STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING _____ B. WING _____	C 02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 02/16/2021 through 02/17/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/16/2021 through 02/17/2021. Two complaints were investigated during the survey. VA00050206 with one allegation, was substantiated without deficient practice. VA00050267 with two allegations, was unsubstantiated with no deficient practice identified. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow. The census in this 90 certified bed facility was 71 at the time of the survey. The survey sample consisted of eighteen (18) current resident reviews, and three (3) closed record reviews.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		3/9/21

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

Electronically Signed | 02/26/2021

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
	495411	A. BUILDING _____ B. WING _____	C 02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 686	Continued From page 1 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to implement interventions for the prevention and/or treatment of pressure ulcers for three of 21 residents in the survey sample. Wound treatment orders for Resident #24's toe ulcer were not implemented as recommended by the wound consultant and per manufacturer's recommendation for administration of Santyl ointment. Resident #43's heel ulcer was observed without a physician ordered dressing and protective boot in place. Resident #15 was observed without a protective boot in use for pressure ulcer prevention. The findings include: 1. Resident #24 was admitted to the facility on 5/9/13 with a re-admission on 7/27/15. Diagnoses for Resident #2 included diabetes, neuropathy, asthma, gout, anxiety, depression, hypertension, atherosclerotic heart disease, chronic pain, dementia, heart failure and fractured clavicle. The minimum data set (MDS) dated 12/27/20 assessed Resident #24 as cognitively intact. During an interview with Resident #24, the resident stated new shoes rubbed a blister on one of her left toes and nurses provided daily	F 686	F686 Corrective Action(s): Resident # 24□s wound treatment orders have been implemented as recommended by the wound consultant and per manufacture□s recommendation for administration of Santyl. Resident # 43□s has the physician ordered dressing in place to her right heel as well as the physician ordered boot to right foot. Resident # 15□s bunny boots are in place. Identification of Deficient Practices/Corrective Action(s): All residents have the potential to be affected. All residents with orders for use of Santyl have been reviewed to ensure the orders are being implemented as recommended by the wound consultant and manufacture□s recommendation and are being followed. All residents with orders for bunny boots have been checked and their bunny boots are in place as applicable. All residents with ordered dressings have been visually checked for placement and all dressing were in place. Systemic Change(s): 100% licensed nursing staff will be in serviced by DON/ADON on pressure injury prevention/treatment policy and will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING _____ B. WING _____	C 02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 686	Continued From page 2 dressing changes to the open wound. Resident #24's clinical record documented a current physician's order dated 2/2/21 to cleanse the open area on the left 2nd toe with normal saline or wound cleanser, pat dry, apply Santyl topically then cover with dry dressing each day for wound healing. The clinical record documented weekly assessments of Resident #24's left toe ulcer by a wound consultant nurse practitioner (NP). The assessment dated 2/9/21 documented treatment of the following wounds on the resident's left 2nd toe that were from "friction with use of new shoes w/o [without] socks," with contributing factors of diabetes, neuropathy and dementia: full thickness ulceration of the left proximal 2nd toe measuring 4 x 0.2 x 0.1 (length by width by depth in centimeters) and full thickness ulceration of the left distal 2nd toe measuring 1.0 x 0.7 x 0.2 cm, 100% slough prior to debridement with small amount of non-odorous serous drainage. On 2/2/21, the wound consultant documented instructions to avoid use of wound cleanser on the toe wounds. The wound consultant's notes dated 2/2/21 and 2/9/21 documented treatment for the left second toe as, "...Cleanse site with normal saline or sterile water (Do not use wound cleanser, this may decrease effectiveness of Santyl (collagenase)...Apply Santyl (collagenase) ointment (nickel thickness) to wound base - Cover with foam dressing...Provide this care daily and as needed..." On 2/17/21 at 7:55 a.m., with the resident's permission, registered nurse (RN) #1 was observed changing the dressing on Resident	F 686	complete a prevention and treatment of pressure ulcer quiz. 100% licensed nursing aides will be in serviced by DON/ADON if a dressing has come off they are to notify charge nurse immediately for reapplication and that all pressure ulcer prevention devices listed on the Kardex should be in place as ordered and all nurses in-serviced by the ADON/DON on placement of devices that are ordered by MD. Treatment nurse/UM will be in-serviced by DON on ensuring that all wound consultant orders are implemented when received. All new wound consultant recommendations will be reviewed by DON/ADON weekly to ensure transcription to orders are accurate. All Department Heads will bring room rounds to standup/stand down daily M-F to review findings to include residents devices are in place. All new admissions with a Braden of moderate □ severe will be reviewed M-F at daily clinical meeting by DON/ADON/UM to ensure pressure ulcer prevention devices are implemented and placed on Kardex. Monitoring: ADON/Ums will round 2x week to all resident rooms with existing wounds and those high risk for breakdown to ensure all ordered devices are in place. Audit results will be reviewed at the monthly QAPI meeting x 3 months. Date of completion March 9th, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING _____ B. WING _____	C 02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 686	Continued From page 3 #24's left second toe. During this dressing change, RN #1 used dermal wound cleanser on a gauze to cleanse the wound prior to applying Santyl ointment. The linear wound was along the top of the left second toe. The wound bed was pink/red in color with resident expressing pain/discomfort when the area was contacted during the dressing change. On 2/17/21 at 10:12 a.m., RN #1 was interviewed about the use of wound cleanser instead of sterile water or saline as recommended by the wound consultant. RN #1 stated a facility nurse was with the wound care provider during assessments and she usually entered any new treatment orders. RN #1 stated the current order for treatment of Resident #24's toe wound had not been changed to include the recommendation about avoiding wound cleanser. RN #1 stated the current order stated wound cleanser or saline could be used. On 2/17/21 at 10:40 a.m., the unit manager (RN #2) was interviewed about the wound consultant's recommendation to avoid wound cleanser with use of Santyl for Resident #24's toe wound. RN #2 reviewed the clinical record and stated the facility nurse that accompanied the wound specialist usually entered any new orders for changes in treatment. RN #2 stated, "We didn't pay attention." RN #2 stated the treatment orders were not updated to discontinue the wound cleanser and include the foam dressing as recommended by the wound care consultant. The manufacturer's prescriber information for Santyl (collagenase) describes the topical agent as an enzymatic ointment used for debriding chronic dermal ulcers. Listed under precautions is, "The optimal pH range of collagenase is 6 to 8.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING _____ B. WING _____	C 02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 686	Continued From page 4 Higher or lower pH conditions will decrease the enzyme's activity and appropriate precautions should be taken. The enzymatic activity is also adversely affected by certain detergents, and heavy metal ions such as mercury and silver which are used in some antiseptics. When it is suspected such materials have been used, the site should be carefully cleansed by repeated washings with normal saline before Collagenase Santyl Ointment is applied...Cleansing materials such as Dakin's solution and normal saline are compatible with Collagenase Santyl Ointment..." Administration instructions documented,"...Prior to application the wound should be cleansed of debris and digested material by gently rubbing with a gauze pad saturated with normal saline solution, or with the desired cleansing agent compatible with Collagenase Santyl Ointment..." (1) These findings were reviewed with the administrator and director of nursing during a meeting on 2/17/21 at 3:45 p.m. (1) Collagenase Santyl Ointment prescriber information. 2016. Smith & Nephew, Inc. Fort Worth, Texas. 2/18/21. www.santyl.com. 2. Resident #43 was admitted to the facility on 11/10/20 with a re-admission on 12/30/20. Diagnoses for Resident #43 included anemia, aphasia, cerebral infarction, hypertension, urinary tract infection, urinary retention, left-side hemiplegia, depression and metabolic encephalopathy. The minimum data set (MDS) dated 1/27/21 assessed Resident #43 with severely impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING _____ B. WING _____	C 02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 686	Continued From page 5 Resident #43's clinical record documented the resident was admitted with a pressure ulcer on her right heel. On 2/17/21 at 8:22 a.m., Resident #43 was observed in bed. The resident was pulling with use of her right hand on the grab rail. The resident was moving her right leg/foot about with her right foot at times over the edge of the bed. The right foot was bare. There was no dressing on the right heel or protective boot in place. On 2/17/21 at 9:52 a.m., accompanied by registered nurse (RN) #1, a dressing change to Resident #43's right heel ulcer was observed. Upon arrival to the room, Resident #43 was observed in bed with no dressing, sock or protective boot on the right foot/heel. The resident was moving her foot back and forth with the right heel rubbing against the sheets. Scattered streaks of red colored drainage were observed on the sheets near the resident's foot. There was no pillow or elevation device in or near the bed. There was a protective boot in a chair against the wall across from the bed. RN #1 cleansed, treated and applied a new dressing to the right heel ulcer as ordered. The pressure ulcer was on the inner part of the right heel, was circular in shape and approximately dime sized. The wound bed was pink and without odor. Resident #43's clinical record documented a physician's order dated 2/16/21 to cleanse the right heel with wound cleanser, apply hydrogel with a composite dressing each day. The most recent wound consultant assessment dated 2/16/21 documented the resident had a stage 3 pressure ulcer measuring 1.4 x 1.3 by 0.2 (length	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING _____ B. WING _____	C 02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 686	Continued From page 6 by width by depth in centimeters) with slough and moderate amount of serosanguineous drainage. Resident #43's plan of care (revised 12/23/20) documented the resident was at risk of skin breakdown and had a pressure ulcer on her heel. Interventions to promote healing and prevent further skin breakdown included, "...keep clean and dry...monitor for s/s [signs/symptoms] of infection...notify md [physician] prn [as needed] with any changes...prevalon boot to right foot as resident allows...provide/assist/encourage resident to turn in bed frequently and prn, float heels intermittently as resident allows..." The clinical record including nursing notes documented no explanation of why the pressure ulcer dressing and protective boot were not in place when observed on 2/17/21. On 2/17/21 at 9:55 a.m., RN #1 performing the dressing change was interviewed about Resident #42's right heel ulcer. RN #1 stated she did not know why the dressing, sock or boot were not in place. RN #1 stated she found the dressing off when she assessed the resident just prior to the observed dressing change. RN #1 stated the resident was supposed to have a dressing covering the pressure ulcer and a protective boot. On 2/17/21 at 10:07 a.m., the certified nurses' aide (CNA#1) caring for Resident #43 was interviewed about the protective boot and/or dressing for right heel. CNA #1 stated she came to work today (2/17/21) at 7:00 a.m. she found Resident #43 with a bare right foot. CNA #1 stated the right heel had no dressing, sock or boot in place. CNA #1 stated she thought the protective boot was used when the resident was	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING _____ B. WING _____	C 02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 686	Continued From page 7 in the wheelchair. CNA #1 stated she did not know why the resident had no dressing or sock her right foot/heel. On 2/17/21 at 10:37 a.m., the registered nurse unit manager (RN #2) was interviewed about care and treatment for Resident #43's right heel ulcer. RN #2 stated the resident's heels were supposed to be floated when in bed with use of a pillow and a boot in place on the right foot for protection. These findings were reviewed with the administrator and director of nursing during a meeting on 2/17/21 at 3:45 p.m. 3. Resident #15 was admitted to the facility on 9/27/16. Diagnoses for Resident #15 included; Abnormal posture, dementia, Alzheimer's disease, and failure to thrive. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/10/20. Resident #15 was assessed with long and short-term memory loss and severely impaired in decision making skills. On 02/16/21 at 01:31 PM, Resident #15 was observed laying in bed with legs crossed and right foot hanging off the side of the bed with no sock on. An interview with Resident #15 was attempted but Resident #15 was not interviewable. On 02/17/21 Resident #15's medical record was reviewed. An active order with an origination date of 11/16/20 instructed "Provena boots [feet protectors] to bilateral heels q [every] shift for protection." On 02/16/21 at 9:55 AM, Resident #15 was observed laying in bed, legs crossed, and again	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING _____ B. WING _____	C 02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 686	Continued From page 8 did not have Provena boots in place. On 02/17/21 at 10:08 AM, certified nurse assistant (CNA #2) also observed Resident #15 without Provena boots and verbalized unawareness that an order was in place. After looking around in Resident #15's closet CNA #2 found the protectors and placed them on Resident #15's feet. An observation was made of Resident #15's heels at this time, the left heel had a quarter size reddened area and was without open areas. On 02/17/21 at 03:50 PM the above information was presented to the administrator, director of nursing and nurse consultants No other information was presented prior to exit conference on 02/17/21.	F 686		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 observation, resident interview, staff interview and clinical record review, the facility staff failed to implement interventions to minimize pain during a dressing change for one of 21 residents in the survey sample. Resident #24 was not offered any interventions to minimize pain/discomfort during a dressing change to a left toe wound.	F 697	F697 Corrective Action(s): Resident # 24 now has orders for a premed topical to be used prior to dressing change. Identification of Deficient Practices/Corrective Action(s):	3/9/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING _____ B. WING _____	C 02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 697	Continued From page 9 The findings include: Resident #24 was admitted to the facility on 5/9/13 with a re-admission on 7/27/15. Diagnoses for Resident #2 included diabetes, neuropathy, asthma, gout, anxiety, depression, hypertension, atherosclerotic heart disease, chronic pain, dementia, heart failure and fractured clavicle. The minimum data set (MDS) dated 12/27/20 assessed Resident #24 as cognitively intact. During an interview with Resident #24, the resident stated new shoes rubbed a blister on one of her left toes and nurses provided daily dressing changes to the open wound. On 2/17/21 at 7:55 a.m., with the resident's permission, registered nurse (RN) #1 was observed changing the dressing on Resident #24's left second toe. When RN #1 removed the resident's sock from the left foot, there was no dressing on the left second toe wound. Resident #24 winced and stated her toe hurt as the sock was removed. Resident #24 stated the wound consultant scraped the wound yesterday (2/16/21) and the toe had been very tender and painful since. Resident #24 stated her left foot "hurt all night." Without any further pain assessment or attempts/offers of interventions to minimize pain/discomfort, RN #1 proceeded to cleanse the left second toe wound with use of cleanser soaked gauze pads. Each time the wound was contacted during cleansing the resident winced and stated, "Ouch, ouch...it hurts." RN #1 stated she was sorry and proceeded to pat the wound	F 697	All residents have the potential to be affected. All residents with orders for dressing changes have been interviewed in regards to pain during the treatment. Any residents answering yes now have orders to pre-medicate beforehand. Systemic Change(s): 100% licensed nurses will be in serviced by DON/ADON on pain management with dressing changes and specifically if a resident complains of pain during a dressing change they are to stop and notify MD immediately for orders. 100% licensed nurses all educated by DON/ADON to not write on a dressing once it is applied, dates and initials are to be written prior to placing. Monitoring: The UM/ADON will 1x week observe a dressing change on 2 residents to assess for accuracy and observe the competency of the nurse assessing for pain during the dressing change. Audit results will be reviewed at the monthly QAPI meeting x 3 months. Date of completion March 9th, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING _____ B. WING _____	C 02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 697	Continued From page 10	F 697		

with a dry gauze. When RN #1 applied the prescribed Santyl ointment directly to the wound, Resident #24 winced and pulled her foot back stating her toe hurt. RN #1 applied an adhesive dressing to the toe. RN #1's gloves stuck to the edge of the adhesive dressing and caused pressure to the wound when she pulled the glove loose. RN #1 wrote the date and her initials on the surface of the dressing after applying it to the resident's toes. Resident #24 yelled out, "It hurts, it hurts" as RN #1 applied and wrote on the dressing. RN #1 offered no interventions for pain relief prior to or during the dressing change.

Resident #24's clinical record documented a current physician's order dated 2/2/21 to cleanse the open area on the left 2nd toe with normal saline or wound cleanser, pat dry; apply Santyl topically; cover with dry dressing each day for wound healing.

The clinical record documented weekly assessments of Resident #24's left toe ulcer by a wound consultant nurse practitioner (NP). The assessment dated 2/9/21 documented treatment of the following wounds on the resident's left 2nd toe that were from "friction with use of new shoes w/o [without] socks," with contributing factors of diabetes, neuropathy and dementia. The wounds were assessed as a full thickness ulceration of the left proximal 2nd toe measuring 4 x 0.2 x 0.1 (length by width by depth in centimeters) and a full thickness ulceration of the left distal 2nd toe measuring 1.0 x 0.7 x 0.2 cm with 100% slough prior to debridement and small amount of non-odorous serous drainage.

The resident's plan of care (revised 1/23/21) documented the resident was at risk of pain due

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING _____ B. WING _____	C 02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 697	Continued From page 11 to chronic pain, osteoarthritis, neuropathy, gout and shoulder pain. Interventions to decrease and provide adequate pain relief included, "assess for increased, decreased pain...assist with positioning for comfort...meds/labs/treatments as ordered...monitor for fatigue and provide rest periods...Notify MD [physician] as needed with any changes...Provide distractions prn..." This care plan documented the resident had a wound on the left second toe. Interventions for care of the left toe wound included, "...notify md [physician] with any changes..." The clinical record documented a physician's order dated 2/14/21 for Tylenol 650 milligrams every 4 hours as needed for pain. On 2/17/21 at 10:12 a.m., RN #1 that performed the dressing change was interviewed about the resident's expression of pain/discomfort. RN #1 stated the resident was seen on 2/16/21 by the wound consultant and the wound was debrided. RN #1 stated she should not have written on the dressing after it was in placed on the resident's toe. RN #1 stated she was not aware of any standard protocol for pain and the resident only had an order for Tylenol as needed in addition to her scheduled medications. On 2/17/21 at 10:40 a.m., the unit manager (RN #2) was interviewed about Resident #24's dressing change and no offering of interventions for pain relief. RN #2 stated she was not aware the resident had pain during dressing changes. RN #2 stated the wound consultant debrided the wound on 2/16/21 and this could have caused the increased pain. RN #2 stated the only order for prn (as needed) pain medication was Tylenol every 4 hours.	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. BUILDING _____ B. WING _____	C 02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RIDGE HEALTH & REHAB	189 MONICA BLVD LYNCHBURG, VA 24502

(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 697	Continued From page 12 These findings were reviewed with the administrator and director of nursing during a meeting on 2/17/21 at 3:45 p.m.	F 697		