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|---|---|---|---|
| | 495105 | A. BUILDING _____ B. WING _____ | R-C 09/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| {E 000} | Initial Comments | {E 000} | | |
| {F 000} | INITIAL COMMENTS<br><br>The unannounced Medicare/Medicaid second revisit to the standard survey conducted on 6/29/2021 through 7/1/2021, was conducted on 9/21/2021. The first revisit survey was conducted on 8/10/2021. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements.<br><br>The census in this 180 certified bed facility was 128 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents # 201 through 213). | {F 000} | | |
| F 580 SS=E | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in | F 580 | | 10/11/21 |

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

Electronically Signed | 10/01/2021

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|---|---|---|---|---|
| F 580 | Continued From page 1<br>§483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to notify the physician in a timely manner of medication (Hydrocodone) not given per order, for one of thirteen residents, Resident #201.<br><br>Findings were:<br><br>Resident #201 was admitted to the facility on | F 580 | The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility | |

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|---|---|---|---|---|
| F 580 | Continued From page 2<br>02/01/2020 with the following diagnoses, including but not limited to: COPD (chronic obstructive pulmonary disease), malignant neoplasm of the endometrium, vascular dementia and hypertension.<br><br>The most recent MDS (minimum data set) was a quarterly review with an ARD (assessment reference date) of 06/23/2021. Resident #201 was assessed as moderately impaired with a cognitive summary score of "10".<br><br>On 09/21/2021 the clinical record was reviewed. The physician order section contained the following: "HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain."<br><br>The progress note section included the following documentation:<br><br>"09/11/2021 20:44 [8:44 p.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain Medication on Order."<br><br>"09/13/2021 12:06 [p.m.] Medication not available, notified pharmacy."<br><br>"09/13/2021 13:51 [1:51 p.m.] Not available ordered from pharmacy."<br><br>"09/14/2021 07:17 [a.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain Awaiting medications from pharmacy."<br><br>"09/14/2021 14:42 [2:42 p.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG | F 580 | has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F 580<br>1. Resident 201, MD was notified of medications not given and new orders obtained as needed.<br>2. Current residents medication administration records were reviewed to assure that residents receiving hydrocodone are receiving medication as ordered and if not then MD was notified and new orders obtained as needed.<br>3. SDC/ Designee will in service staff on process of what to do and who to notify when medication are not available by 10/8/21.<br>4. DON/Designee will monitor for missed medication administration report at least 5 times per week and appropriate follow up<br>5. Results of all monitoring will be brought to the QAPI committee and reviewed for tracking and trending and progressive disciplinary action as needed.<br>6. Compliance date 10/11/21 | |

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|---|---|---|---|---|
| F 580 | Continued From page 3 | F 580 | | |

Give 1 tablet by mouth three times a day for Pain Script faxed pharmacy. NP [nurse practitioner] aware."

"09/15/2021 07:27 [a.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain Awaiting medication from pharmacy. Script sent to pharmacy. NP aware."

"09/15/2021 13:16 [1:16 p.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain Script sent to pharmacy. NP aware."

"09/15/2021 20:54 [8:54 p.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain On order"

"09/16/2021 09:18 [a.m.] Lortab 5-35 mg [Same as HYDROcodone-Acetaminophen 5-325- the 35 is a typo] not available in cart for administration at this time. New script printed and forwarded to [name] NP for signature. Order faced to [name of pharmacy] and should arrive with evening delivery per [name of pharmacy representative]. NP and resident made aware."

"09/17/2021 12:14 [p.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain hold until arrive from pharmacy NP [name] aware medication script has been faxed."

Additional progress notes regarding the hydrocodone were written until 09/20/2021. The MAR (Medication administration record was reviewed. Resident #201's last dose of physician

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|---|---|---|---|---|
| F 580 | Continued From page 4 | F 580 | | |

ordered Hydrocodone was administered on 09/11/2021 at 2:00 p.m. The nurse practitioner was not notified until 09/14/2021 (after eight missed doses) that Resident #201 was not receiving her medications. A new prescription was sent to the pharmacy on 09/16/2021. The medication was still not available for administration during the survey on 09/21/2021. There was no documentation that the nurse practitioner or the physician were notified after 09/17/2021 that the medication was still not available.

A meeting was held with the administrator, the DON (director of nursing) and the two corporate nurse consultants on 09/21/2021 at approximately 4:00 p.m. Concerns were voiced that Resident #201 had not received her pain medication as ordered and neither the physician nor nurse practitioner were notified for three days. The question was asked as to what should have happened. The corporate nurse consultant stated, "If the medications are not here, the nurse needs to call the pharmacy and see where they are, every time...not say someone else called, they need to continue calling and notify the physician that the medicine isn't being given as ordered...every time it is scheduled...and they need to write a descriptive progress note...each nurse is responsible for medication administration on her shift." The note from 09/17/2021 was discussed. There was no order on the POS to hold the Hydrocodone. The corporate nurse consultant was asked if there was some place else that the order might be written. He stated, "No, if there was an order that is where it would be."

No further information was received prior to the

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|---|---|---|---|---|
| F 580 | Continued From page 5<br>exit conference on 09/21/2021. | F 580 | | |
| {F 657} SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interview, the facility staff failed to review and revise the comprehensive care plan for three of 13 residents in the survey sample: Residents # 209, # 211, and # 206. Resident # 209 had TED | {F 657} | F657<br>1. Resident 209 and 211 Care plan was updated to remove TED Hose<br>2. Resident 206 care plan was updated to include use of splint as indicated. | 10/11/21 |

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|---|---|---|---|
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|---|---|---|---|---|
| {F 657} | Continued From page 6<br>hose on the care plan that had been discontinued. Resident # 211 had TED (anti-embolism stockings) on the current care plan that had been discontinued 9/13/19. Resident # 206 had a hand splint on the care plan carried forward from a previous admission that was no longer ordered.<br><br>Findings include:<br><br>1. Resident #209 was readmitted to the facility on 12/20/20. Diagnoses for Resident #209 included; Quadriplegia, type 2 diabetes, multiple sclerosis, stroke, contractors, and chronic pain. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 8/18/21. Resident #209 was assessed with a cognitive score of 15 indicating cognitively intact.<br><br>On 9/21/21 Resident #209's care plan was reviewed and documented an intervention (for skin integrity) created on 6/20/19 for "Compression stockings on in the AM [morning] and off at HS [hours of sleep]."<br><br>On 9/21/21 at 1:00 PM, Resident #209 was laying in bed without compression stockings. When asked about the stockings, Resident #209 said the stockings have not been put on in a long time and was not sure of the reasoning.<br><br>On 9/21/21/ at 1:20 PM, licensed practical nurse (LPN #4, assigned to Resident #209) was interviewed concerning the stockings. LPN #4 was not aware of the care plan intervention.<br><br>On 9/21/21 at 1:30 PM, registered nurse (RN #1, MDS coordinator) was interviewed. RN #1 said | {F 657} | 3. Current residents that wear TED hose and use splints were audited to assure correct orders in place for TED Hose and Splints and care plan update for these items<br>4. SDC to in service staff on how to revise and update care plans using the new orders report by 10/8/21<br>5. DON/Designee will monitor updates to care plan by using the new order report that they will review at least 5 times a week to assure that care plans are updated as indicated<br>6. Results of all monitoring will be brought to the QAPI committee and reviewed for tracking and trending and progressive disciplinary action as needed.<br>7. Compliance date 10/11/21 | |

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|---|---|---|---|
| | 495105 | A. BUILDING _____ B. WING _____ | R-C 09/21/2021 |

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|---|---|---|---|---|
| {F 657} | Continued From page 7 | {F 657} | | |

she had completed Resident #209's most recent MDS assessment. When asked about the compression stocking intervention, RN #1 reviewed the intervention and said she would look into it.

On 9/21/21 at 1:50 PM, RN #1 stated the compression stockings had originated as an order on 6/13/19 and included on the care plan, was discontinued on 12/23/19 but was never discontinued from the care plan as it should have been. RN #1 said the care plan had now been updated and compression stockings discontinued.

On 9/21/21 at 4:15 PM the above information was presented to the director of nursing and administrator.

No other information was presented prior to exit conference on 9/21/21.

2. Resident # 211 was admitted to the facility 8/14/19 with a readmission date of 6/2/20. Diagnoses for Resident # 211 included, but were not limited to: lung cancer, pulmonary hypertension, vascular dementia, and diabetes.

The most recent MDS (minimum data set) was an annual assessment dated 8/11/21 and had the resident assessed as having moderate impairment in cognition with a score of 06 out of 15.

The clinical record was reviewed 9/21/21 beginning at 1:00 p.m. The current care plan included interventions for bilateral lower extremity edema (BLE). The "Focus" area included "resident has BLE. "Goals: The resident will

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|---|---|---|---|
| | 495105 | A. BUILDING _____ B. WING _____ | R-C 09/21/2021 |

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|---|---|---|---|---|
| {F 657} | Continued From page 8 | {F 657} | | |

have no complications r/t (related to) edema through the review date." "Interventions" included "TED hose on/off as ordered." The creation date of the care plan was 10/21/19, with a revision date of 8/19/21.

A review of the current POS (physician order summary) for September 2021 did not include an order for TED hose. A review of discontinued orders revealed the order for TED hose had been discontinued 9/13/19.

On 9/21/21 at 2:23 p.m. the MDS coordinator was interviewed about the care plan intervention remaining on the care plan. She stated "When the order was discontinued, that should have come off the care plan."

The above findings were shared with the administrator, IDON (interim director of nursing) and two corporate nurses during a meeting with facility staff 9/21/21 beginning at 4:00 p.m.

No further information was provided prior to the exit conference.

3. Resident # 206 was admitted to the facility on 9/10/2018, and most recently readmitted on 9/9/2021. Resident # 206's diagnoses at admission included anemia, atrial fibrillation, hypertension, urinary tract infection, thyroid disorder, arthritis, non-Alzheimer's dementia, anxiety disorder, cataracts, morbid obesity, bacteremia, contractures, and encephalopathy.

According to a Significant Change Minimum Data Set with an Assessment Reference Date of 9/15/2021, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out

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|---|---|---|---|
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|---|---|---|---|---|
| {F 657} | Continued From page 9 | {F 657} | | |

of 15. Under Section G (Functional Status), the resident was assessed as totally dependent with two person physical assist for transfer; as totally dependent with one person physical assist for bathing, and locomotion on and off the nursing unit; as needing extensive assistance with one person physical assist for dressing and personal hygiene; as needing supervision with one person physical assist for eating; and as not walking in her room or on the unit corridor during the look-back period.

Resident # 206's care plan for physical mobility was not reviewed and revised following her readmission on 9/10/2018.

Review of Resident # 206's comprehensive care plan, contained in her Electronic Health Record, revealed the following Focus (Problem) in the area of physical mobility: "The resident has limited physical mobility r/t (related to) limited ROM (Range of Motion), weakness, splint LUE (Left Upper Extremity)." The Goals for the Focus included, "Resident will maintain present muscle strength and endurance without evidence of contractures through next review; and, The resident will have splint applied to maintain correct alignment through next review."

The single intervention for the Focus was, "Apply splint LUE hand splint."

Further review of the care plan Focus for the area of physical mobility noted that the Focus and Intervention were revised on 6/22/2021, and the Goals were revised on 6/28/2021.

Review of the Progress Notes in Resident # 206's Electronic Health Record revealed the following

| 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 _____ | R-C 09/21/2021 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 657} | Continued From page 10 | {F 657} | | |

entry:

8/27/2021 - 10:30 a.m. - "Individual's L (left) palm assessed for pressure area per PT (Physical Therapy). Observed palm, it had some pink areas. No broken skin integrity observed. Wash cloth rolled and placed in palmar grasp. Nails are trimmed and short. No foul odor, drainage, or swelling noted. Will continue to monitor...waiting on a new hand brace for individual per PT."

At 1:25 p.m. on 9/21/2021, Resident # 206 was observed in her room, lying in her bed. The resident did not have hand splint on her left or right hand, and the hand roll (wash cloth) had slipped out of the palm of her left hand. This was also observed by LPN # 1 (Licensed Practical Nurse), who was in the room at the time, and who repositioned the hand roll in the resident's left hand.

At 2:10 p.m. on 9/21/2021, PTA # 1 (Physical Therapy Assistant) was interviewed regarding the hand splint for Resident # 206. According to PTA # 1, when the resident went to the hospital she was using the hand splint. PTA # 1 said she would look in to whether or not the resident had a hand splint, and if a new one was on order.

At 2:45 p.m. on 9/21/2021, PTA # 1 reported back that when Resident # 206 returned to the facility from the hospital, she returned with additional contractures. "The splint is not on order," PTA # 1 said. "Therapy has not decided what type of splint would be best for her."

The findings were discussed during a meeting at 4:15 p.m. on 9/21/2021 that included the Administrator, Interim Director of Nursing,

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|---|---|---|---|
| | 495105 | A. BUILDING _____ B. WING _____ | R-C 09/21/2021 |

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| LYNCHBURG HEALTH & REHABILITATION CENTER | 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502 |

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|---|---|---|---|---|
| {F 657} | Continued From page 11<br>Executive Nurse, Nurse Consultant, and the survey team. | {F 657} | | |
| {F 684} SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, resident interview, and clinical record review, the facility staff failed to follow physician orders for five (5) of thirteen (13) residents in the survey sample. Resident #201 was not administered Hydrodocone-Acetaminophen three times per day as ordered; Resident #213 was not sent to the orthopedic physician for cast removal as ordered; Resident #203 was not weighed daily and the physician was not notified of a three (3) pound weight gain; Resident #205 did not receive Vancomycin as ordered; and Resident #210 did not receive ophthalmic solution (eye drops) as ordered.<br><br>Findings were:<br><br>1. Resident #201 was admitted to the facility on 02/01/2020 with the following diagnoses, including but not limited to: COPD (chronic obstructive pulmonary disease), malignant neoplasm of the endometrium, vascular dementia | {F 684} | F684<br>1. Resident 201,205 and 210 MD was notified of not getting medications and no new orders.<br>2. Resident 213 was sent to orthopedic clinic and prior to survey and cast was removed.<br>3. Resident 203 weigh was obtained and reviewed with the MD and new orders were obtained.<br>4. Current residents were audited using the missed administration report for any missing medications and MD notified as ordered.<br>5. Current residents with orders for daily weights reviewed and new orders obtained and will be reviewed weekly in weight meeting and MD notified as needed.<br>6. Current residents with appointments to orthopedic clinic will be reviewed at least 5 times per week in morning | 10/11/21 |

| 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 _____ | R-C 09/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| {F 684} | Continued From page 12<br>and hypertension.<br><br>The most recent MDS (minimum data set) was a quarterly review with an ARD (assessment reference date) of 06/23/2021. Resident #201 was assessed as moderately impaired with a cognitive summary score of "10".<br><br>On 09/21/2021 the clinical record was reviewed. The physician order section contained the following: "HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain."<br><br>The progress note section included the following documentation:<br><br>"09/11/2021 20:44 [8:44 p.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain Medication on Order."<br><br>"09/13/2021 12:06 [p.m.] Medication not available, notified pharmacy."<br><br>"09/13/2021 13:51 [1:51 p.m.] Not available ordered from pharmacy."<br><br>"09/14/2021 07:17 [a.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain Awaiting medications from pharmacy."<br><br>"09/14/2021 14:42 [2:42 p.m.] HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain Script faxed pharmacy. NP [nurse practitioner] aware." | {F 684} | meeting and follow up as needed.<br>7. SDC will in service staff on process of what to do for missing medications, follow up of appointments and tracking of weights per orders Results of all monitoring will be brought to the committee and reviewed for tracking and trending and progressive disciplinary action as nee<br>8. DON/Designee will monitor the shift report at least 5 times per week for any missing medications, missed appointments and weight changes and appropriate corrective action as needed.<br>9. Results of all monitoring will be brought to the QAPI committee and reviewed for tracking and trending and progressive disciplinary action as needed.<br>10. Compliance date 10/11/21 | |

| 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 _____ | R-C 09/21/2021 |

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|---|---|
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|---|---|---|---|---|
| {F 684} | Continued From page 13 | {F 684} | | |

"09/15/2021 07:27 [a.m.]
HYDROcodone-Acetaminophen Tablet 5-325 MG
Give 1 tablet by mouth three times a day for Pain
Awaiting medication from pharmacy. Script sent to pharmacy. NP aware."

"09/15/2021 13:16 [1:16 p.m.]
HYDROcodone-Acetaminophen Tablet 5-325 MG
Give 1 tablet by mouth three times a day for Pain
Script sent to pharmacy. NP aware."

"09/15/2021 20:54 [8:54 p.m.]
HYDROcodone-Acetaminophen Tablet 5-325 MG
Give 1 tablet by mouth three times a day for Pain
On order"

"09/16/2021 09:18 [a.m.] Lortab 5-35 mg [Same as HYDROcodone-Acetaminophen 5-325- the 35 is a typo] not available in cart for administration at this time. New script printed and forwarded to [name] NP for signature. Order faced to [name of pharmacy] and should arrive with evening delivery per [name of pharmacy representative]. NP and resident made aware."

"09/17/2021 12:14 [p.m.]
HYDROcodone-Acetaminophen Tablet 5-325 MG
Give 1 tablet by mouth three times a day for Pain
hold until arrive from pharmacy NP [name] aware medication script has been faxed."

On 09/21/2021 at approximately 2:00 p.m., LPN (licensed practical nurse) #2 was interviewed. She was assigned to give medications to Resident #201 her medicine and was asked if all of Resident #201's medication had been given as ordered. She stated, "She doesn't have any of her pain medicine here, it's supposed to be coming. She was asked if she had called the pharmacy.

| 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 _____ | R-C 09/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LYNCHBURG HEALTH & REHABILITATION CENTER | 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502 |

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|---|---|---|---|---|
| {F 684} | Continued From page 14 | {F 684} | | |

She stated, "No, they said it's coming."

Resident #201 was interviewed at approximately 2:10 p.m. She was asked if she was having any pain. She stated, "No, not right now. I am okay." She was asked if she had been getting her pain medications. She stated, "I don't know, I just take what they give me."

A meeting was held with the administrator, the DON (director of nursing) and the two corporate nurse consultants on 09/21/2021 at approximately 4:00 p.m. Concerns were voiced that Resident #201 had not received her pain medication as ordered. The question was asked as to what should have happened if physician ordered medication was not available for administration. The corporate nurse consultant stated, "If the medications are not here, the nurse needs to call the pharmacy and see where they are, every time...not say someone else called, they need to continue calling and notify the physician that the medicine isn't being given as ordered..and they need to write a descriptive progress note...each nurse is responsible for medication administration on her shift."

No further information was received prior to the exit conference on 09/21/2021.

2. Resident #213 was admitted to the facility on 05/21/2021. Her diagnoses included but were not limited to: Encephalopathy, vascular dementia, and adult failure to thrive. her initial MDS (minimum data set) with an ARD (assessment reference date) of 05/30/2021, assessed Resident #213 as severely impaired with a cognitive status score of "06".

| 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 _____ | R-C 09/21/2021 |

| 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 684} | Continued From page 15 | {F 684} | | |

The clinical record was reviewed on 09/21/2021 at approximately 11:00 a.m. Resident #213 had a fall at the facility on 07/14/2021 which resulted in an acute fracture of her distal radius. She was sent to the emergency room and a short arm cast was applied. Her returning instructions to the facility were: "Do Not Get Cast Wet-if wet return to [name of orthopedic service] for cast removal. F/U [follow up] in 1 month."

The physician order sheet at the facility was reviewed and contained the following: "07/14/2021 f/u appointment with [name of orthopedic service] on 08/13/2021 at 1:05 p.m."

The progress note section included the following documentation:

"09/13/2021 11:49 [a.m.] ...contacted [name of orthopedic service] to f/u on resident's cast. They stated she was supposed to have cast off a month ago and to send her asap [as soon as possible] to walk-in clinic at [address]. They are M-F 8am-7pm. Scheduler [name] made aware to schedule transport asap."

"09/17/2021 10:28 [a.m.] Resident returned from appt [appointment] with [name of ortho service]. They removed her cast and stated she can be WBAT [weight bearing as tolerated] to right wrist..."

At approximately 12:50 p.m., Resident #213 was observed lying in bed. She was had her covers pulled up across her chest and was eating lunch with her left hand. She was asked if she could pull her right arm out from under the covers. She stated, "No, I want my ice cream."

| 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 _____ | R-C 09/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LYNCHBURG HEALTH & REHABILITATION CENTER | 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502 |

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|---|---|---|---|---|
| {F 684} | Continued From page 16 | {F 684} | | |

At approximately 2:45 p.m., the corporate nurse consultant was asked why Resident #213 had not gone to get her cast removed in August as ordered. He stated, "I can't answer that, the order was there."

The above information was discussed during an end of the survey meeting on 09/21/2021 at approximately 4:00 p.m.

No further information was obtained prior to the exit conference on 09/21/2021.

3. Resident # 203 was admitted to the facility 8/31/17 with diagnoses to include, but were not limited to: congestive heart failure, osteoarthritis, heart disease, and diabetes.

The most recent MDS (minimum data set) was a quarterly assessment dated 7/27/21 and had the resident scored as cognitively intact with a total score of 13 out of 15.

An order dated 7/30/21 on the current POS (physician order summary) documented, "Daily weights in the morning. Call cardiovascular if weight increases greater than 3-5 pounds."

The MAR (medication administration record) was then reviewed for weights. From 9/15/21 to 9/17/21, the resident's weight increased 3.3 pounds; there was no documentation for a weight obtained 9/16/21.

The record was then reviewed for notification to the cardiovascular physician but no documentation was located.

On 9/21/21 at approximately 3:45 p.m. LPN (licensed practical nurse) # 2 was interviewed

| 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 _____ | R-C 09/21/2021 |

| 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 684} | Continued From page 17 | {F 684} | | |

about the notification to cardiology regarding the 3.3 weight gain for Resident # 203. LPN # 2 looked through the clinical record and stated "I have no answer. That should have been called to cardiology, but looks like it wasn't."

The facility staff were advised of the above findings during a meeting 9/21/21 beginning at 4:00 p.m. The corporate nurse stated "The resident says she doesn't want to see her weight. She often refuses to be weighed. She will only allow us to weigh her a couple of times per week." It was explained that the issue was no notification of a 3.3 pound weight gain per the physician order.

No further information was provided prior to the exit conference.

4. Resident #205 was admitted to the facility originally on 02/18/21, with the most current readmission on 09/10/21. Diagnoses for resident #205 included, but were not limited to: anemia congestive heart failure, high blood pressure, peripheral vascular disease, right bellow the knee amputation, and diabetes.

The most current MDS [minimum data set] was a quarterly assessment dated 08/16/21. This MDS assessed the resident with a cognitive score of 13, indicating the resident was intact for daily decision makings skills.

On 09/21/21, during the resident's clinical record review, a hospital discharge dated 09/10/21 at 1:15 PM was observed. The discharge summary documented, "...C. difficile diarrhea...patient started on po [by mouth] Vancomycin...medication changes: ...Take Vancomycin 4 more days for C.diff..."

| 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 _____ | R-C 09/21/2021 |

| 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 684} | Continued From page 18 | {F 684} | | |

Resident #205's admission orders to the facility were then reviewed. An order dated 09/10/21 at 3:56 PM documented, "...Vancomycin...capsule 125 mg [milligrams]...by mouth...four times a day everyday 0900-1300-1700-2100 until 09/14/21..."

The MAR [medication administration record] was then reviewed and revealed that the medication was not started until the following day [09/11/21 at 5:00 PM]. According to the physician's order the resident should have received a dose at 9 AM and 1 PM, 5 PM and 9 PM. The MAR did not start until 5 PM, and there was no signature to evidence that Resident #205 received the ordered dose at 5:00 PM or at 9:00 PM. Resident #205 received four doses on 09/12/21. On 09/13/21, only three doses were documented as given. On 09/14/21, only two doses were given according to the MAR. Resident #205 should have received 4 doses each day starting on 09/11/21, per the physician's orders.

On 09/21/21 at approximately 3:00 PM, Corporate Nurse #1 and the administrator were made aware that according to the above information, Resident #205 had did not received at least four doses of the Vancomycin. The facility staff were asked for any information regarding the missed doses for Resident #205.

At approximately 5:00 PM Corporate Nurse #1 stated that as far as he could tell the resident got the medication.

No further information and/or documentation was presented prior to the exit conference.
5. Resident # 210 was admitted to the facility on 3/13/2018, and most recently readmitted on

| 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 _____ | R-C 09/21/2021 |

| 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 684} | Continued From page 19 | {F 684} | | |

5/8/2021. Resident # 210's diagnoses at readmission included cerebral vascular disease, anemia, hypertension, renal insufficiency, pneumonia, diabetes mellitus, hyperlipidemia, aphasia, non-Alzheimer's dementia, depression, dysphagia, and polyneuropathy.

According to the most recent Quarterly Minimum Data Set with an Assessment Reference Date of 9/1/2021, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 out of 15.

Resident # 210 had the following physician's order, dated 9/10/2021: Ofloxacin Solution 0.3% - Instill 2 drop in right eye three times a day for conjunctivitis for 7 days.

Review of the Progress Notes in the resident's Electronic Health Record revealed the following entry:
9/14/2021 - 12:56 p.m. - "Mr. (name of resident) missed a dose of her (sic) medication for conjunctivitis on 9/10 1400 (2:00 p.m.), 2100 (9:00 p.m.), and 9/11 1400 dose. Education provided to nursing in what to do if meds (medications) had not arrived from the pharmacy or could not be located...."

Review of the Medication Administration Record in the resident's Electronic Health Record verified the Ofloxacin was not administered as ordered twice on 9/10/2021, and once on 9/11/2021. The order written on 9/10/2021 was discontinued on 9/14/2021.

On 9/14/2021, the following new order for the ophthalmic solution was written: Ofloxacin

| 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 _____ | R-C 09/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LYNCHBURG HEALTH & REHABILITATION CENTER | 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502 |

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|---|---|---|---|---|
| {F 684} | Continued From page 20<br>Solution 0.3% - Instill 2 drop in right eye one time only for conjunctivitis for 4 days.<br><br>According to the Medication Administration Record in the resident's Electronic Health Record, the medication was administered as ordered on 9/14/2021, but was not administered on 9/15, 9/16, or 9/17/2021.<br><br>There was no documentation to indicate why the medication was not administered for three of the four days ordered.<br><br>The findings were discussed during a meeting at 4:15 p.m. on 9/21/2021 that included the Administrator, Interim Director of Nursing, Executive Nurse, Nurse Consultant, and the survey team. No explanation was offered at that time as to why the medication was not administered according to the orders of 9/10/2021 or 9/14/2021. | {F 684} | | |
| {F 695} SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review, the facility staff failed to ensure one of thirteen residents was administered | {F 695} | F695<br>1. Resident 201 oxygen was applied at the time of survey. | 10/11/21 |

| 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 _____ | R-C 09/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LYNCHBURG HEALTH & REHABILITATION CENTER | 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502 |

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|---|---|---|---|---|
| {F 695} | Continued From page 21<br>oxygen as ordered by the physician, Resident #201.<br><br>Findings were:<br><br>During initial tour of the facility on 09/21/2021 at approximately 9:15 a.m., Resident #201 was observed lying in bed. She was sitting in bed, her nasal cannula was laying on the bed beside her, partially under the covers. She was asked why her oxygen was off. She stated, "I think they took it off of me."<br><br>Resident #201 was admitted to the facility on 02/01/2020 with the following diagnoses, including but not limited to: COPD (chronic obstructive pulmonary disease), malignant neoplasm of the endometrium, vascular dementia and hypertension.<br><br>The most recent MDS (minimum data set) was a quarterly review with an ARD (assessment reference date) of 06/23/2021. Resident #201 was assessed as moderately impaired with a cognitive summary score of "10".<br><br>The clinical record was reviewed at approximately 11:00 a.m. The physician orders included: "Oxygen therapy-Oxygen at 1 liters per minute via nasal cannula every shift for SOB [shortness of breath]".<br><br>At 12:00 p.m., Resident #201 was observed with her nasal cannula off. The oxygen tubing and nasal cannula were observed still in the bed, partially under the covers.<br><br>At 12:50 p.m., Resident #201 was sitting in bed, her lunch tray was in front of her. Her nasal | {F 695} | 2. Current residents receiving oxygen were audited to assure orders are correct and resident are wearing oxygen as ordered.<br>3. SDC will in service staff on application of oxygen and monitoring liter flow.<br>4. DON/Designee will monitor residents wearing oxygen on rounds at least 5 time per week and if resident refuses or does not have oxygen on at time of observation will apply and notify MD as needed.<br>5. Results of all monitoring will be brought to the QAPI committee and reviewed for tracking and trending and progressive disciplinary action as needed.<br>6. Compliance Date 10/11/21 | |

| 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 _____ | R-C 09/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LYNCHBURG HEALTH & REHABILITATION CENTER | 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502 |

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|---|---|---|---|---|
| {F 695} | Continued From page 22<br>cannula remained on the bed under the covers. She was again asked if she had taken her oxygen off. She stated, "No, I think they did."<br><br>The unit manager, LPN (Licensed Practical Nurse) #3 was at the nurse's station and was asked about Resident #201's oxygen. She stated, "She had it on this morning, she can take it off herself." LPN #3 went to Resident #201's room and placed the nasal cannula back on Resident #201. LPN #3 stated, "She can take it off herself." LPN #3 was asked if Resident #201 was care planned as removing her oxygen, she did not answer. Resident #201 was asked if she had taken her oxygen off. She stated, "No, I didn't."<br><br>The care plan and progress notes were reviewed. There were no entries indicating that Resident #201 removed her oxygen herself or was noncompliant with oxygen usage.<br><br>The above information was reviewed during an end of the day meeting on 09/21/2021 at approximately 4:00 p.m. with the DON (director of nursing) administrator, and corporate nurse consultant.<br><br>No further information was obtained prior to the exit conference on 09/21/2021. | {F 695} | | |
| F 755 SS=E | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law | F 755 | | 10/11/21 |

| 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 _____ | R-C 09/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 755 | Continued From page 23<br>permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to ensure medications were available for two of 13 residents, Resident # 201 and Resident # 210. Resident #201 did not receive Hydrocodone three times per day as ordered by the physician because it was not available for administration. Resident # 210 was not administered Ofloxacin three times a day as ordered, and once a day as ordered.<br><br>The findings were: | F 755 | F 755<br>1. Resident 201 and 210 MD was notified of residents not receiving medications as ordered and no new orders obtained.<br>2. Current residents medication administration records were reviewed to assure that residents receiving hydrocodone and Ofloxcin are receiving medication as ordered and if not then MD was notified and new orders obtained as needed. | |

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|---|---|---|---|
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| F 755 | Continued From page 24<br><br>1. Resident #201 was admitted to the facility on 02/01/2020 with the following diagnoses, including but not limited to: COPD (chronic obstructive pulmonary disease), malignant neoplasm of the endometrium, vascular dementia and hypertension.<br><br>The most recent MDS (minimum data set) was a quarterly review with an ARD (assessment reference date) of 06/23/2021. Resident #201 was assessed as moderately impaired with a cognitive summary score of "10".<br><br>On 09/21/2021 the clinical record was reviewed. The physician order section contained the following: "HYDROcodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth three times a day for Pain."<br><br>The progress note section was reviewed. From 09/11/2021 through 09/20/2021, the nursesb documented that the medication Hydrocodone-Acetaminophen 5-325 mg was not available for administration. Entries in the nurses notes regarding the medication included: "Medication on order; not available ordered from pharmacy; On order; Awaiting medications from pharmacy, script sent to pharmacy."<br><br>The MAR (Medication administration record was reviewed. Resident #201's last dose of physician ordered Hydrocodone was administered on 09/11/2021 at 2:00 p.m. At the time of the survey on 09/21/2021 she had missed a total of 30 doses of Hydrocodone.<br><br>On 09/21/2021 at approximately 2:00 p.m., LPN (licensed practical nurse) #2 was interviewed. | F 755 | 3. SDC/ Designee will in service staff on process of what to do and who to notify when medication are not available by 10/8/21.<br>4. DON/Designee will monitor for missed medication administration report at least 5 times per week and appropriate follow up<br>5. Results of all monitoring will be brought to the QAPI committee and reviewed for tracking and trending and progressive disciplinary action as needed.<br>6. Compliance date 10/11/21 | |

| 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 _____ | R-C 09/21/2021 |

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|---|---|---|---|---|
| F 755 | Continued From page 25 | F 755 | | |

She was assigned to give medications to Resident #201 her medicine and was asked if all of Resident #201's medication had been given as ordered. She stated, "She doesn't have any of her pain medicine here, it's supposed to be coming. She was asked if she had called the pharmacy. She stated, "No, they said it's coming."

A meeting was held with the administrator, the DON (director of nursing) and the two corporate nurse consultants on 09/21/2021 at approximately 4:00 p.m. Concerns were voiced that Resident #201 had not received her pain medication as ordered. The question was asked as to what should have happened when the nurses saw the medication was not on the medication cart. The corporate nurse consultant stated, "If the medications are not here and the nurse needs to call the pharmacy and see where they are, every time...not say someone else called, they need to continue calling and notify the physician that the medicine isn't being given as ordered..and they need to write a descriptive progress note...each nurse is responsible for medication administration on her shift." He was asked why the medication had not been delivered. He stated, "I don't know, I need to follow up with the pharmacy." During then meeting the survey team was told that the whole company had switched to a new pharmacy on 09/01/2021 and that medications for the residents were being delivered from North Carolina three times per day. He was asked if the nurses knew how to contact the pharmacy. He stated, "There are numbers for the new pharmacy at the nurses stations. The telephone number for the pharmacy was requested and received.

At approximately 4:30 p.m., the pharmacist, OS

| 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 _____ | R-C 09/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LYNCHBURG HEALTH & REHABILITATION CENTER | 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502 |

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|---|---|---|---|---|
| F 755 | Continued From page 26 | F 755 | | |

(other staff) #5 was contacted at the pharmacy. He was asked why Resident #201's Hydrocodone had not been delivered. He looked up the information and stated, "We got a new prescription on September 16th. It was filled and sent out that evening. Let me check with my driver." He returned to the phone and stated, "The medication was delivered on 09/17/2021 and signed for by [Name of RN #2] at 3:02 a.m." He was asked how much hydrocodone had been delivered. He stated, "Thirty tablets." He was asked how he knew they were delivered on that date at that time. He stated, "We keep a history of the medications. The medication was placed in Tote #14189...I also have the delivery receipt that the driver just sent to me. It shows the time and date the tote was delivered and the signature of the person who received it at the facility." He was asked when prior to 09/17/2021 the medication Hydrocodone had been delivered for Resident #201. He stated, "That was the first time. We just took over on September 1st. They probably had medicine there from the previous pharmacy that carried them over until then. That's why we needed a new prescription in order to fill it."

No further information was received prior to the exit conference on 09/21/2021.

2. Resident # 210 was admitted to the facility on 3/13/2018, and most recently readmitted on 5/8/2021. Resident # 210's diagnoses at readmission included cerebral vascular disease, anemia, hypertension, renal insufficiency, pneumonia, diabetes mellitus, hyperlipidemia, aphasia, non-Alzheimer's dementia, depression, dysphagia, and polyneuropathy.

According to the most recent Quarterly Minimum

| 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 _____ | R-C 09/21/2021 |

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|---|---|---|---|---|
| F 755 | Continued From page 27 | F 755 | | |

Data Set with an Assessment Reference Date of 9/1/2021, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 out of 15.

Resident # 210 had the following physician's order, dated 9/10/2021: Ofloxacin Solution 0.3% - Instill 2 drop in right eye three times a day for conjunctivitis for 7 days.

Review of the Progress Notes in the resident's Electronic Health Record revealed the following entry:
9/14/2021 - 12:56 p.m. - "Mr. (name of resident) missed a dose of her (sic) medication for conjunctivitis on 9/10 1400 (2:00 p.m.), 2100 (9:00 p.m.), and 9/11 1400 dose. Education provided to nursing in what to do if meds (medications) had not arrived from the pharmacy or could not be located...."

Review of the Medication Administration Record in the resident's Electronic Health Record verified the Ofloxacin was not administered as ordered twice on 9/10/2021, and once on 9/11/2021. The order written on 9/10/2021 was discontinued on 9/14/2021.

On 9/14/2021, the following new order for the ophthalmic solution was written: Ofloxacin Solution 0.3% - Instill 2 drop in right eye one time only for conjunctivitis for 4 days.

According to the Medication Administration Record in the resident's Electronic Health Record, the medication was administered as ordered on 9/14/2021, but was not administered on 9/15, 9/16, or 9/17/2021.

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|---|---|---|---|
| | 495105 | A. BUILDING _____ B. WING _____ | R-C 09/21/2021 |

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| F 755 | Continued From page 28<br><br>There was no documentation to indicate why the medication ordered on 9/14/2021 was not administered for three of four days.<br><br>The findings were discussed during a meeting at 4:15 p.m. on 9/21/2021 that included the Administrator, Interim Director of Nursing, Executive Nurse, Nurse Consultant, and the survey team. No explanation was offered at that time as to why the medication was not available for administration as ordered for either the order of 9/10/2021 or the order of 9/14/2021. | F 755 | | |
| F 800 SS=D | Provided Diet Meets Needs of Each Resident<br>CFR(s): 483.60<br><br>§483.60 Food and nutrition services.<br>The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review, the facility staff failed to ensure food preferences were honored for one of thirteen residents, Resident #201.<br><br>Findings were:<br><br>Resident #201 was admitted to the facility on 02/01/2020 with the following diagnoses, including but not limited to: COPD (chronic obstructive pulmonary disease), malignant neoplasm of the endometrium, vascular dementia and hypertension. | F 800 | F 800<br>1. Resident 201 has had food preferences reviewed and updated as needed.<br>2. Current residents food preferences were reviewed and updated as indicated with the residents<br>3. Dietary Manager will educate staff on need to honor food preferences per tray carts.<br>4. Unit Manager/ Designee will review 3 residents per day to assure that food preferences were met<br>5. Results of all monitoring will be | 10/11/21 |

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|---|---|---|---|
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|---|---|---|---|---|
| F 800 | Continued From page 29<br>The most recent MDS (minimum data set) was a quarterly review with an ARD (assessment reference date) of 06/23/2021. Resident #201 was assessed as moderately impaired with a cognitive summary score of "10".<br><br>On 9/21/21 at 12:50 p.m., Resident #201 was observed sitting in bed with her lunch tray was in front of her. She was asked if she was going to eat her lunch. She stated, "No, I don't like it." She was asked what she didn't like. She stated, "I don't like fish, that's fish, I don't eat rice, that's rice, and those green beans are raw, I don't like raw beans...I ate my roll with some butter on it. That will do I guess."<br><br>Her tray card was observed. Beside the "Note" section was: "No Chicken, Fish, Turkey". Her Lunch menu listed on the tray card was, "Baked Breaded Pollock...buttered noodles, buttered green beans, dinner roll..." Resident #201 was asked if she would like something else. She stated, "I don't know what they have."<br><br>The dietary manager was interviewed at approximately 1:05 p.m. regarding Resident #201's lunch tray. He stated, "I will get her something else." He then asked one of the dietary workers to make Resident #201 a "PBJ" (Peanut butter and jelly sandwich). He stated, "I watched when they plated the food, they missed that and I did too...I just came here last Monday and I am trying to get everything straight...the previous dietary manager didn't have anyone's preferences...I have a system online called SNO [simplified nutrition online]...when I put in there that she doesn't like fish it will won't show up as an option on her tray card anymore...the notes at the bottom of the tray cards like that are missed." | F 800 | brought to the QAPI committee and reviewed for tracking and trending and progressive disciplinary action as needed.<br>6. Compliance date 10/11/21 | |

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|---|---|---|---|---|
| F 800 | Continued From page 30<br><br>At 1:25 p.m., the dietary manager came to the conference room and stated, "I got her preferences in August when I came here to help the other dietary manager out, she didn't mention fish, but I took it off today." He was asked regardless of her preferences he took in August, if the tray card read, "No Fish" would that not suffice to let the staff know to give her something else. He stated, "Yes, we should have seen that...it won't happen again."<br><br>The above information was reviewed during an end of the day meeting on 09/21/2021 at approximately 4:00 p.m. with the DON (director of nursing) administrator, and corporate nurse consultants.<br><br>No further information was obtained prior to the exit conference on 09/21/2021. | F 800 | | |