respect to how the plan of correction will be monitored: The results of room rounds will be presented to the Quality Assurance and Performance Improvement Committee quarterly for 3 quarters starting on December 17th, 2024. During and at the conclusion of 3 quarters, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for implementation and ongoing compliance with all components of

this Plan of Correction and address/resolve any variance that may occur. The Executive Director or designee will verify the status of this Plan of Correction is reviewed and discussed at Quality Assurance/Improvement Meetings and action initiated when/if necessary.

Standard #: 22VAC40-73-970-E

Description: Based on documentation review and interview with staff, the facility failed to ensure a record of he required fire and emergency evacuation drills included identity of the person conducting the drill; the method used for notification of the drill; any special conditions simulated; and the time it took to complete the drill; and problems encountered (if any).

Evidence:

1. The 09/10/2024 fire drill documents show four staff members participated in fire drills, but no resident names are listed as participating. However, there is a section printed on the form labeled" Resident Participation".

2.The 08/21/2024 fire drill documents show thirteen staff members participated in fire drills, but no resident names are listed as participating. However, there is a section printed on the form labeled" Resident Participation".

3. On 9/20/2024, during an interview Staff #1 stated that residents did participate, but they didn't document the participation or names of those participating.

Plan of Correction: A. With respect to the specific resident/situation cited: Facility provided a record of the required fire and emergency evacuation drills including a printed list of current residents for purposes of participation as the facility form has a section for this.
B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: Maintenance Coordinator (MC) or designee will have participating residents sign the attendance record following every fire and emergency drill or have this section removed from facility form.
C. With respect to what systemic measures have been put into place to address the stated concern: Maintenance Coordinator (MC) or designee will conduct monthly audits for three months and then quarterly for three quarters to check that the form is following company policy and/or current regulations.
D. With respect to how the plan of correction will be monitored: The results of the fire and emergency drill audits will I presented to the Quality Assurance and Performance Improvement Committee quarterly starting on December 17th, 2024.
During and at the conclusion of one year, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for implementation and ongoing compliance with all components of this Plan of Correction and address/resolve any variance that may occur. The Executive Director or designee will verify the status of this Plan of Correction is reviewed and discussed at Quality Assurance/Improvement Meetings and action initiated when/if necessary.

Standard #: 22VAC40-90-30-B

Description:	Based on record review, facility failed to ensure that the sworn statement or affirmation shall be completed for all applicants for employment. Evidence: 1. Staff #I3, date of hire 02/28/2005, most recent Sworn Statement was not completed or signed. 2. Form was missing answers to questions two, three, and four. a.Question two: Have you ever been convicted of a crime? b. Question three: Are you subject to any pending criminal charges? C. Question four: Affirming the truth and completion of the form and signature.
Plan of Correction:	A. With respect to the specific resident/situation cited: Team member file contained a blank sworn disclosure to be completed by end of 2024. File also contained completed form for 2023, 2016 as well as the original signed 2/25/2005. B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: The Business Office Coordinator (BOC) or designee will complete an audit of team member records for regulation compliance with respect to sworn disclosure requirements. Any records identified to be deficient will be addressed. C. With respect to what systemic measures have been put into place to address the stated concern: The BOC or designee will audit team member files on a quarterly basis to ensure compliance with VA DSS regulation 22 VAC 63.21720. D. With respect to how the plan of correction will be monitored: The results of the quarterly audit will be presented to the Quality Assurance and Performance Improvement Committee for one year. During and at the conclusion of one year, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. The Executive Director or designee is responsible for implementation and ongoing compliance with all components of this Plan of Correction and address/resolve any variance that may occur. The Executive Director or designee will verify the status of this Plan of Correction is reviewed and discussed at Quality Assurance/Improvement Meetings and action initiated when/if necessary.

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Sunrise at Reston Town Center
1778 Fountain Drive
Reston, VA 20190
(703) 956-8930

Current Inspector: Jacquelyn Kabiri (703) 397-3017

Inspection Date: June 20, 2024

Complaint Related: No

Areas Reviewed:

Administration and Administrative Services
Personnel
Staffing and Supervision
Admission, Retention and Discharge of Residents
Resident Care and Related Services
Resident Accommodations and Related Provisions
Building and Grounds
Emergency Preparedness
Additional Requirements for Facilities that Care for Adults with Cognitive Impairments
Background Checks for Assisted Living Facilities
Sworn Statement

Comments:

Type of inspection: Monitoring
Date(s) of inspection and time the licensing inspector was on-site at the facility for each day of the inspection: 06/20/2024
The Acknowledgement of Inspection form was signed and left at the facility for each date of the inspection.

Number of residents present at the facility at the beginning of the inspection: 71
The licensing inspector completed a tour of the physical plant that included the building and grounds of the facility.
Number of resident records reviewed: 6
Number of staff records reviewed: 4
Number of interviews conducted with residents: 1
Number of interviews conducted with staff: 3
Observations by licensing inspector: Licensing Inspector observed residents eating breakfast and lunch and participating in activity programs. This Licensing Inspector also observed medications being administered to residents.
Additional Comments/Discussion:

An exit meeting was conducted to review the inspection findings.

The evidence gathered during the inspection determined non-compliance with applicable standard(s) or law, and violation(s) were documented on the violation notice issued to the facility. The licensee has the opportunity to submit a plan of correction to indicate how the cited violation(s) will be addressed in order to return the facility to compliance and maintain future compliance with applicable standard(s) or law.

If the licensee wishes to provide a plan of correction: (i) type the plan on a separate Word document, (ii) identify the standard violation number being addressed, (iii) include the date the violation will be corrected, (IV) do not include any names or confidential information, and (V) return to the licensing inspector by email within five (5) business days of the exit interview.

Compliance with all applicable regulations and law shall be maintained and any areas of noncompliance must be corrected.

Within 15 calendar days of your receipt of the inspection findings (inspection summary, violation notice, and supplemental information), you may request a review and discussion of these findings with the inspector's immediate supervisor. To make a request for review and discussion, you must contact the licensing supervisor at the regional licensing office that serves your geographical area.

Regardless of whether a supervisory review has been requested, the results of the inspection will be posted to the DSS public website within 5 business days of your receipt of the Inspection Summary and/ or Violation Notice.

The department's inspection findings are subject to public disclosure.

Please Note: A copy of the findings of the most recent inspection are required to be posted on the premises of the facility.

For more information about the VDSS Licensing Programs, please visit: www.dss.virginia.gov

Should you have any questions, please contact Sarah Pearson, Licensing Inspector at (540) 680-9469 or by email at sarah.pearson@dss.virginia.gov

Violations:

Standard #: 22VAC40-73-1090-A

Description: Based on resident record review and staff interview, the facility failed to have an assessment of serious cognitive impairment completed prior to admission to a safe, secure environment.
Evidence:

Resident 2, admitted to a safe, secure environment on 9/29/2023, had an assessment of serious cognitive impairment completed on 10/2/2023.

Plan of Correction: A. With respect to the specific resident/situation cited: Resident did not experience any negative outcomes from residing in the reminiscence neighborhood prior to the physician completing the Assessment of Serious Cognitive Impairment form. Form was completed two days after the resident transitioned to memory care.
B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: The RCD conducted an audit of current residents? records who were internal transfers to confirm clinical psychologist or physician completed the Assessment for Serious Cognitive Impairment form prior to transition into the reminiscence neighborhood. All forms for Assessment of Serious Cognitive impairment were completed prior to internal transfers to the reminiscence neighborhood except for resident listed in citation.
C. With respect to what systemic measures have been put into place to address the stated concern: The RCD or designee will conduct quarterly audits to confirm the Assessment for Serious Cognitive Impairment Form is completed prior to internal transfer from assisted living to the reminiscence neighborhood. Findings will be discussed at quarterly QAPI meeting. The QAPI committee will evaluate the results of the audits after 9 months and determine if additional action is warranted or if the review period needs to be extended.
D. With respect to how the plan of correction will be monitored: The Executive Director or designated coordinator is responsible for implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.

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Sunrise at Reston Town Center
1778 Fountain Drive
Reston, VA 20190
(703) 956-8930

Current Inspector: Jacquelyn Kabiri (703) 397-3017

Inspection Date: June 9, 2023

Complaint Related: No

Areas Reviewed:

22VAC40-73 GENERAL PROVISIONS
22VAC40-73 ADMINISTRATION AND ADMINISTRATIVE SERVICES2VAC40-73 GENERAL PROVISIONS
22VAC40-73 PERSONNEL
22VAC40-73 STAFFING AND SUPERVISION
22VAC40-73 ADMISSION, RETENTION, AND DISCHARGE OF RESIDENTS
22VAC40-73 RESIDENT CARE AND RELATED SERVICES
22VAC40-73 RESIDENT ACCOMODATIONS AND RELATED PROVISIONS
22VAC40-73 BUILDING AND GROUNDS
22VAC40-73 EMERGENCY PREPAREDNESS
22VAC40-73 ADDITIONAL REQUIREMENTS FOR FACILITIES THAT CARE FOR ADULT
63.2 General Provisions.

63.2 Protection of adults and reporting
63.2 Licensure and Registration Procedures
63.2 Facilities and Programs
22VAC40-90 Background Checks for Assisted Living Facilities
22VAC40-90 The Sworn Statement or Affirmation
22VAC40-90 The Criminal History Record Report
22VAC40-80 THE LICENSE
22VAC40-80 THE LICENSING PROCESS

Technical Assistance:

Documentation was discussed with the provider.

Comments:

An unannounced renewal inspection was conducted on 6/9/23. At the time of entrance, 62 residents were in care. Meals, medication administration, and activities were observed. Building and grounds were inspected. Records were reviewed. The sample size consisted of eight resident records and four staff records. Violations were discussed and an exit meeting was held.

The evidence gathered during the inspection determined non-compliance with applicable standard(s) or law, and violation(s) were documented on the violation notice issued to the facility. The licensee has the opportunity to submit a plan of correction to indicate how the cited violation(s) will be addressed in order to return the facility to compliance and maintain future compliance with applicable standard(s) or law.

If the licensee wishes to provide a plan of correction: (I) type the plan on a separate Word document, (II) identify the standard violation number being addressed, (III) include the date the violation will be corrected, (IV) do not include any names or confidential information, and (V) return to the licensing inspector by email within five (5) business days of the exit interview.

For more information about the VDSS Licensing Programs, please visit: www.dss.virginia.gov

Should you have any questions, please contact Marshall Massenberg, Licensing Inspector at (703) 431-4247 or by email at m.massenberg@dss.virginia.gov.

Violations:

Standard #: 22VAC40-73-1100-B

Description: Based on record review, the facility failed to ensure that a review of continued appropriateness is completed annually for each resident in the special care unit.
Evidence: Resident #6's record was reviewed during the inspection. The most recent review of continued appropriateness, included in Resident #6's record, was dated 4/26/22. The review was more than a year old, at the time of the inspection.

Plan of Correction: The VA REVIEW OF APPROPRIATENESS OF CONTINUED RESIDENCE IN SPECIAL CARE UNIT for Resident #6 was signed by The Executive Director and placed it in the resident?s chart on 6/9/2023.

The Executive Director re-educated the neighborhood coordinator on the requirements for REVIEW OF APPROPRIATENESS OF CONTINUED RESIDENCE IN SPECIAL CARE UNIT for all residents living in the Reminiscence neighborhood.

The Neighborhood Coordinator (RC) or Designee will audit all the resident?s medical charts in the Reminiscence Neighborhood to verify a review of appropriateness of continued residence in special care unit was completed annually for each resident in the special care unit and is filed in the medical record.

The Neighborhood Coordinator (RC) or Designee will verify the VA REVIEW OF APPROPRIATENESS OF CONTINUED RESIDENCE IN SPECIAL CARE UNIT is signed and placed in the medical chart for residents in the Reminiscence Neighborhood at 6 months, and annually thereafter.

The results of the audit for the presence of the most up to date form will be presented to the Quality Assurance and Performance Improvement Committee monthly for three months. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action
or extend the review period.

The Executive Director or designee is responsible for implementation and ongoing compliance with all components of this Plan of Correction and address/resolve any variance that may occur.

The Executive Director or designee will verify the status of this Plan of Correction is reviewed and discussed at Quality Assurance/Improvement Meetings and action initiated when/if necessary.

Standard #: 22VAC40-73-260-A

Description: Based on record review, the facility failed to ensure that each direct care staff member maintains current certification in first aid from the American Red Cross, American Heart Association, National Safety Council, American Safety and He Institute, community college, hospital, volunteer rescue squad, or fire department. The certification must either be in a first aid or include adult first aid. Each direct care staff member who does not have current certification in first aid, sh receive certification in first aid within 60 days of employment.
Evidence: No documentation was provided, during the inspection, to confirm that Staff #4 (hired 12/2/22) has current first aid certification. Staff #4's record contained documentation of current CPR certification, but not first aid.

Plan of Correction: Staff #4 will attend First Aid training on June 27, 2023. A copy of the certificate of completion will be filed in Staff #4's personnel record and a copy will be presented to Surveyor.

The Business Office Coordinator (BOC) will complete an audit of First Aid training records for all team members to verify that they have a current First Aid certification. Any staff person identified as missing First Aid training will be scheduled

for the next available training.

New team members will be asked to present current First Aid certification on the first day of hire to the community. A copy of certification will be kept in the appropriate HR file in accordance with regulation. If a new team member is found not to have First Aid certification, they will be enrolled in a certification course for completion within 60 days of employment.

The BOC and/or designee will audit team member files monthly to maintain compliance with First Aid regulations. For team members identified, First Aid recertification will be completed within 30 days and required documentation placed in HR file.

During the Quality Assurance and Performance Improvement (QAPI) meeting and up to 3 months following the implementation of the Plan of Correction (POC), the Executive Director will review the POC and the results of the audit with the Department Heads. Additional improvement plans will be developed and implemented as necessary, including training to correct any deficient practices.

The Executive Director or designee is responsible for implementation and ongoing compliance with the components of this Plan of Correction and for addressing and resolving variances that may occur.

The Executive Director or designee will verify the status of this Plan of Correction is reviewed and discussed at Quality Assurance/Improvement Meetings and action initiated when/if necessary.