STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ___ B. WING ___	C 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT LYNCHBURG NURSING & REHABILITATION CENTER	**2081 LANGHORNE ROAD LYNCHBURG, VA 24501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 2	F 657		

There were three separate care plans for falls. These care plans did not include Resident #1's falls on 7/27/19 or 8/10/19 nor the intervention for bilateral fall mats.

Fall mats were observed in Resident #1's room on 9/11/19 at 9:15 a.m.

The DON (director of nursing) was interviewed on 09/11/2019 at 1:30 p.m. regarding care plans. The DON stated, "The MDS coordinators update care plans. The nurses can, but MDS updates ninety percent of the time."

RN #1 (registered nurse), MDS Coordinator, was interviewed at 1:40 p.m. regarding care plan updates. RN #1 stated, "That nurse (MDS) is no longer here. It looks like her care plan wasn't updated as it should have been. I will go in and clean it up."

The Administrator and DON were informed of the above during a meeting with the surveyor on 09/11/2019 at 3:30 p.m. No further information was provided.

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F 657	Continued From page 1	F 657		

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 observation, staff interview, clinical record review, and in the course of a complaint investigation, facility staff failed to review and revise a comprehensive care plan (CCP) regarding falls, ambulation, mobility and transfers, for one of five residents in the survey sample, Resident #1.

Findings included:

Resident #1 was originally admitted to the facility on 05/02/2019 and readmitted on 08/01/2019 with diagnoses including, but not limited to: Dementia, COPD (chronic obstructive pulmonary disease), Left Femur Fracture with ORIF (open reduction internal fixation) and Hospice.

The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 08/09/2019. Resident #1 was assessed as moderately impaired in his cognitive status with a total cognitive score of eight (08) out of 15.

Resident #1's clinical record was reviewed on 09/10/2019 at 3:30 p.m. During this review the CCP was noted to include two separate, conflicting care plans for mobility, ambulation and transfers. A total of six care plans for these three activities. Each area included a care plan for these activities to occur independently and another care plan requiring staff assistance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/17/2019
FORM APPROVED
OMB NO. 0938-0391

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	495151	A. BUILDING ______ B. WING ______	C 09/11/2019

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CURIS AT LYNCHBURG NURSING & REHABILITATION CENTER	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 09/10/2019 through 09/11/2019. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 105 at the time of the survey. The survey sample consisted of four current Resident reviews (Residents #1 through #4) and one closed record review (Resident #5).	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	F 657	1. The Care Plan has been reviewed and revised to reflect the correct status of mobility, ambulation and transfers for Resident #1. Resident #1's care paln has been revised to reflect the appropriate number of and interventions for falls with floor mats and other interventions care planned. Date certain: 9/24/2019. 2. Current resident's care plans have been reviewed and revised to reflect that the appropriate mobility, transfer and ambulatory status as well as to assure that falls and interventions are accurately care planned. Date certain: 10/7/2019. 3. Nursing Administrative staff and direct care nurses have been in-serviced by the MDS staff and DON or designee on care plan entries and procedures for revisions of care plans. All changes in mobility, transfers, ambulation status and any current falls with interventions will be reviewed at the morning clinical meeting and the care plans updated or revised appropriately at that time as necessary. Date certain: 10/7/2019. 4. On a weekly basis the DON or designee will audit 5 care plans to assure that resident's mobility, transfer and ambulatory status are accurate and that the care plan reflects current falls and appropriate interventions. The findings of these audits will be reviewed at the monthly/Quarterly QA to assure that compliance is achieved and maintained and to identify any trends/patterns. 5. 10/14/2019.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dilston W Adams
TITLE: Administrator
(X6) DATE: 09/26/2019

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.