PRINTED: 12/06/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			C 08/10/2021	
	ROVIDER OR SUPPLIER RG HEALTH & REHABII	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F 0	00			
F 607 SS=D	standard survey cond 07/01/21, was condu Corrections are required. CFR Part 483 Federa Requirements. One during the survey. We substantiated with described at the time of the consisted of 10 curre (Residents 101 throus Develop/Implement ACFR(s): 483.12(b)(1) \$483.12(b)(1) Prohib neglect, and exploital misappropriation of residents 101 throus \$483.12(b)(1) Prohib neglect, and exploital misappropriation of residents 101 throus \$483.12(b)(2) Establisto investigate any surseppose \$483.12(b)(3) Include paragraph \$483.95, This REQUIREMENT by: Based on resident in clinical record review and in the course of a facility failed to imple procedures for investigates.	ired for compliance with 42 al Long Term Care complaint was investigated A00052776 and was efficient practice. Bo certified bed facility was e survey. The survey sample ent Resident reviews gh 110). Abuse/Neglect Policies 1-(3) ty must develop and licies and procedures that: it and prevent abuse, tion of residents and esident property, ish policies and procedures	F 6	07			
ABORATORY I	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	 :E		<u> </u>		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/07/2021

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.

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		COMPI	(X3) DATE SURVEY COMPLETED		
		495105	B. WING		001	; 10/2021		
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	06/	10/2021		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 607	Continued From pa	age 1	F 60	07				
	Findings include:							
	08/02/21. Diagnos but were not limited weakness, UTI [uri encephalopathy, R	s admitted to the facility on ses for Resident #110 included, d to: uncontrolled diabetes, nary tract infection], A [rheumatoid arthritis], anxiety orbid obesity, and diabetic foot						
	The most current N this resident was s	ADS [minimum data set] for till in progress.						
	08/02/21 documen	Imission assessment dated ted the resident as alert and and intact for cognition.						
	08/02/21 at 1:37 P	nission nursing note dated M documented that the and oriented and able to make						
	interviewed in her that a few days after was hungry and was her roommate some stated that she we and that when she sounded an alarm, it, staff members of that she couldn't leduring that process member [couldn't is against the metal of her ribs and that she days after that to g	45 AM, Resident #110 was room. Resident #110 stated er she was admitted that she as going to walk to get her and rething to eat. Resident #110 on to a side door of the facility opened the door it must have and although she didn't hear ame running at her and yelling ave. The resident stated that is, she was pushed by a staff dentify the staff member] door/pole and it physically hurt he went to the hospital a few et checked out. Resident #110 se told her to call 911. When						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE S COMPLI	
		495105	B. WING _			08/1	0/2021
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STA 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	TE, ZIP CODE	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTION CROSS-REFERENCE CROSS-REFER	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page	e 2	F 6	607			
	asked why the nurse stated that she didn't	didn't call, the resident know.					
	nurse, but did not kno had not seen that nur	that she did report it to a ow the nurse's name and se since she reported it to lought it was the night of the					
		records were then reviewed esent [08/10/21]. Progress ne following:					
	staff member from Th threw her up against then stated against th	l: "Resident stated that a nursday [08/05/21] night had the bedrails of the bed, and ne wallNurse reported to bensed practical nurse (LPN)					
	Thursday of hitting he her against the bed ra	"accused staff from er. First she said they threw ails, and then said they threw t the front doorsignature of					
	resident's sister] in re hospital of reports of [complained of] bruisi in ribssister states, often when she has a infections'ER called they did not find anyther fracturessignature of	ng to left forearm and pain 'she becomes confused lot of pain and has bladder I to send back and stated ning and X-ray showed no					
		nt's roomresidentstated I y, the girl shoved me into a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			l	C 10/2021
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	ΣE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 607	broken they just hurt have called the admi mail, and I have told anything. I just don't resident, no visual br have a bruise to left to was called and inform been having behavior staff and calling 911. facility at 9:45 going #12." Resident #110's clinic behaviors of threater A hospital emergency dated 08/07/21 at 11 back to facility] docur stated on Thursday's foodescorted back into a metal doorha An X-ray dated 08/07 chest and ribs was redocumented, "no pabnormalitiesno evright sided rib fracture. A progress note date documented, "Patie hospital follow upin 08/07/21 for chest was assaultcomplaining nursing [DON] was a allegation towards as upsignature of FNF	bs might be broken well not on the insideI [resident] nistrator and left him a voice everybody but no one will do trust yallWriter assessed uises to ribs, resident does upper forearmthe DON ned writer the resident has rs threatening staff, fightingresident called 911 and left to ERsignature of LPN cal records did not document aing and/or fighting staff. Y room documentation report 155 AM [time of discharge mented, "in via EMSpt with staffand was pushed aving right rib pain" Y/21 of the resident's right eviewed. The report leural effusionno bony idence of acute displaced ess" d 08/9/21 and timed 2:37 PM ent evaluated today for emergency room on all contusion, alleged of rib painDirector of ware of the patient's	F	607			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495105	B. WING			1	C 10/2021
	ROVIDER OR SUPPLIER	LITATION CENTER		5615	EET ADDRESS, CITY, STATE, ZIP CODE 5 SEMINOLE AVENUE ICHBURG, VA 24502		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 607	aware of Resident #1 stated that she was no [date of alleged incident resident attempting to stated that she follow Friday and the reside about it. The DON stocalled the police [Fridallegations of abuse. morning of 08/07/21 [this information and administrator and the administrator atted to midday on Saturday. No documentation corresident's clinical recording the police or if report. The investigation on abuse policy was requadministrator was the been reported to the administrator then stahim as abuse. A late entry progress 08/06/21 at 5:58 AM AM] documented, " confusionrequested arthritisnerve pill should be about the pill on the bedside thatsignature of DC	were asked if they were 10's allegations. The DON nade aware on Thursday, ent] after the incident of the leave the facility. The DON red up with the resident on ant didn't know anything rated that the resident later lay] and reported to them The DON stated that on the resident reported allegation to the resident it was reported to him and be located in the resident resident there was any type of the alleged abuse, and the resident had state Agency. The resident that it wasn't reported to note by the DON dated [created on: 08/07/21 10:02 .alert with resident threw resident	F	607			
	regarding the abuse a	anegations.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		495105	B. WING _			C 08/10/2021		
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	•	30/10/2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 607	Continued From pag		F	507				
	"Abuse/Investigative"A licensed nurse any and all reported patientabuse, neg safety by removing or otherNurse will and/or Director of N closely monitor and behavior and condit evaluate any injury. must notify the follor physicianresponsi or DON will notify th PresidentAn incide by a licensed nurse his/her must initiate hours of their knowledge of their know	e/Reporting" documented, will immediately respond to I allegations of staff to Ilectnurse will assure patient the accused employee, visitor notify the Administrator ursing immediatelynurse will document thoroughly the ion of the patient involved toall patients involvednurse wing: attending ible partyThe Administrator ieir Nurse Consultant or Vice ent report must be completedThe Administrator and/or and investigation within 24 edge of the alleged incident. cludes interviewing all staff ind indirectly)all patients histrator and/or his/her diately notify (within 24 hours) of the alleged incident to acy]immediately notify adult						
	statement from CNA #2 and a time line of documented, "I was 6:15 PM [Resident # food and how she was restaurant close to f start going towards	200 PM, the DON presented a A [certified nursing assistant] if events. The statement working on 08/5/21 around #110] was arguing about her vanted to go to [name of facility]. All of a sudden she the door, I explained to t she will set the alarm off and						
	she stated get the h front of the door to p incline fall. She yell	rell out of my way; I jumped in orevent her from taking a [sic] I'm getting out of this d from help [sic] everyone						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONST	TRUCTION	(X3) DATE	SURVEY PLETED
		495105	B. WING _			1	C 10/2021
	ROVIDER OR SUPPLIER	ILITATION CENTER		5615 SE	ADDRESS, CITY, STATE, ZIP CODE MINOLE AVENUE BURG, VA 24502	, 50.	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R 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 607	fight us and hit me; turn [you] in. I explayed didn't do anythin dated 08/10/21." The time line of ever follows: 08/07/21 [Saturday and reported pt called the night before couldn't get pain me. At 10:20 AM [Saturday and reported pt called the night before couldn't get pain me. At 10:20 AM [Saturday and reported pt called the night before couldn't get pain me. At 10:30 AM, DON Thursday 08/05/21 was on the med car CNA attempting to sthrough the double the other end of the resident witnessed that Resident #110	e door because was trying to She also stated I'm going to ained and the nurse told her ag wrongsignature of CNA #2 nts were documented as 10:17 AM] LPN #10 called ed 911 again; she [resident] ore [Friday] stating she eds. day August 7], [DON] notified d administrator of the abuse	F	607			
	being interviewed re allegations, there w other staff statemen no statements from was no no documer were reported to the	as no documentation of any ats [other than CNA #2]; and any other residents. There neutation that the allegations e state agency.					

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F 607	Continued From page implemented their about for Resident #110.	e 7 use policy and procedures	F 60	07			
F 609 SS=D	neglect, exploitation, must: §483.12(c)(1) Ensure involving abuse, neglimistreatment, includir source and misappropriate reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not rest the administrator of the officials (including to adult protective service for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the adesignated represent accordance with State Survey Agency, within incident, and if the all appropriate correctives.	violations (4) se to allegations of abuse, or mistreatment, the facility that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and the state state law provides the results of all administrator or his or her active and to other officials in the law, including to the State in 5 working days of the eged violation is verified exaction must be taken.	F 60	09			
		terview, staff interview,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495105	B. WING _			C 08/10/2021		
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		00/10/2021		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 609	and in the course of facility failed to repowithin 2 hours to the agency for one of 1 sample, Resident # Findings include: Resident #110 was 08/02/21. Diagnos but were not limited weakness, UTI [urinencephalopathy, R. and depression, moulcer of right foot. The most current M this resident was stand to person a 08/02/21 document oriented to person a 18/02/21 at 1:37 PM resident was alert a needs known. On 08/10/21 at 11:4 interviewed in her resident a few days after was hungry and was her roommate some stated that she were and that when she	w, facility document review f a complaint investigation, the ort an allegation of abuse e administrator or to the state 0 residents in the survey 110. admitted to the facility on es for Resident #110 included, I to: uncontrolled diabetes, nary tract infection], A [rheumatoid arthritis], anxiety orbid obesity, and diabetic foot	F	509				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			C 08/10/2021	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		56/10/2021	
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F 609	member [couldn't ide against the metal doc her ribs and that she days after that to get stated that the nurse asked why the nurse stated that she didn't Resident #110 stated nurse, but did not known had not seen that nurse. Resident #110 the incident. The resident's clinical from admission to pronotes documented, the object of the stated against the pronotes documented against then stated against the DONsignature of lie #10." 08/07/21 at 1:53 PM: Thursday of hitting her against the bed in her against the wall at LPN #10." 08/07/21 at 3:09 PM: resident's sister] in resident's sister] in resident's sister] in resident's sister states, often when she has a sister when she has a sister states.	she was pushed by a staff ntify the staff member] or/pole and it physically hurt went to the hospital a few checked out. Resident #110 told her to call 911. When didn't call, the resident know. If that she did report it to a low the nurse's name and rese since she reported it to anought it was the night of the large sent [08/10/21]. Progress the following: It: "Resident stated that a nursday [08/05/21] night had the bedrails of the bed, and the wallNurse reported to be censed practical nurse (LPN) "accused staff from the er. First she said they threw that the front doorsignature of the gards to pt [patient] going to	F 6	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495105	B. WING		C 08/10/2021
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	1 00/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 609	fracturessignature of 08/07/21 at 3:15 PM writer called to reside was beat up Thursda pole and I think my ril broken they just hurt have called the admin mail, and I have told anything. I just don't resident, no visual brinhave a bruise to left the was called and inform been having behavior staff and calling 911 facility at 9:45 going the #12." A hospital emergency dated 08/07/21 at 11: back to facility] docur stated on Thursday's foodescorted back into a metal doorha An X-ray dated 08/07 chest and ribs was redocumented, "no plabnormalitiesno eviright sided rib fracture. A progress note dated documented, "Patie hospital follow upin 08/07/21 for chest was redocumented."Patie hospital follow upin 08/07/21 for chest was redocumented."Patie hospital follow upin 08/07/21 for chest was	hing and X-ray showed no of LPN #11." documented, "At 0915 ant's roomresidentstated I y, the girl shoved me into a be might be broken well not on the insideI [resident] instrator and left him a voice everybody but no one will do trust yallWriter assessed uises to ribs, resident does apper forearmthe DON ned writer the resident has resthreatening staff, fighting aresident called 911 and left to ERsignature of LPN I room documentation report 55 AM [time of discharge nented, "in via EMSpt heleft the facilityto get with staffand was pushed ving right rib pain" I/21 of the resident's right eviewed. The report leural effusionno bony idence of acute displaced ess" d 08/9/21 and timed 2:37 PM ent evaluated today for emergency room on all contusion, alleged of rib painDirector of ware of the patient's	F 60	9	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER JRG HEALTH & REHAB	SILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	1 00.10.2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE COMPLETION		
F 609	On 08/10/21 at 3:45 and corporate nurse aware of Resident # stated that she was [date of alleged inci resident attempting stated that she follo Friday and the resident attempting stated that she follo Friday and the resident about it. The DON called the police [Frallegations of abuse morning of 08/07/27 this information and administrator and the administrator and the administrator stated midday on Saturday. The investigation or abuse policy was readministrator was the been reported to the administrator then shim as abuse. The facility's abuse "Abuse/Investigative"A licensed nurse any and all reported patientabuse, neg safety by removing or otherNurse will and/or Director of No closely monitor and behavior and condite evaluate any injury. must notify the follo	IP [family nurse practitioner]." 5 PM, the DON, administrator ever asked if they were asked if they and a legations. The DON wed up with the resident on lent didn't know anything stated that the resident later iday] and reported to them asked if they are not allegation to the are nurse consultant. The athat it was reported to him asked if this incident had asked if this incident had asked at this time. The nen asked if this incident had asked that it wasn't reported to allegations of staff to glectnurse will assure patient the accused employee, visitor notify the Administrator ursing immediatelynurse will document thoroughly the ion of the patient involved toall patients involvednurse	F 609				

DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G		COMPLETED	
	495105	B. WING _		08	C / 10/2021	
OVIDER OR SUPPLIER G HEALTH & REHABIL	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	1 00	10/2021	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE	
or DON will notify the PresidentAn incider by a licensed nurse nis/her must initiate a nours of their knowled. This investigation included (directly and nvolved (directly and nvolvedthe Administrate of their knowledge of their knowledge of name of state agency or otective services." There was no docume of abuse by Resident reported to the administrate of the administrate of the administrate of the state agency with \$\frac{4}{2}\$110. This is a complaint denvestigate/Prevent/CCFR(s): 483.12(c)(2)-	ir Nurse Consultant or Vice of report must be completed. The Administrator and/or and investigation within 24 dage of the alleged incident. Under interviewing all staff indirectly)all patients strator and/or his/her ately notify (within 24 hours) the alleged incident to allege to the State alleged incident was a that facility staff reported at the administrator or to alleged Violation and the correct Alleged Violation alleged Violation alleged to allegations of abuse, see to allegations of abuse,					
violations are thoroug §483.12(c)(3) Preven neglect, exploitation,	t further potential abuse, or mistreatment while the					
	Continued From page or DON will notify the PresidentAn incider by a licensed nurse inis/her must initiate a nours of their knowled (directly and nvolved (directly and nvolvedthe Administed graphs of state agency or both their knowledge of name of state agency or between the president of their knowledge of name of state agency or between the protective services." There was no document of abuse by Resident reported to the adminited protective services. There was no document of abuse by Resident reported to the adminited protective services. There was no document of abuse by Resident reported to the adminited protective services. There was no document of abuse by Resident reported to the adminited protective services. There was no document of abuse by Resident reported to the adminited protective services. There was no document of abuse by Resident reported to the adminited protective services. There was no document of abuse to the adminited protective services. There was no document of abuse by Resident reported to the adminited protective services. There was no document of abuse by Resident reported to the adminited protect and allegation of abuse the state agency with \$410. This is a complaint dependent of abuse the state agency with \$410. This is a complaint dependent of abuse the state agency with \$410. This is a complaint dependent of abuse the state agency with \$410. This is a complaint dependent of abuse the state agency with \$410. This is a complaint dependent of abuse the state agency with \$410. This is a complaint of abuse the state agency with \$410.	A95105 WIDER OR SUPPLIER G HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 or DON will notify their Nurse Consultant or Vice PresidentAn incident report must be completed by a licensed nurseThe Administrator and/or nis/her must initiate and investigation within 24 nours of their knowledge of the alleged incident. This investigation includes interviewing all staff involved (directly and indirectly)all patients involvedthe Administrator and/or his/her designee will immediately notify (within 24 hours) of their knowledge of the alleged incident to name of state agency]immediately notify adult protective services." There was no documentation that the allegation of abuse by Resident #110 were immediately reported to the administrator or the the State Agency. No further information or documentation was presented to evidence that facility staff reported an allegation of abuse to the administrator or to the state agency within 2 hours for Resident #110. This is a complaint deficiency. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(12)-(4) S483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	A BUILDIN 495105 B. WING	A BUILDING 495105 WIND WINDER OR SUPPLIER G HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE DE YPULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 or DON will notify their Nurse Consultant or Vice PresidentAn incident report must be completed by a licensed nurseThe Administrator and/or his/her must initiate and investigation within 24 nours of their knowledge of the alleged incident to name of state agency)Immediately notify adult protective services." There was no documentation that the allegation of abuse by Resident #110 were immediately eported to the administrator or to the state agency within 2 hours for abuse to the administrator or to the state agency within 2 hours for Resident #110 were immediately eported to allegate administrator or to the state agency within 2 hours for Resident #110. No further information or documentation was presented to evidence that facility staff reported an allegation of abuse to the administrator or to the state agency within 2 hours for Resident #110. Fefor State agency within 2 hours for Resident #110. Fefor State agency within 2 hours for Resident #110. Fefor State agency within 2 hours for Resident #110. Fefor State agency within 2 hours for Resident #110. Fefor State agency within 2 hours for Resident #110. Fefor State agency within 2 hours for Resident #110. Fefor State agency within 2 hours for Resident #110. Fefor State agency within 2 hours for Resident #110. Fefor State agency within 2 hours for Resident #110. Fefor State agency within 2 hours for Resident #110. Fefor State agency within 2 hours for Resident #10. Fefor State agency within 2 hours for Resident #10. Fefor State Agency within 2 hours for Resident #10. Fefor State Agency within 2 hours for Resident #10. Fefor State Agency within 2 hours for Resident #10. Fefor State Agency within 2 hours for Resident #10. Fefor State Agency within 2 hours for Resident #10. Fefor State Agency was a hours for Reside	A BUILDING 495105 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE SETS SEMINOLE AVENUE LYNCHBURG, VA 24502 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 or DON will notify their Nurse Consultant or Vice PresidentAn incident report must be completed by a licensed nurse The Administrator and/or sisher must initiate and investigation within 24 hours of their knowledge of the allegad incident. This investigation includes interviewing all staff rovolved. (directly and indirectly) all patients rovolved the Administrator and/or his/her designee will immediately notify (within 24 hours) of their knowledge of the allegation of abuse by Resident #110 were immediately proported to the administrator or to the teach and allegation of abuse by Resident #110 were immediately proported to the administrator or to the state agency. No further information or documentation was presented to evidence that facility staff reported an allegation of abuse to the administrator or to the state agency within 2 hours for Resident #110. This is a complaint deficiency, rivestigate/Prevent/Correct Alleged Violation DFR(s): 483.12(c)(2)-(4) 3483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. 3483.12(c)(3) Prevent further potential abuse, reglect, exploitation, or mistreatment while the	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495105	B. WING		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	08/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 610	Continued From page	÷ 13	F 61	0	
	designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on resident in clinical record review, and in the course of a facility failed to thorou allegation of abuse fo survey sample, Residence.	administrator or his or her ative and to other officials in the law, including to the State of 5 working days of the eged violation is verified action must be taken. It is not met as evidenced terview, staff interview, a facility document review or complaint investigation, the lighly investigate and or one of 10 residents in the lent #110. Resident #110 mer and bruised her ribs, the implete a thorough			
	Findings include:				
	08/02/21. Diagnoses but were not limited to weakness, UTI [urina encephalopathy, RA]	dmitted to the facility on for Resident #110 included, or uncontrolled diabetes, ry tract infection], (rheumatoid arthritis], anxiety old obesity, and diabetic foot			
	The most current MD this resident was still	S [minimum data set] for in progress.			
		ission assessment dated I the resident as alert and d intact for cognition.			
	The resident's admiss 08/02/21 at 1:37 PM of	sion nursing note dated documented that the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			C 8/10/2021	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		0/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 610	needs known. On 08/10/21 at 11:45 interviewed in her root that a few days after was hungry and was her roommate somet stated that she went and that when she op sounded an alarm, and it, staff members can that she couldn't leav during that process, smember [couldn't ideagainst the metal door her ribs and that she days after that to get stated that the nurse asked why the nurse stated that she didn't Resident #110 stated nurse, but did not know had not seen that nur her. Resident #110 the incident. The resident's clinical	AM, Resident #110 was om. Resident #110 stated she was admitted that she going to walk to get her and hing to eat. Resident #110 to a side door of the facility bened the door it must have and although she didn't hear the running at her and yelling the resident stated that she was pushed by a staff intify the staff member] or/pole and it physically hurt went to the hospital a few checked out. Resident #110 told her to call 911. When didn't call, the resident know. If that she did report it to a ow the nurse's name and rese since she reported it to nought it was the night of the	F 6	10			
	staff member from The threw her up against then stated against the	f: "Resident stated that a nursday [08/05/21] night had the bedrails of the bed, and ne wallNurse reported to censed practical nurse (LPN)					

) DATE SURVEY COMPLETED			
		495105	B. WING _			C 08/10/2021
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		00/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 610	Thursday of hitting in her against the bed her against the wall LPN #10." 08/07/21 at 3:09 PM resident's sister] in rhospital of reports of [complained of] bruin in ribssister states often when she has infections'ER called they did not find any fracturessignature 08/07/21 at 3:15 PM writer called to resid was beat up Thursd pole and I think my broken they just hur have called the adminal, and I have told anything. I just don' resident, no visual bhave a bruise to left was called and infor been having behavior staff and calling 911 facility at 9:45 going #12." Resident #110's clin behaviors of threater dated 08/07/21 at 1:	fi: "accused staff from her. First she said they threw rails, and then said they threw at the front doorsignature of fi: "spoke with [name of regards to pt [patient] going to feing hit by staff, c/o sing to left forearm and pain of she becomes confused a lot of pain and has bladdered to send back and stated of thing and X-ray showed no for LPN #11." If documented, "At 0915 lent's roomresidentstated I lay, the girl shoved me into a ribs might be broken well not to on the insideI [resident] hinistrator and left him a voice of trust yallWriter assessed bruises to ribs, resident does upper forearmthe DON med writer the resident has bors threatening staff, fightingresident called 911 and left to ERsignature of LPN ical records did not document ining and/or fighting staff.	F6	310		
	, , , , , , , , , , , , , , , , , , ,	ımented, "in via EMSpt sheleft the facilityto get				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPI IDENTIFICATION N		LTIPLE CONSTRUCTION DING	(X3) DATE COMF	SURVEY PLETED
4951	05 B. WING	S		C / 10/2021
NAME OF PROVIDER OR SUPPLIER LYNCHBURG HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		
(X4) ID SUMMARY STATEMENT OF DEFICIENT PREFIX (EACH DEFICIENCY MUST BE PRECEDED TAG REGULATORY OR LSC IDENTIFYING INFOR	BY FULL PREF	FIX (EACH CORRECTIV G CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 610 Continued From page 16 foodescorted back with staffand was into a metal doorhaving right rib pain An X-ray dated 08/07/21 of the resident chest and ribs was reviewed. The report documented, "no pleural effusionno abnormalitiesno evidence of acute dis right sided rib fractures" A progress note dated 08/9/21 and time documented, "Patient evaluated today hospital follow upin emergency room of 08/07/21 for chest wall contusion, allege assaultcomplaining of rib painDirect nursing [DON] was aware of the patient' allegation towards assault and followed upsignature of FNP [family nurse practice of FNP [family nurse practice of FNP [family nurse practice of Alleged incident] after the incide resident attempting to leave the facility. stated that she was made aware on The [date of alleged incident] after the incide resident attempting to leave the facility. stated that she followed up with the resident attempting to leave the facility stated that she followed up with the resident attempting to leave the facility. Stated that she followed up with the resident allegations of abuse. The DON stated the morning of 08/07/21 [Saturday] she ther this information and allegation to the administrator and the nurse consultant. administrator and the nurse consultant. administrator stated that it was reported midday on Saturday. The investigation on the alleged abuse, abuse policy was requested at this time administrator was then asked if this incidentification.	s pushed " 's right rt bony placed d 2:37 PM r for on ed or of 's stitioner]." inistrator were The DON ursday, ent of the The DON dent on thing ent later o them hat on the n reported The to him and the . The	610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	3	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495105	B. WING				C 10/2021
NAME OF PROVIDER OR SUI		ITATION CENTER	,	5	STREET ADDRESS, CITY, STATE, ZIP CODE 615 SEMINOLE AVENUE LYNCHBURG, VA 24502	, 00.	
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A late entry 08/06/21 at AM] docume confusionI arthritisne the pill on the thatsignat of resident's interview was regarding the The facility's "Abuse/Inve "A license any and all a patientabus safety by re or otherNu and/or Direct closely monbehavior an evaluate any must notify a physicianr or DON will Presidentby a license his/her must hours of the This investig involved (direct involved (direct involvedth designee with of their known arthritis	progress 5:58 AM ented, " requested allegation as conducted allegation as conducted allegation as conducted allegation as conducted and condition and do con	note by the DON dated [created on: 08/07/21 10:02 .alert with I pain meds for rheumatoid e requestedresident threw e table[stating] I don't want N." There was not mention ns of abuse or that an eted with the resident fallegations.	F	610			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495105	B. WING		08/10/2021
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	1 00/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 610	Continued From pa	ge 18	F 6	10	
	statement from CNA#2 and a time line of documented, "I was 6:15 PM [Resident # food and how she was restaurant close to fistert going towards [Resident #110] that she stated get the historian fall. She yell damn place. I yelled came running to the fight us and hit me; turn [you] in. I explained we didn't do anythin dated 08/10/21." The time line of ever follows: 08/07/21 [Saturday and reported pt called the night before couldn't get pain me. At 10:20 AM [Saturday and reported pt called the night before couldn't get pain me. At 10:30 AM, DON 6 Thursday 08/05/21 awas on the med car CNA attempting to significant the other end of the	day August 7], [DON] notified d administrator of the abuse			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE S COMPL	
		495105	B. WING _			08/1	; 0/2021
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 635 SS=D	out of the door and signing crazy. There was no documbeing interviewed regallegations. There was other staff statements were no statements there was no other in investigation than who No further information presented to evidence a thorough investigate abuse by Resident # This is a complaint of Admission Physician CFR(s): 483.20(a) §483.20(a) Admission At the time each resimust have physician immediate care. This REQUIREMENT by: Based on resident in clinical record review complaint investigation ensure admission or and treatment of a diffor the one of 10 resimples include:	vas fighting staff trying to get tated that she [resident] was nentation of Resident #110 garding the above as no documentation of any is [other than CNA #2. There from any other residents, and information for the nat was presented above. In or documentation was be that facility staff completed the tion for an allegation of 110. Deficiency. Orders for Immediate Care	F 6				
		annua to the racinty on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED				
		495105	B. WING _				C 10/2021
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, 4 5615 SEMINOLE AV LYNCHBURG, VA		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 635	08/02/21. Diagnoses but were not limited to weakness, UTI [urinal encephalopathy, RA] and depression, mortulcer of right foot. The most current MD this resident was still Resident #110's adm 08/02/21 documented oriented to person and The resident's admiss 08/02/21 at 1:37 PM resident was alert and needs known. On 08/10/21 at 1:37 PM resident was alert and needs known. On 08/10/21 at 11:45 conducted with Resident stated that selected the selected foot ulustaff had only change she had been there, physician's order was Resident #110 clinical There was a physicial mupirocin and adapticallusing of the right of place with foam dressed medipore tape daily effoot ulcer [Order Date 08/07/21]." This treat days after admission	for Resident #110 included, or uncontrolled diabetes, ry tract infection], [rheumatoid arthritis], anxiety old obesity, and diabetic foot. S [minimum data set] for in progress. Ission assessment dated di the resident as alert and di intact for cognition. Ission nursing note dated documented that the di oriented and able to make. AM, an interview was lent #110 in her room. The he was about a week ago he exact day] and that she car on her right foot and that ad the dressing once since. The resident stated that the story wound care once a day. Il records were reviewed. In order for, "right foot, apply	F	535			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495105	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	00	3/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 635	Further review of the revealed discharge ir [prior to admission to documented, "Disch Documentation08/0 right foot Appreciate follow up with them a instructionsdischarg care nursing facilityf wound care clinicw. changedaily, right fadaptic to the hemori foot and secure in plakerlix secure with me recommendations: with documented, "she I right foot that is stablicare servicessignated The hospital discharge regarding Resident # were not implemented facility. The order for ordered until 08/05/2 admission] and the truntil 08/07/21 [five date of the decords] were review. The order was added 08/05/21 11:45 AM], 08/07/21, but the trea 08/08/21 according to The resident's base literation.	resident's clinical records astructions from the hospital the facility] that harge 12/21diabetic foot ulcer of wound care input. She will as an outpatientdischarge ge patient 08/02/21skilled follow up1 to 2 weeks, bound care dressing pot, apply mupirocin and thagic callusing of the right ace with foam dressing or dipore tapefollow up with house MD [medical hab" PM, an MD note has a chronic wound on her eaShe is admitted for skilled ure of MD." ge orders/instructions 110's right diabetic foot ulcer d upon admission to the care of this wound was not 1 [three days after eatment was not initiated by after admission]. [treatment administration and for the month of August. It to the TAR [order date: the start date was added for atment was not done until	F 63				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495105	B. WING			C 08/10/2021	
	ROVIDER OR SUPPLIER RG HEALTH & REHABIL	LITATION CENTER	•	56	TREET ADDRESS, CITY, STATE, ZIP CODE 615 SEMINOLE AVENUE YNCHBURG, VA 24502		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 635 F 655 SS=D	(DON) was interviewed information. The DOI know why this order was date was added for the No further information provided prior to the eat 6:45 PM to evidence immediate care order foot ulcer that was prefacility. This is a complaint de Baseline Care Plan CFR(s): 483.21(a)(1)- §483.21 Comprehense	PM, the director of nursing ed regarding the above N stated that she did not was not added on admission added on the 5th that a start ne 7th. In or documentation was exit conference on 08/10/21 ce that this resident had as for the care of a diabetic essent upon admission to the efficiency.		635			
	implement a baseline that includes the instress effective and personthat meet professiona. The baseline care plate (i) Be developed with admission. (ii) Include the minimum necessary to properly including, but not limit	cility must develop and e care plan for each resident ructions needed to provide centered care of the resident al standards of quality care. an must- in 48 hours of a resident's um healthcare information y care for a resident ted to- d on admission orders.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUC	TION		PLETED
		495105	B. WING				C 10/2021
	ROVIDER OR SUPPLIER	LITATION CENTER		5615 SEMINO	RESS, CITY, STATE, ZIP CODE DLE AVENUE G, VA 24502	1 33/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- '	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD E OSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From pag	e 23	F	355			
	(E) Social services.(F) PASARR recomm	nendation, if applicable.					
	care plan if the comp (i) Is developed with admission. (ii) Meets the require	plan in place of the baseline plan in place of the baseline prehensive care plan- plan in 48 hours of the resident's ements set forth in paragraph accepting paragraph (b)(2)(i) of					
	resident and their re of the baseline care limited to: (i) The initial goals of	acility must provide the presentative with a summary plan that includes but is not of the resident. e resident's medications and					
	on behalf of the facil (iv) Any updated info of the comprehensiv This REQUIREMEN	facility and personnel acting					
	clinical record review complaint investigati develop a baseline of services related to a	nterview, staff interview, and in the course of a on, the facility failed to eare plan for care and diabetic foot ulcer for one of urvey sample, Resident #110.					
	Findings include:						
	08/02/21. Diagnose	admitted to the facility on s for Resident #110 included, to: uncontrolled diabetes, ary tract infection],					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		NSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/10/2021	
		495105	B. WING				
NAME OF PROVIDER OR SUPPLIER					ET ADDRESS, CITY, STATE, ZIP CODE	1 06/	10/2021
LYNCHBURG HEALTH & REHABILITATION CENTER				5615 SEMINOLE AVENUE 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLETION	
F 655	Continued From page 24		F 6	355			
		rheumatoid arthritis], anxiety oid obesity, and diabetic foot					
	The most current MDS [minimum data set] for this resident was still in progress.						
	Resident #110's admission assessment dated 08/02/21 documented the resident as alert and oriented to person and intact for cognition.						
	08/02/21 at 1:37 PM	sion nursing note dated documented that the d oriented and able to make					
	conducted with Resideresident stated that stated that stated that stated that stated that stated that a diabetic foot uld staff had only change she had been there.	AM, an interview was ent #110 in her room. The ne was about a week ago ne exact day] and that she cer on her right foot and that d the dressing once since The resident stated that the for wound care once a day.					
	There was a physicia mupirocin and adapticallusing of the right f place with foam dress medipore tape daily e foot ulcer [Order Date 08/07/21]." This treat days after admission	I records were reviewed. In order for, "right foot, apply to to the hemorrhagic foot wound and secure in sing or kerlix secured with every day shift for diabetic e: 08/05/21] [Start Date: Imment was ordered three and was not scheduled to we days after admission].					
		resident's clinical records structions from the hospital the facility] that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C 08/10/2021	
		495105 B. WIN					
NAME OF PROVIDER OR SUPPLIER LYNCHBURG HEALTH & REHABILITATION CENTER				5615	EET ADDRESS, CITY, STATE, ZIP CODE SEMINOLE AVENUE CHBURG, VA 24502	1 00/	10/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	655			