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	495105	A. BUILDING _____ B. WING _____	C 05/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNCHBURG HLTH & REHAB CNTR	5615 SEMINOLE AVENUE LYNCHBURG, VA 24502

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 5/17/2021 through 5/18/2021. One complaint, VA00051846 was unsubstantiated and with related deficiencies cited. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 141 at the time of the survey. The survey sample consisted of 2 current Resident's (Resident's #1 and #3) reviews and 1 closed record review, Resident #2.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		6/25/21

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

Electronically Signed | 05/28/2021

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F 656	Continued From page 1 rehabilitative services the nursing facility will provide as a result of PASARR 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. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, the facility staff failed to develop a CCP (comprehensive care plan) for behaviors for one of 3 residents in the survey sample (Resident #2) . Findings included: Resident #2 was admitted to the facility on 03/17/21. Diagnoses on admission for Resident #2 included, but were not limited to: Dementia without behavioral disturbance, anemia, atrial fibrillation, high blood pressure, coronary artery disease, RA (rheumatoid arthritis), diabetes mellitus, depression, history of a stroke, and cortical blindness.	F 656	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. 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 alleged deficiencies cited have been or will be corrected by the date or dates indicated. " 1- Directly following the finding of care plan not updated care plan reviewed.	

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F 656	Continued From page 2 The most current MDS (minimum data set) was an admission assessment dated 03/23/21. This MDS assessed the resident with a cognitive score of 8, indicating the resident was moderately impaired for daily decision making skills. The resident was not assessed on this MDS as having any behaviors. During a complaint investigation on 05/17/21 through 05/18/21, Resident #2's entire clinical record was reviewed. The progress notes revealed that Resident #2 developed behaviors starting approximately a week after admission to the facility, with the behaviors increasing throughout the resident's stay, until discharge on 05/12/21. According to the nursing notes, the behaviors for Resident #2 started on 03/18/21, when the resident needed redirection from staff for going through closets and attempting to get his roommate out of bed. On 03/24/21 the NP [nurse practitioner] documented the resident was seen for, "worsening dementia" and Resident #2 had increased confusion and was repeatedly getting up unsupervised. A nursing note dated 04/01/21 [4:16 am] documented, "Resident has been combative...yelling, trying to fight CNA (certified nursing assistant) and nurse...up at nursing station naked, pushing another resident around in her wheel chair...will not sit down...going into other resident's rooms...refusing to put his pants and brief on...screaming heard from hallway...went to check...resident had taken off his pants and brief, had gotten in bed with his son	F 656	Resident no longer at facility. " 2-An audit was conducted that identified no other similar resident issue. " 3-Director of nursing or designee will provide education to all licensed staff related to state and federal regulations regarding updating care plans for behaviors. " 4-Director of nursing or designee will audit behaviors notes to ensure appropriate interventions have been performed and care plans updated. Once a week for 4 weeks. " 5-Any identified issues will be corrected immediately and addressed by the QAPI committee quarterly. " 6-Date of compliance 6/25/2021	

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F 656	Continued From page 3	F 656		

[Resident #2's roommate]. Resident's hand was on his son's thigh telling him to lay down with him...got resident out of his son's bed and put him in wc [wheel chair] resident became combative...keeps wandering into other resident's room..."

A nursing note dated 04/09/21 documented, "...sat up at nurses station...talking loudly and aggressively...kept standing up and ambulating unsteadily...stated, 'I don't give a f... if I fall...handsy, grasping on to staff...given snack...very active..."

A nursing note dated 04/12/21 timed 5:30 PM documented, "...observed to pick up/sling wheel chair in the direction of staff. Resident is blind with unsteady gait, up walking around...unable to redirect...using profanity, completely unaware of his safety and those around him...attempted to redirect...very agitated and swinging his arms...refuses to sit..."

A medical progress note by the FNP (family nurse practitioner) dated 04/13/21 [2:13 PM] documented, "...being evaluated today for increased behaviors...multiple episodes of combative behavior...orders were given for one-time dose of Haldol 0.5 mg [milligrams]...no behaviors have been reported since then...currently taking cymbalta 20 mg daily for depression...Aricept 10 mg daily for dementia...Start Seroquel 25 mg twice daily...Ativan 0.5 mg BID [twice daily] prn [as needed] for agitation...refer to psych for further evaluation and management..."

A psychiatric evaluation was completed on 04/19/21. The evaluation documented, "...initial

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evaluation...confusion, insomnia, agitation, depression, dementia...patient has been combative and agitated...some improvements since medications were added...provided education and counseling regarding safety issues to the faculty and staff...dementia with behavioral disturbance...non pharmacological interventions...maintain a quiet, stress free environment...encourage...activities...social gatherings...gentle redirection...reassurance...approach the patient in a way that does not escalate distress and resultant behavioral dysregulation...monitor for mood changes or behaviors...caregivers has been provided with education on dementia disease management and health behavior changes..."

A nursing note dated 04/14/21 documented resident was attempting to ambulate unsafely in room.

A nursing note dated 04/28/21 documented the resident was getting out of his wheel chair, very difficult to redirect and having increased agitation and combativeness towards staff, and Ativan was given.

A nursing note dated 04/29/21 documented that the resident was standing and walking around with an unsteady gait, redirection attempted, resident begins to yell out at staff, difficult to redirect and resident stating he wants to go home, and the staff administered Ativan.

A psychiatric evaluation was completed on 05/03/21. The evaluation documented, "...follow up evaluation...depression, confusion, agitation...dementia...and mood disorder...staff

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report the patient continues to have increased confusion and agitation...has also had inappropriate sexual behaviors...continues to try to get in bed with his son and will take off his brief and other clothes...after interview and review of chart will lower Seroquel 12.5 mg twice a day times 5 days then discontinue...will add Ativan 0.5 mg in the evening and at night for behavioral disturbances..as this is when patient becomes most aggressive and agitated...monitor closely for medication effectiveness and worsening of symptoms and follow up as needed...provided caregiver education and counseling regarding safety issues to the faculty and staff...dementia with behavioral disturbance...non pharmacological interventions...maintain a quiet, stress free environment...encourage...activities...social gatherings...gentle redirection...reassurance...approach the patient in a way that does not escalate distress and resultant behavioral dysregulation...monitor for changes in mood or behaviors...please contact team...psychiatry as needed for concerns and consultations..."

On 05/05/21 [7:14 am] a note documented, "...staff observed resident [Resident #2] was not in his bed and found in son's bed [Resident #1] naked..."

On 05/08/21 [11:16 pm] a note documented, "...yelling...resident hitting his roommate while sitting on his roommate's bed and was yelling that he needed to do what he told him to do...roommate brief open and he was yelling...resident yelling and combative..."

On 05/09/21 [7:44 am] a note documented,

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"...combative with staff...attempting to hit staff...was hitting on son and attempting to hit another resident...Resident sent to ER [emergency room] for evaluation..."

On 05/09/21 [2:22 pm] a note documented, "...back from ER via stretcher...labs all look good, no evidence of infection...Suspect worsening of his dementia and needs medication titrated...Continue discussions with niece about possibility of looking at a different facility...to facilitate patients long term care...no new orders given..."

On 05/10/21 [11:58 am] a medical note by the FNP documented,"...patient sent to ED [emergency department] on 05/02/21 and 05/09/21...was not admitted either time...on 05/09/21 patient was sent to the ED for increased episodes of aggressive behavior...history of dementia with behavioral problems...felt his dementia is worsening...start Seroquel 25 mg twice daily...continue Ativan as ordered...may need to make adjustments to medications based on behaviors in the future..."

On 05/12/21 [7:14 pm] A nursing note documented, "...constantly getting out of wheel chair and ambulating this shift, redirectable...no aggressive behaviors at this time...has been reaching arms out and touching people inappropriately, however he is unknowing what he is grabbing, he is easily redirectable..."

On 05/12/21 [5:57 am] A nursing note documented, "...resident found in bed with son...resident was naked...son's bottoms down..."

On 05/12/21 [7:41 am] A nursing note

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documented, "...behavior note completed...about resident getting in bed with [son]...Resident got combative and verbally abusive...contacted RP [responsible party]...UM [unit manager] and DON [director of nursing] notified..."

On 05/12/21 [7:50 am] A nursing note documented, "...send to hospital for evaluation and treat for aggressive behaviors..."

Resident #2's CCP (comprehensive care plan) was reviewed and documented, "...potential for feelings of isolation/sadness...encourage communication...activities...monitor for signs/symptoms of sadness related to decreased visitation...notify MD [medical doctor] as needed for symptoms of depression related to feelings of isolation...the resident has impaired cognitive function/dementia or impaired thought processes related to dementia...cue, reorient, and supervise as needed...monitor and document/report any changes in cognitive function, specifically change in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others...mental status...The resident use psychotropic medications...monitor for side effects and effectiveness..."

The comprehensive care plan did not include any of the above mentioned behaviors or interventions how to manage the behaviors. There was no careplan for desired outcome and/or goals, there were no interventions that listed actions taken, no treatments, procedures, or activities designed to treat and/or manage the resident's behaviors.

A policy titled, "Behavior-Behavior

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Assessment/Behavior Monitor" was reviewed and documented, "...Problematic behavior shall be assessed and monitored. Factors influencing behaviors as well as management interventions shall be evaluated and care planned....an assessment related to patterns of behavior will be completed in order to clarify the underlying cause...and help develop effective management interventions...The interdisciplinary team will develop a plan of care to attain or maintain the highest practicable level of psychosocial well-being while pursing causes and interventions for the disruptive behavior...the care plan will identify behavior problems, have measurable goals, appropriate interventions and be coordinated with...the team, patient, and family..."

On 05/17/21 at approximately 3:05 PM, SW [social worker] #2 was interviewed regarding the above information. The SW stated that her thoughts were the Resident #2 was confused and that there was no intention behind the behaviors and that a care plan should have been developed for the behaviors the resident was having to effectively attempt management of them.

On 05/18/21 at approximately 10:00 am, the survey team met with the DON, administrator and corporate nurse making them aware of concerns regarding Resident #2's ongoing and worsening behaviors and that care plan was not been developed with interventions to address the management of the behaviors.

The DON stated, "absolutely", when asked if a care plan should have been developed for Resident #2 in the area of behaviors. The DON stated that wasn't sure why it wasn't.

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F 656	Continued From page 9 No further information and/or documentation was presented prior to the exit conference on 05/18/21.	F 656		
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. (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 and clinical record review, the facility staff failed to review and revise the CCP (comprehensive care plan) in the area of	F 657	" 1- Care plan for resident was reviewed while surveyors on site. Resident no longer in facility.	6/25/21

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F 657	Continued From page 10 psychotropic medications for one of 3 residents, Resident #2. Findings include: Resident #2 was admitted to the facility on 03/17/21. Diagnoses on admission for Resident #2 included, but were not limited to: Dementia without behavioral disturbance, anemia, atrial fibrillation, high blood pressure, coronary artery disease, RA (rheumatoid arthritis), diabetes mellitus, depression, history of a stroke, and cortical blindness. The most current MDS (minimum data set) was an admission assessment dated 03/23/21. This MDS assessed the resident with a cognitive score of 8, indicating the resident was moderately impaired for daily decision making skills. The resident was assessed as receiving an antidepressant, but no other psychotropic medications. The physician's orders were reviewed and revealed Resident #2 was admitted on the medication Cymbalta 20 mg [milligrams] for depression. A progress note by the FNP [family nurse practitioner] dated 04/13/21 [2:13 pm] documented that the resident received a one time dose of Haldol 0.5 mg [milligrams] for behaviors on 04/12/21, this note also documented the resident would be started on Seroquel 25 mg twice daily and Ativan 0.5 mg twice daily for behaviors and agitation. The MARs [medication administration records] were reviewed and revealed that Resident #2 did	F 657	" 2-Director of nursing or designee will audit current care plans to ensure any behaviors, medications addressing behaviors and interventions are appropriately reflected. " 3-Director of nursing or designee will educate all licensed staff on the care planning process to accurately reflect behaviors, and interventions. " 4- Director of nursing or designee will audit new or changed orders twice weekly for 4 weeks to ensure those changes are appropriately reflected on the care plan. Any identified issues will be corrected immediately and addressed by the QAPI committee quarterly. " 5-Date of compliance 6/25/2021	

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receive Haldol 0.5 mg on 04/12/21 and that Seroquel and Ativan were started on on 04/13/21.

The resident received these medications from 04/13/21 [order date] up through 05/12/21 [date of discharge].

Resident #2's CCP (comprehensive care plan) was reviewed and documented, "The resident uses psychotropic medications (antidepressant)...monitor for side effects and effectiveness..."

The care plan did not have any information at all regarding the Haldol, Seroquel and/or Ativan, any type of monitoring, interventions or goals.

On 05/18/21 at 10:00 am, the administrator, DON [director of nursing] and the corporate nurse were made aware in a meeting with the survey team. The DON stated that the resident's care plan should have been reviewed and revised to include all of the medications and stated that the resident's current care plan was "generic".

No further information and/or documentation was presented prior to the exit conference on 05/18/21.