STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. BUILDING _____ B. WING _____	C 08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 06/29/21 through 07/01/21, was conducted on 08/10/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. One complaint was investigated during the survey. VA00052776 and was substantiated with deficient practice. The census in this 180 certified bed facility was 156 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents 101 through 110).	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility document review and in the course of a complaint investigation, the facility failed to implement abuse policies and procedures for investigating and reporting abuse for one of 10 residents in the survey sample, Resident #110.	F 607		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/07/2021

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F 607	Continued From page 1	F 607		

Findings include:

Resident #110 was admitted to the facility on 08/02/21. Diagnoses for Resident #110 included, but were not limited to: uncontrolled diabetes, weakness, UTI [urinary tract infection], encephalopathy, RA [rheumatoid arthritis], anxiety and depression, morbid obesity, and diabetic foot ulcer of right 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.

The resident's admission nursing note dated 08/02/21 at 1:37 PM documented that the resident was alert and oriented and able to make needs known.

On 08/10/21 at 11:45 AM, Resident #110 was interviewed in her room. Resident #110 stated that a few days after she was admitted that she was hungry and was going to walk to get her and her roommate something to eat. Resident #110 stated that she went to a side door of the facility and that when she opened the door it must have sounded an alarm, and although she didn't hear it, staff members came running at her and yelling that she couldn't leave. The resident stated that during that process, she was pushed by a staff member [couldn't identify the staff member] against the metal door/pole and it physically hurt her ribs and that she went to the hospital a few days after that to get checked out. Resident #110 stated that the nurse told her to call 911. When

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	495105	A. BUILDING _____ B. WING _____	C 08/10/2021

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F 607	Continued From page 2	F 607		

asked why the nurse didn't call, the resident stated that she didn't know.

Resident #110 stated that she did report it to a nurse, but did not know the nurse's name and had not seen that nurse since she reported it to her. Resident #110 thought it was the night of the incident.

The resident's clinical records were then reviewed from admission to present [08/10/21]. Progress notes documented, the following:

08/07/21 at 10:00 AM: "Resident stated that a staff member from Thursday [08/05/21] night had threw her up against the bedrails of the bed, and then stated against the wall...Nurse reported to DON...signature of licensed practical nurse (LPN) #10."

08/07/21 at 1:53 PM: "...accused staff from Thursday of hitting her. First she said they threw her against the bed rails, and then said they threw her against the wall at the front door...signature of LPN #10."

08/07/21 at 3:09 PM: "...spoke with [name of resident's sister] in regards to pt [patient] going to hospital of reports of being hit by staff, c/o [complained of] bruising to left forearm and pain in ribs...sister states, 'she becomes confused often when she has a lot of pain and has bladder infections'...ER called to send back and stated they did not find anything and X-ray showed no fractures...signature of LPN #11."

08/07/21 at 3:15 PM documented, "...At 0915 writer called to resident's room...resident...stated I was beat up Thursday, the girl shoved me into a

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F 607	Continued From page 3	F 607		

pole and I think my ribs might be broken well not broken they just hurt on the inside...I [resident] have called the administrator and left him a voice mail, and I have told everybody but no one will do anything. I just don't trust yall...Writer assessed resident, no visual bruises to ribs, resident does have a bruise to left upper forearm...the DON was called and informed writer the resident has been having behaviors threatening staff, fighting staff and calling 911...resident called 911 and left facility at 9:45 going to ER...signature of LPN #12."

Resident #110's clinical records did not document behaviors of threatening and/or fighting staff.

A hospital emergency room documentation report dated 08/07/21 at 11:55 AM [time of discharge back to facility] documented, "...in via EMS...pt stated on Thursday she...left the facility...to get food...escorted back with staff...and was pushed into a metal door...having right rib pain..."

An X-ray dated 08/07/21 of the resident's right chest and ribs was reviewed. The report documented, "...no pleural effusion...no bony abnormalities...no evidence of acute displaced right sided rib fractures..."

A progress note dated 08/9/21 and timed 2:37 PM documented, "...Patient evaluated today for hospital follow up...in emergency room on 08/07/21 for chest wall contusion, alleged assault...complaining of rib pain...Director of nursing [DON] was aware of the patient's allegation towards assault and followed up...signature of FNP [family nurse practitioner]."

On 08/10/21 at 3:45 PM, the DON, administrator

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F 607	Continued From page 4	F 607		

and corporate nurse were asked if they were aware of Resident #110's allegations. The DON stated that she was made aware on Thursday, [date of alleged incident] after the incident of the resident attempting to leave the facility. The DON stated that she followed up with the resident on Friday and the resident didn't know anything about it. The DON stated that the resident later called the police [Friday] and reported to them allegations of abuse. The DON stated that on the morning of 08/07/21 [Saturday] she then reported this information and allegation to the administrator and the nurse consultant. The administrator stated that it was reported to him midday on Saturday.

No documentation could be located in the resident's clinical records regarding the resident calling the police or if there was any type of report.

The investigation on the alleged abuse, and the abuse policy was requested at this time. The administrator was then asked if this incident had been reported to the State Agency. The administrator then stated that it wasn't reported to him as abuse.

A late entry progress note by the DON dated 08/06/21 at 5:58 AM [created on: 08/07/21 10:02 AM] documented, "....alert with confusion...requested pain meds for rheumatoid arthritis...nerve pill she requested...resident threw the pill on the bedside table...[stating] I don't want that...signature of DON." There was not mention of resident's allegations of abuse or that an interview was conducted with the resident regarding the abuse allegations.

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F 607	Continued From page 5	F 607		

The facility's abuse policy titled, "Abuse/Investigative/Reporting" documented, "...A licensed nurse will immediately respond to any and all reported allegations of staff to patient...abuse, neglect...nurse will assure patient safety by removing the accused employee, visitor or other...Nurse will notify the Administrator and/or Director of Nursing immediately...nurse will closely monitor and document thoroughly the behavior and condition of the patient involved to evaluate any injury...all patients involved ...nurse must notify the following: attending physician...responsible party...The Administrator or DON will notify their Nurse Consultant or Vice President...An incident report must be completed by a licensed nurse...The Administrator and/or his/her must initiate and investigation within 24 hours of their knowledge of the alleged incident. This investigation includes interviewing all staff involved (directly and indirectly)...all patients involved...the 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."

At approximately 5:00 PM, the DON presented a statement from CNA [certified nursing assistant] #2 and a time line of events. The statement documented, "I was working on 08/5/21 around 6:15 PM [Resident #110] was arguing about her food and how she wanted to go to [name of restaurant close to facility]. All of a sudden she start going towards the door, I explained to [Resident #110] that she will set the alarm off and she stated get the hell out of my way; I jumped in front of the door to prevent her from taking a incline fall. She yell [sic] I'm getting out of this damn place. I yelled from help [sic] everyone

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F 607	Continued From page 6	F 607		

came running to the door because was trying to fight us and hit me; She also stated I'm going to turn [you] in. I explained and the nurse told her we didn't do anything wrong...signature of CNA #2 dated 08/10/21."

The time line of events were documented as follows:

08/07/21 [Saturday 10:17 AM] LPN #10 called and reported pt called 911 again; she [resident] called the night before [Friday] stating she couldn't get pain meds.

At 10:20 AM [Saturday August 7], [DON] notified nurse consultant and administrator of the abuse allegation by Resident #110.

At 10:30 AM, DON called the nurse working on Thursday 08/05/21 and the nurse stated that she was on the med cart when she witnessed the CNA attempting to stop the resident from going through the double doors in the back. She was at the other end of the hallway and that another resident witnessed the whole thing and stated that Resident #110 was fighting staff trying to get out of the door and stated that she [resident] was going crazy.

There was no documentation of the resident being interviewed regarding the above allegations, there was no documentation of any other staff statements [other than CNA #2]; and no statements from any other residents. There was no no documentation that the allegations were reported to the state agency.

No further information and/or documentation was presented to evidence that facility staff

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F 607	Continued From page 7 implemented their abuse policy and procedures for Resident #110. This is a complaint deficiency.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview,	F 609		

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F 609	Continued From page 8	F 609		

clinical record review, facility document review and in the course of a complaint investigation, the facility failed to report an allegation of abuse within 2 hours to the administrator or to the state agency for one of 10 residents in the survey sample, Resident #110.

Findings include:

Resident #110 was admitted to the facility on 08/02/21. Diagnoses for Resident #110 included, but were not limited to: uncontrolled diabetes, weakness, UTI [urinary tract infection], encephalopathy, RA [rheumatoid arthritis], anxiety and depression, morbid obesity, and diabetic foot ulcer of right 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.

The resident's admission nursing note dated 08/02/21 at 1:37 PM documented that the resident was alert and oriented and able to make needs known.

On 08/10/21 at 11:45 AM, Resident #110 was interviewed in her room. Resident #110 stated that a few days after she was admitted that she was hungry and was going to walk to get her and her roommate something to eat. Resident #110 stated that she went to a side door of the facility and that when she opened the door it must have sounded an alarm, and although she didn't hear it, staff members came running at her and yelling that she couldn't leave. The resident stated that

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	495105	A. BUILDING _____ B. WING _____	C 08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 9	F 609		

during that process, she was pushed by a staff member [couldn't identify the staff member] against the metal door/pole and it physically hurt her ribs and that she went to the hospital a few days after that to get checked out. Resident #110 stated that the nurse told her to call 911. When asked why the nurse didn't call, the resident stated that she didn't know.

Resident #110 stated that she did report it to a nurse, but did not know the nurse's name and had not seen that nurse since she reported it to her. Resident #110 thought it was the night of the incident.

The resident's clinical records were then reviewed from admission to present [08/10/21]. Progress notes documented, the following:

08/07/21 at 10:00 AM: "Resident stated that a staff member from Thursday [08/05/21] night had threw her up against the bedrails of the bed, and then stated against the wall...Nurse reported to DON...signature of licensed practical nurse (LPN) #10."

08/07/21 at 1:53 PM: "...accused staff from Thursday of hitting her. First she said they threw her against the bed rails, and then said they threw her against the wall at the front door...signature of LPN #10."

08/07/21 at 3:09 PM: "...spoke with [name of resident's sister] in regards to pt [patient] going to hospital of reports of being hit by staff, c/o [complained of] bruising to left forearm and pain in ribs...sister states, 'she becomes confused often when she has a lot of pain and has bladder infections'...ER called to send back and stated

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F 609	Continued From page 10	F 609		

they did not find anything and X-ray showed no fractures...signature of LPN #11."

08/07/21 at 3:15 PM documented, "...At 0915 writer called to resident's room...resident...stated I was beat up Thursday, the girl shoved me into a pole and I think my ribs might be broken well not broken they just hurt on the inside...I [resident] have called the administrator and left him a voice mail, and I have told everybody but no one will do anything. I just don't trust yall...Writer assessed resident, no visual bruises to ribs, resident does have a bruise to left upper forearm...the DON was called and informed writer the resident has been having behaviors threatening staff, fighting staff and calling 911...resident called 911 and left facility at 9:45 going to ER...signature of LPN #12."

A hospital emergency room documentation report dated 08/07/21 at 11:55 AM [time of discharge back to facility] documented, "...in via EMS...pt stated on Thursday she...left the facility...to get food...escorted back with staff...and was pushed into a metal door...having right rib pain..."

An X-ray dated 08/07/21 of the resident's right chest and ribs was reviewed. The report documented, "...no pleural effusion...no bony abnormalities...no evidence of acute displaced right sided rib fractures..."

A progress note dated 08/9/21 and timed 2:37 PM documented, "...Patient evaluated today for hospital follow up...in emergency room on 08/07/21 for chest wall contusion, alleged assault...complaining of rib pain...Director of nursing [DON] was aware of the patient's allegation towards assault and followed

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F 609	Continued From page 11	F 609		

up...signature of FNP [family nurse practitioner]."

On 08/10/21 at 3:45 PM, the DON, administrator and corporate nurse were asked if they were aware of Resident #110's allegations. The DON stated that she was made aware on Thursday, [date of alleged incident] after the incident of the resident attempting to leave the facility. The DON stated that she followed up with the resident on Friday and the resident didn't know anything about it. The DON stated that the resident later called the police [Friday] and reported to them allegations of abuse. The DON stated that on the morning of 08/07/21 [Saturday] she then reported this information and allegation to the administrator and the nurse consultant. The administrator stated that it was reported to him midday on Saturday.

The investigation on the alleged abuse, and the abuse policy was requested at this time. The administrator was then asked if this incident had been reported to the State Agency. The administrator then stated that it wasn't reported to him as abuse.

The facility's abuse policy titled, "Abuse/Investigative/Reporting" documented, "...A licensed nurse will immediately respond to any and all reported allegations of staff to patient...abuse, neglect...nurse will assure patient safety by removing the accused employee, visitor or other...Nurse will notify the Administrator and/or Director of Nursing immediately...nurse will closely monitor and document thoroughly the behavior and condition of the patient involved to evaluate any injury...all patients involved...nurse must notify the following: attending physician...responsible party...The Administrator

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F 609	Continued From page 12 or DON will notify their Nurse Consultant or Vice President...An incident report must be completed by a licensed nurse...The Administrator and/or his/her must initiate and investigation within 24 hours of their knowledge of the alleged incident. This investigation includes interviewing all staff involved (directly and indirectly)...all patients involved...the 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.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		

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	495105	A. BUILDING _____ B. WING _____	C 08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 13	F 610		

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, clinical record review, facility document review and in the course of a complaint investigation, the facility failed to thoroughly investigate and allegation of abuse for one of 10 residents in the survey sample, Resident #110. Resident #110 alleged staff pushed her and bruised her ribs, the facility staff did not complete a thorough investigation related to the alleged abuse.

Findings include:

Resident #110 was admitted to the facility on 08/02/21. Diagnoses for Resident #110 included, but were not limited to: uncontrolled diabetes, weakness, UTI [urinary tract infection], encephalopathy, RA [rheumatoid arthritis], anxiety and depression, morbid obesity, and diabetic foot ulcer of right 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.

The resident's admission nursing note dated 08/02/21 at 1:37 PM documented that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 610	Continued From page 14	F 610		

resident was alert and oriented and able to make needs known.

On 08/10/21 at 11:45 AM, Resident #110 was interviewed in her room. Resident #110 stated that a few days after she was admitted that she was hungry and was going to walk to get her and her roommate something to eat. Resident #110 stated that she went to a side door of the facility and that when she opened the door it must have sounded an alarm, and although she didn't hear it, staff members came running at her and yelling that she couldn't leave. The resident stated that during that process, she was pushed by a staff member [couldn't identify the staff member] against the metal door/pole and it physically hurt her ribs and that she went to the hospital a few days after that to get checked out. Resident #110 stated that the nurse told her to call 911. When asked why the nurse didn't call, the resident stated that she didn't know.

Resident #110 stated that she did report it to a nurse, but did not know the nurse's name and had not seen that nurse since she reported it to her. Resident #110 thought it was the night of the incident.

The resident's clinical records were then reviewed from admission to present [08/10/21]. Progress notes documented, the following:

08/07/21 at 10:00 AM: "Resident stated that a staff member from Thursday [08/05/21] night had threw her up against the bedrails of the bed, and then stated against the wall...Nurse reported to DON...signature of licensed practical nurse (LPN) #10."

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	495105	A. BUILDING _____ B. WING _____	C 08/10/2021

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F 610	Continued From page 15	F 610		

08/07/21 at 1:53 PM: "...accused staff from Thursday of hitting her. First she said they threw her against the bed rails, and then said they threw her against the wall at the front door...signature of LPN #10."

08/07/21 at 3:09 PM: "...spoke with [name of resident's sister] in regards to pt [patient] going to hospital of reports of being hit by staff, c/o [complained of] bruising to left forearm and pain in ribs...sister states, 'she becomes confused often when she has a lot of pain and has bladder infections'...ER called to send back and stated they did not find anything and X-ray showed no fractures...signature of LPN #11."

08/07/21 at 3:15 PM documented, "...At 0915 writer called to resident's room...resident...stated I was beat up Thursday, the girl shoved me into a pole and I think my ribs might be broken well not broken they just hurt on the inside...I [resident] have called the administrator and left him a voice mail, and I have told everybody but no one will do anything. I just don't trust yall...Writer assessed resident, no visual bruises to ribs, resident does have a bruise to left upper forearm...the DON was called and informed writer the resident has been having behaviors threatening staff, fighting staff and calling 911...resident called 911 and left facility at 9:45 going to ER...signature of LPN #12."

Resident #110's clinical records did not document behaviors of threatening and/or fighting staff.

A hospital emergency room documentation report dated 08/07/21 at 11:55 AM [time of discharge back to facility] documented, "...in via EMS...pt stated on Thursday she...left the facility...to get

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F 610	Continued From page 16	F 610		

food...escorted back with staff...and was pushed into a metal door...having right rib pain..."

An X-ray dated 08/07/21 of the resident's right chest and ribs was reviewed. The report documented, "...no pleural effusion...no bony abnormalities...no evidence of acute displaced right sided rib fractures..."

A progress note dated 08/9/21 and timed 2:37 PM documented, "...Patient evaluated today for hospital follow up...in emergency room on 08/07/21 for chest wall contusion, alleged assault...complaining of rib pain...Director of nursing [DON] was aware of the patient's allegation towards assault and followed up...signature of FNP [family nurse practitioner]."

On 08/10/21 at 3:45 PM, the DON, administrator and corporate nurse were asked if they were aware of Resident #110's allegations. The DON stated that she was made aware on Thursday, [date of alleged incident] after the incident of the resident attempting to leave the facility. The DON stated that she followed up with the resident on Friday and the resident didn't know anything about it. The DON stated that the resident later called the police [Friday] and reported to them allegations of abuse. The DON stated that on the morning of 08/07/21 [Saturday] she then reported this information and allegation to the administrator and the nurse consultant. The administrator stated that it was reported to him midday on Saturday.

The investigation on the alleged abuse, and the abuse policy was requested at this time. The administrator was then asked if this incident had been reported to the State Agency. The

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F 610	Continued From page 17	F 610		

administrator then stated that it wasn't reported to him as abuse.

A late entry progress note by the DON dated 08/06/21 at 5:58 AM [created on: 08/07/21 10:02 AM] documented, "....alert with confusion...requested pain meds for rheumatoid arthritis...nerve pill she requested...resident threw the pill on the bedside table...[stating] I don't want that...signature of DON." There was not mention of resident's allegations of abuse or that an interview was conducted with the resident regarding the abuse allegations.

The facility's abuse policy titled, "Abuse/Investigative/Reporting" documented, "...A licensed nurse will immediately respond to any and all reported allegations of staff to patient...abuse, neglect...nurse will assure patient safety by removing the accused employee, visitor or other...Nurse will notify the Administrator and/or Director of Nursing immediately...nurse will closely monitor and document thoroughly the behavior and condition of the patient involved to evaluate any injury...all patients involved ...nurse must notify the following: attending physician...responsible party...The Administrator or DON will notify their Nurse Consultant or Vice President...An incident report must be completed by a licensed nurse...The Administrator and/or his/her must initiate and investigation within 24 hours of their knowledge of the alleged incident. This investigation includes interviewing all staff involved (directly and indirectly)...all patients involved...the 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."

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F 610	Continued From page 18	F 610		

At approximately 5:00 PM, the DON presented a statement from CNA [certified nursing assistant] #2 and a time line of events. The statement documented, "I was working on 08/5/21 around 6:15 PM [Resident #110] was arguing about her food and how she wanted to go to [name of restaurant close to facility]. All of a sudden she start going towards the door, I explained to [Resident #110] that she will set the alarm off and she stated get the hell out of my way; I jumped in front of the door to prevent her from taking a incline fall. She yell [sic] I'm getting out of this damn place. I yelled from help [sic] everyone came running to the door because was trying to fight us and hit me; She also stated I'm going to turn [you] in. I explained and the nurse told her we didn't do anything wrong...signature of CNA #2 dated 08/10/21."

The time line of events were documented as follows:

08/07/21 [Saturday 10:17 AM] LPN #10 called and reported pt called 911 again; she [resident] called the night before [Friday] stating she couldn't get pain meds.

At 10:20 AM [Saturday August 7], [DON] notified nurse consultant and administrator of the abuse allegation by Resident #110.

At 10:30 AM, DON called the nurse working on Thursday 08/05/21 and the nurse stated that she was on the med cart when she witnessed the CNA attempting to stop the resident from going through the double doors in the back. She was at the other end of the hallway and that another resident witnessed the whole thing and stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. BUILDING _____ B. WING _____	C 08/10/2021

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F 610	Continued From page 19 that Resident #110 was fighting staff trying to get out of the door and stated that she [resident] was going crazy. There was no documentation of Resident #110 being interviewed regarding the above allegations. There was no documentation of any other staff statements [other than CNA #2. There were no statements from any other residents, and there was no other information for the investigation than what was presented above. No further information or documentation was presented to evidence that facility staff completed a thorough investigation for an allegation of abuse by Resident #110. This is a complaint deficiency.	F 610		
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and in the course of a complaint investigation, the facility failed to ensure admission orders for the immediate care and treatment of a diabetic ulcer were obtained for the one of 10 residents in the survey sample, Resident #110. Findings include: Resident #110 was admitted to the facility on	F 635		

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	495105	A. BUILDING _____ B. WING _____	C 08/10/2021

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F 635	Continued From page 20	F 635		

08/02/21. Diagnoses for Resident #110 included, but were not limited to: uncontrolled diabetes, weakness, UTI [urinary tract infection], encephalopathy, RA [rheumatoid arthritis], anxiety and depression, morbid obesity, and diabetic foot ulcer of right 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.

The resident's admission nursing note dated 08/02/21 at 1:37 PM documented that the resident was alert and oriented and able to make needs known.

On 08/10/21 at 11:45 AM, an interview was conducted with Resident #110 in her room. The resident stated that she was about a week ago [couldn't remember the exact day] and that she had a diabetic foot ulcer on her right foot and that staff had only changed the dressing once since she had been there. The resident stated that the physician's order was for wound care once a day.

Resident #110 clinical records were reviewed. There was a physician order for, "right foot, apply mupirocin and adaptic to the hemorrhagic callusing of the right foot wound and secure in place with foam dressing or kerlix secured with medipore tape daily every day shift for diabetic foot ulcer [Order Date: 08/05/21] [Start Date: 08/07/21]." This treatment was ordered three days after admission and was not scheduled to start until 08/07/21, five days after admission.

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	495105	A. BUILDING _____ B. WING _____	C 08/10/2021

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F 635	Continued From page 21	F 635		

Further review of the resident's clinical records revealed discharge instructions from the hospital [prior to admission to the facility] that documented, "...Discharge Documentation...08/02/21...diabetic foot ulcer of right foot Appreciate wound care input. She will follow up with them as an outpatient...discharge instructions...discharge patient 08/02/21...skilled care nursing facility..follow up...1 to 2 weeks, wound care clinic...wound care dressing change...daily, right foot, apply mupirocin and adaptic to the hemorrhagic callusing of the right foot and secure in place with foam dressing or kerlix secure with medipore tape...follow up recommendations: with house MD [medical doctor] at inpatient rehab..."

On 08/03/21 at 1:14 PM, an MD note documented, "...she has a chronic wound on her right foot that is stable...She is admitted for skilled care services...signature of MD."

The hospital discharge orders/instructions regarding Resident #110's right diabetic foot ulcer were not implemented upon admission to the facility. The order for care of this wound was not ordered until 08/05/21 [three days after admission] and the treatment was not initiated until 08/07/21 [five days after admission].

The resident's TARs [treatment administration records] were reviewed for the month of August. The order was added to the TAR [order date: 08/05/21 11:45 AM], the start date was added for 08/07/21, but the treatment was not done until 08/08/21 according to the documentation.

The resident's base line care plan was then reviewed and there was no care plan for at all for

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	495105	A. BUILDING _____ B. WING _____	C 08/10/2021

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F 635	Continued From page 22 wound care. On 08/10/21 at 6:00 PM, the director of nursing (DON) was interviewed regarding the above information. The DON stated that she did not know why this order was not added on admission or why the order was added on the 5th that a start date was added for the 7th. No further information or documentation was provided prior to the exit conference on 08/10/21 at 6:45 PM to evidence that this resident had immediate care orders for the care of a diabetic foot ulcer that was present upon admission to the facility. This is a complaint deficiency.	F 635		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. BUILDING _____ B. WING _____	C 08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 23	F 655		

(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, clinical record review and in the course of a complaint investigation, the facility failed to develop a baseline care plan for care and services related to a diabetic foot ulcer for one of 10 residents in the survey sample, Resident #110.

Findings include:

Resident #110 was admitted to the facility on 08/02/21. Diagnoses for Resident #110 included, but were not limited to: uncontrolled diabetes, weakness, UTI [urinary tract infection],

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	495105	A. BUILDING _____ B. WING _____	C 08/10/2021

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F 655	Continued From page 24	F 655		

encephalopathy, RA [rheumatoid arthritis], anxiety and depression, morbid obesity, and diabetic foot ulcer of right 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.

The resident's admission nursing note dated 08/02/21 at 1:37 PM documented that the resident was alert and oriented and able to make needs known.

On 08/10/21 at 11:45 AM, an interview was conducted with Resident #110 in her room. The resident stated that she was about a week ago [couldn't remember the exact day] and that she had a diabetic foot ulcer on her right foot and that staff had only changed the dressing once since she had been there. The resident stated that the physician's order was for wound care once a day.

Resident #110 clinical records were reviewed. There was a physician order for, "right foot, apply mupirocin and adaptic to the hemorrhagic callusing of the right foot wound and secure in place with foam dressing or kerlix secured with medipore tape daily every day shift for diabetic foot ulcer [Order Date: 08/05/21] [Start Date: 08/07/21]." This treatment was ordered three days after admission and was not scheduled to start until 08/07/21 [five days after admission].

Further review of the resident's clinical records revealed discharge instructions from the hospital [prior to admission to the facility] that

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F 655	Continued From page 25	F 655		

documented, "...Discharge Documentation...08/02/21...diabetic foot ulcer of right foot Appreciate wound care input. She will follow up with them as an outpatient...discharge instructions...discharge patient 08/02/21...skilled care nursing facility..follow up...1 to 2 weeks, wound care clinic...wound care dressing change...daily, right foot, apply mupirocin and adaptic to the hemorrhagic callusing of the right foot and secure in place with foam dressing or kerlix secure with medipore tape...follow up recommendations: with house MD [medical doctor] at inpatient rehab..."

On 08/03/21 at 1:14 PM, an MD note documented, "...she has a chronic wound on her right foot that is stable...She is admitted for skilled care services...signature of MD."

The resident's base line care plan was then reviewed and there was no care plan for at all for wound care.

On 08/10/21 at 6:00 PM, the director of nursing (DON) was interviewed regarding the above information. The DON stated that she did not know why this order was not added on admission or why a base line care plan was not developed on admission for wound care.

No further information or documentation was provided prior to the exit conference on 08/10/21 at 6:45 PM to evidence that this resident had a base line care plan in place for care of services of a diabetic foot ulcer that was present upon admission to the facility.

This is a complaint deficiency.