PRINTED: 05/03/2022 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						R-C	
		495105	B. WING _			02/10/2022	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
LYNCHBU	RG HEALTH & REHABIL	ITATION CENTER		5615 SEMINOLE AVENUE LYNCHBURG, VA 24502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
E 000	Initial Comments		EC	000			
E 023 SS=F	revisit to the abbrevial conducted 11/29/21 the conducted 2/8/22 three are required for complete federal requirements. Preparedness in Long Policies/Procedures ff CFR(s): 483.73(b)(5). §403.748(b)(5), §460. §441.184(b)(5), §460. §483.73(b)(5), §485.68(b)(3), §485.68	hrough 11/30/21 was ough 2/10/22. Corrections Iliance with CFR 483.73, the for Emergency	ΕC	023		3/23/22	
	develop and impleme policies and procedur plan set forth in paragassessment at paragrand the communication this section. The policies and procedur following:] [(5) or (3),(4),(6)] A syndocumentation that protects confidentialit secures and maintain						
	procedures. (5) A sys	tem of care documentation					
ARORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

Electronically Signed 03/02/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		495105	B. WING _			R-C 02/10/2022	
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	'	01/10/2022	
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E 023	Continued From page that does the followi (i) Preserves patient (ii) Protects confider (iii) Secures and ma records. *[For OPOs at §486 procedures. (2) A st documentation that donor information, p potential and actual secures and maintain This REQUIREMEN by: Based on staff internand facility documer failed to ensure accord when internet for the facility. Findings were: On 02/08/2022 at apadministrator, DON corporate nurse con #3) were interviewed.	ge 1 ng: information. itiality of patient information. intains the availability of	E 0	DEFICIENCY)	owing hission to hent with heported hion cited hices. The hin of he with all he facility he facility he facility he facility		
	staff were unable to records. She was as had been down. The come back up before administrative staff vaccessed the electrorinternet was down. I back up computer thand TARS (medicati treatment administrative working either. I thin	access the electronic health ked how long the internet administrator stated it had		deficiencies cited have been or w corrected by the date or dates in E023 The center now has access to the when the internet is not functional Current residents in the center has potential to be affected. Licensed nurses will be educated Regional Director of Clinical	vill be dicated. e EHR all.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _			0
		495105	B. WING				-C 10/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				56	615 SEMINOLE AVENUE		
LYNCHBU	RG HEALTH & REHAB	SILITATION CENTER		Ľ	YNCHBURG, VA 24502		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
E 023	Continued From pag	ge 2	E	023			
		d if the phones used were			Services/designee on the proper		
		lity. She stated, "No, they			procedure for accessing the EHR durin	a	
		e was asked how care was			times of internet outage. The educatio	-	
		es either did not have a			will include how to sign on to the		
	•	ne did not have the capability			designated computer and printer requir	ed	
	1 -	ne records. She stated,			to access the EHR during times of inte		
	"That's a good point				disruption. The DON/designee will not		
					the Regional Director of Clinical Servic	- 1	
	Per the policy "Docu	umentation in the Event of			when the internet service has been		
	Computer Outage",	dated 11/01/2019, "The unit			disrupted and when accessing the EHF	₹.	
	manager is respons			The DON/designee will ensure weekly	the		
	complete and adequ			EMAR back up computer and printer a	·e		
	Computer System Downtime Emergency				functional. In addition, the DON/desig	nee	
	Packet(s) are available and accessible for				will have 5 nurses weekly demonstrate		
		ion on each unit in the event			their ability to access the EHR via the		
		n is unavailable." Also			EMAR back up computer and printer.		
	1 -	cket from the facility's			The results of the review will be discus		
		ovider on how to access			at the monthly QAPI meeting. Once the		
	_ ·	cket, "The facility should not			QAPI committee determines the proble	m	
	_	ency situation arises to			no longer exists, the reviews will be		
		to locate the EMAR backup			conducted on a random basis.		
	reports on the comp	outer.			The Administrator/Director of Nursing a		
	A meeting with the	OON administrator and four			responsible for implementation of the p of correction.	ıdlı	
	_	DON, administrator and four ts was held on 02/09/2022 at			Date of compliance- 3/23/2022		
		net downtime was discussed.			5410 01 00111p11a1106- 0/20/2022		
		Ve weren't entering the correct					
	· ·	ackup computerthe domain					
		ctly, we were using a forward					
		sed to be a backwards					
		sed their phonesthose					
		nere today and signed off all					
		S for the downtime" The					
		nsultant (admin #3) stated,					
		out that everyone had to have					
		name and password before					
	-	wn and had to have used that					
	computer before in	order to access itno one					
	here had been on th	nat computer before so we					

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E 024 SS=E	nurse consultant were problem, the computer correctly or no one had one of the nursing unsaid the computer waduring the downtime. During a meeting with and the corporate nur 02/10/2022 at 12:15 pleased that no one the electronic records downtime from 11:30 02/07/2022. It was also time of the survey, the what the problem was time of the survey, the what the problem was CFR(s): 483.73(b)(6) §403.748(b)(6), §416 §441.184(b)(6), §460 §483.73(b)(6), §483.4 §485.68(b)(4), §485.6 §485.920(b)(5), §491 [(b) Policies and procedure policies and procedure plan set forth in paraga and the communication this section. The policies reviewed and updote the communication of the survey of the communication of the communication of the communication of the communication. The policies reviewed and updote the communication of the communication of the communication of the communication.	e DON and the corporate e asked which was the er was not being accessed ad access. The DON called its and stated, "They just as not working on Monday the screen was blue." In the DON, the administrator rese consultant on o.m, concerns were er in the facility had access to a during the internet a.m. until 2:30 p.m. on so discussed that until the er facility had not identified as with the back up system. In was obtained prior to the 2/10/2022.		024			3/23/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		CCTION (X5) OULD BE COMPLETION PROPRIATE DATE
E 024	Continued From page policies and procedured following:] (6) [or (4), (5), or (7) volunteers in an emergency in a staffing strategies, ir for integration of State health care profession during an emergency and other strategies to address emergency. *[For RNHCIs at §40 procedures. (6) The emergency and other strategies to address emergency. *[For Hospice at §41 procedures. (4) The an emergency and of strategies, including integration of State at health care professioneeds during an emergency and facility documents. This REQUIREMENT by: Based on staff internand facility documents and facility documents and procedures and proced	as noted above] The use of ergency or other emergency including the process and role te and Federally designated onals to address surge needs by. 33.748(b):] Policies and use of volunteers in an er emergency staffing is surge needs during an ergency staffing the process and role for and Federally designated onals to address surge ergency. T is not met as evidenced view, clinical record review at review, the facility staff emergency preparedness res to ensure adequate ree units, from 07:00 p.m. on	E	DEFICIENCY)	due to the
	Findings were: On 02/08/2022 at 3:: DON and corporate staff #3) were intervi	35 p.m., the administrator, consultant (administration ewed and reported that no edications and/or treatments		The DON/Nursing Leadership/Administrator will be by the Regional Director of Clinic Services/designee on the emerg preparedness policies to ensure staffing in the center. The DON /designee will contact the Regior Director of Clinical Services whe	cal ency adequate nal
	were administered to	any of the fifty-five (55)		emergency preparedness policie	s have

OL: VILI	S T STY III EDIO/ II LE G	· CEITTIOLO				<u> </u>	. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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E 024	7:00 p.m. until 02/08/stated there were two building starting at 11 there was a 'call out"; night shift (11:00 p.m #3 as the only nurse stated agency was coand LPN #5 reported 11:00 p.m. The DON East unit, LPN #5 wa the two nurses were sunit. The DON stated worked the building the split the West unit. On 02/09/2022 at 10: of nursing) was intervare we looking at here DON was informed the identified that no mediate been provided to 55 from 7:00 p.m. on 02/02/08/2022. The DO should have come bas worked. I am sorry." Per the policy "Emergand Volunteers" date administrative emerging Center's Master scheen Center's Emergency staff and auxiliary stareplacements"	t unit from 02/07/2022 at 2022 at 7:00 a.m. The DON onurses scheduled for the :00 p.m. The DON stated on 02/07/2022 prior to the . to 7:00 a.m.) leaving LPN in the building. The DON ontacted for a fill-in nurse to work on 02/07/2022 at stated LPN #3 was on the s assigned to South unit and supposed to "split" the West d when only two nurses nat "they [nurses] knew" to 40 a.m., the DON (director riewed. She stated, "What edo we have harm?" The nat concerns had been dications or treatments had residents on the West unit /07/2022 until 7:00 a.m. on N stated, "Retrospectively, I ack in here that night and only the concerns had been great the concerns had been the concerns had	E	024	been activated to ensure there is adequate staffing in the center. The DON/Administrator/Nursing Leadership/designee will review staffind in the center. The DON/Nursing Leadership will be notified when there acall offs to determine if the emergency preparedness policies need to be implemented. The results of the review will be discuss at the monthly QAPI meeting. Once the QAPI committee determines the problem olonger exists, the reviews will be conducted on a random basis. The Administrator/Director of Nursing are sponsible for implementation of the profice correction. Date of compliance-3/23/2022	ng are sed e m	

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
LYNCHRII	RG HEALTH & REHABIL	ITATION CENTER	5615 SEMINOLE AVENUE					
LINOIIDO	NO HEALIN & KENADIL	MANON SENTER		LYNCHBURG, VA 24502				
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E 024	from the nurses list, we more money, we called everything." The DON the calls that were many	ed, "We called everybody we offered a comp rate of ed the agencies, we did N was asked why after all of ade, and no one would take	EC	124				
	She stated, "It was su like to have one nurse with two nurses if we were voiced that a tot	come in to cover the facility. upposed to be coveredwe e on each unit but we do it split the unit." Concerns al of 55 residents did not or treatments due to facility						
{F 000}	No further information exit conference on 02 INITIAL COMMENTS		{F 0	003				
(* 333)	An unannounced Me revisit to the abbrevia conducted 11/29/21 the conducted 2/8/22 throcorrections are required CFR Part 483 Federa Requirements. One of was investigated duri	dicare/Medicaid second ted complaint survey hrough 11/30/21 was ough 2/10/22. Significant ed for compliance with 42						
F 600 SS=G	148 at the time of the consisted of fifty-seve (Residents #201, #20 #258) and one closed #204). Free from Abuse and	0 certified bed facility was survey. The survey sample on current resident reviews 12, #203, #205 through direcord review (Resident Neglect	F€	600		3/23/2	22	
	§483.12 Freedom fro	m Abuse, Neglect, and						

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	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	1 OEITOIZOZZ	
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F 600	neglect, misappropriand exploitation as a includes but is not licorporal punishmen any physical or cher treat the resident's richard the facility and resident review, the facility sof 58 residents in the from neglect. Reside that included Reside through #228 and # provided physician of treatments during the starting on the even working the unit. Far nurse was on the unit any medications/treatments during the starting on the even working the unit. Far nurse was on the unit any medications/treatments during the starting on the even working the unit. Far nurse was on the unit any medications/treatments of the medicines in respon request for the medicines in respon request for the medicines in signification and the starting of the medicines in respon request for the medicines in respon request for the medicines in responsable.	e right to be free from abuse, iation of resident property, defined in this subpart. This mited to freedom from t, involuntary seclusion and mical restraint not required to nedical symptoms. ity must- se verbal, mental, sexual, or coral punishment, or n; T is not met as evidenced Interview, staff interview, view and clinical record aff failed to ensure fifty-four e survey sample were free ents residing on the West unit ents #201, #203, #205, #207 230 through #258, were not ordered medications and/or velve consecutive hours ing of 2/7/22 due to no nurse acility staff, aware that no lit, made no attempt to ensure atments were provided to the during this 12-hour period. A minister Resident #207's pain se to the resident #207 ant pain during this time after doses of narcotic medication,	F 6	F600 Resident #201, 203, 205, 207, 228, 230-258 attending Physician and Resi Representative were notified of reside not receiving their ordered medications/treatments for the 12 hrs. the evening of 2/7/22 into the early morning of 2/8/22. No new orders received. Current residents in the center have the potential to be affected. Center staff will be educated by the Regional Director of Clinical Services/designee on the center special scheduled medications and treatments per MD orders. In addition, the DON/Nursing Leadership/Administrate will be educated by the Regional Director of Clinical Services/designee on the emergency preparedness policies to ensure adequate staffing in the center	nts , ne olicy n will ir s as or ctor	

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		495105	B. WING _			02/	10/2022	
NAME OF P	ROVIDER OR SUPPLIER	•	,	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
LVNGUDI	IDO HEALTH & DEHADI	ITATION CENTER		56	615 SEMINOLE AVENUE			
LYNCHBU	JRG HEALTH & REHABI	LITATION CENTER		Ľ	YNCHBURG, VA 24502			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	6/13/20 with diagnos obesity, hypertension schizoaffective disord stenosis, intervertebrand gastroesophage dated 12/20/21 assect cognitively intact. Resident #207's clinicurrent physician ord following medications Doxepin 150 mg at b Gabapentin 900 mg in neuropathy Methadone 2.5 mg e Morphine sulfate 30 in pain Aquaphor diaper rast inner thighs topically for chaffing Resident #207's MAF medications were no evening of 2/7/22 and The gabapentin was administered on 2/7/2 morphine sulfate and 2/8/22 at 12:00 a.m. morphine sulfate was 6:00 a.m. On 2/8/22 at 2:05 p.r (LPN) #1, working or interviewed. LPN #1 from 7:00 a.m. until 7	admitted to the facility on es that included morbid in, chronic pain syndrome, der, depression, spinal ral disc disorder, lumbago all reflux disease. The MDS issed Resident #207 as a cal record documented lers that included the is and treatments. Redtime for depression three times per day for three times per day for an additional dose of is scheduled for 2/8/22 at in., licensed practical nurse	F	600	The DON /designee will contact the Regional Director of Clinical Services when the emergency preparedness policies have been activated to ensure there is adequate staffing in the center The DON/designee will interview 5 aler and oriented residents weekly to ensur the residents are receiving their medications as per MD orders. The EMAR/ETAR will be reviewed 5x week to ensure medications have been giver and documented as given on the EMAR/ETAR. In addition, The DON/Administrator/Nursing Leadership/designee will review staffind in the center. The DON/Nursing Leadership will be notified when there call offs to determine if the emergency preparedness policies need to be implemented. The results of the review will be discuss at the monthly QAPI meeting. Once the QAPI committee determines the problem longer exists, the reviews will be conducted on a random basis. The Administrator/Director of Nursing a responsible for implementation of the profice correction. Date of compliance-3/23/2022	t t e ly n g are sed e		

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F 600	prior to leaving the bit was no nurse on the on 2/8/22 at 7:00 a.m know who was sched and night shifts on Withere was currently nunit. On 2/8/22 at 2:10 p.m (DON) was interview administered to reside evening of 2/7/22 and The DON stated nurse and sign off a medical (MAR) or treatment at The DON had no expedid not receive medical 2/7/22 and stated should be stated that LPN #2 wand "house supervise shift. On 2/8/22 at 3:35 p.m and corporate consultations with the design of the stated that LPN #2 wand "house supervise shift.	nit manager on East unit uilding. LPN #1 stated there West unit when she arrived n. LPN #1 stated she did not duled to work the evening fest unit. LPN #1 stated o unit manager for the West out manager for the West out manager for the West early morning of 2/8/22. See had 24 hours to clarify ation administration record administration record (TAR). Danation why the residents cations on the evening of e would research and clarify. The did have agency nurses a stated LPN #2, LPN #3 and evening shift. The DON feas the East unit manager for on the 2/7/22 evening man, the administration staff #3) eam and reported that no	F6				
	physician ordered me were administered to residents on the Wes p.m. until 2/8/22 at 7: consultant stated LPI unit manager (LPN # medications on the V when she left on 2/7/ DON stated LPN #2	edications and/or treatments any of the fifty-four (54) at unit from 2/7/22 at 7:00 a.m. The corporate N #1 reported to the East 2) that all the evening Vest unit had been given 22 around 7:30 p.m. The was the "house supervisor" ald have reassigned the					

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F 600	South and West). The not give medications shift because LPN#1 medications on the u DON stated, "There with the shift change." The shift change." The shift change." The stated LPN #4 worked evening of 2/7/22 und stated LPN #2 and LI p.m. with two nurses starting at 11:00 p.m. a "call out" on 2/7/22 p.m. to 7:00 a.m.) lead nurse in the building. was contacted and Li 2/7/22 at 11:00 p.m. was on the East unit, South unit and the two "split" the West unit. On 2/8/22 at 3:45 p.m (LPN #2) was interview was working on East to 11:00 p.m. shift. Laround 7:30 p.m., LP her that she was lead on West unit had beed did not go to the West unit on 2/7/22 awent home, and she the evening medication. "Nobody reported to wasn't aware." LPN left the building on 2/1/12 left the 2/1/12	e facility's three units (East, the DON stated LPN #2 did on West during the evening reported that all the nit had been given. The was a miscommunication at the DON stated LPN #2, LPN and in the building on the sil 11:00 p.m. The DON PN #4 left on 2/7/22 at 11:00 scheduled for the building The DON stated there was prior to the night shift (11:00 wing LPN #3 as the only The DON stated agency PN #5 reported to work on The DON stated LPN #3 LPN #5 was assigned to on urses were supposed to another than the East unit manager ewed. LPN #2 stated she unit on 2/7/22 for 3:00 p.m. PN #2 stated that on 2/7/22 N #1 from West reported to ring and all the medications on given. LPN #2 stated she at unit prior to leaving her PN #2 stated, "I couldn't do meds (medications) on there was no nurse on the offer 7:30 p.m. when LPN #1 thought LPN #1 had given all	F	600			

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		495105	B. WING _			R-C 02/10/2022
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, Z 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	ZIP CODE	OLI I GILLOLL
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		DATE
F 600	a.m. LPN #2 stated in and reported to Sci 11:00 p.m. to work the On 2/8/22 at 4:45 p.r. and corporate consultances (LPN #3 and nurses in the building at 7:00 a.m. The DC nurses worked the building at 7:00 a.m. The DC nurses worked the building at 7:00 p.m. The DC nurses worked the building at 7:00 p.m. The DC nurses worked the building at 7:00 p.m. The DC nurses worked the building at 7:00 p.m. until 2/8/22 stated again, "There shift. On 2/8/22 at 5:10 p.r. prescribed medication administered on Wes 7:00 p.m. until 2/8/22 stated again, "There shift change." On 2/8/22 at 5:20 p.r. by telephone about the LPN #3 stated she wount and helped out op.m. LPN #3 stated she wount back to the East cover South after the LPN #3 stated she wowest unit. LPN #3 stated again she was on 2/7/22 and she was on 2/7/22 and she was on 2/7/22 and she was nurse on West unit un Resident #207 called	an agency nurse was called outh unit on 2/7/22 around	F	500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495105	B. WING _				-C 10/2022	
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, Z 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	ŽIP CODE	<u> </u>		
(X4) ID PREFIX TAG				(X5) COMPLETION DATE				
F 600	there (West unit) untitold Resident #207 the medication because in not count the narcotic change. LPN #3 stat giving narcotics on the come back on me" if LPN #3 stated after 2 LPN #5 were the only with three CNAs. LP check on residents of was working East. Lie CNA working on West problems. On 2/8/22 at 5:35 p.n. interviewed about any evening of 2/7/22. Root get any of her med 7:00 p.m. until 2/8/22 #207 stated that on 2 p.m. dose of gabaper missed a dose of mediand "a psych med" and morphine sulfate schea.m. Resident #207 11:30 p.m., she report nursing assistant) #5 get her scheduled pa #207 stated CNA #5 East unit and reporte luck" as there was not Resident #207 stated phone to the East unit practical nurse) #3 if her the pain medicati LPN #3 told her "no"	there was no nurse back I then." LPN #3 stated she at she could not give her the t was a narcotic and she did	F					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495105	B. WING			R-C 2/10/2022	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZII 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 600	her she did not ha #207 stated she the (South). Resident answered the phowas in with a residere reported that she had asked for the Resident #207 stated the phonurse could come (nurse) won't." Regot a visit or a call #207 stated there the evening/night of after 7:00 p.m. untimorning (2/8/22). in "a lot of pain" domethadone and mishe had pain in her rated pain during the "9 almost 10" (on spain). Resident #2911 to go to the ernobody was here the stated she could in "up and down all in corporate nursing around 2:00 a.m. amedications. Resident #207 spain. Resident #200 a.m. when the medications.	signed nurse was, LPN #3 told we a nurse this shift. Resident then called the other unit #207 stated whoever ne on South stated the nurse lent. Resident #207 stated she needed her pain, psych meds nurse to call her when possible. Ited she did not know who ne but that person told her if the she would and "if not, she sident #207 stated she never from either nurse. Resident was a CNA working the unit on of 2/7/22 but she saw no nurse ill the day shift reported the next Resident #207 stated she was ue to missed doses of orphine. Resident #207 stated ar arms and lower back and he early morning of 2/8/22 as a scale of 0 = no pain, 10 = worst 207 stated she almost called mergency room because to care for her. Resident #207 ot sleep due to the pain, was hight" and even emailed the consultant (administration #3) about not getting her ident #207 stated she last saw on 2/7/22 around 7:00 p.m. and er nurse until 2/8/22 around ne day shift nurse brought her	F	600			
	pain, low back pai	esident had musculoskeletal n, lumbar degenerative joint nic pain due to physical					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495105	B. WING		R-C 02/10/2022
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 600	minimize pain incluencedsMedications analgesia per order pain relieving method therapy, progressive cold application, mustimulationMonitors/sx (signs/symptor painObserve and routine, sleep patter abilities" The plair resident had depressivell-being due to so Interventions to preand promote psychem "Administer medicar resident time to answerbalize feelings pfearsIncrease cor resident/family/care careMonitor/docur response to probler On 2/8/22 at 8:30 pfearsIncrease cor resident/family/care careMonitor/docur response to probler On 2/8/22 at 8:30 pfearsIncrease cor resident/family/care careMonitor/docur response to probler On 2/8/22 at 8:30 pfearsIncrease cor resident/family/care careMonitor/docur response to probler On 2/8/22 at 8:30 pfearsIncrease cor resident/family/care careMonitor/docur response to probler On 2/8/22 at 8:30 pfearsIncrease cor resident/family/care careMonitor/docur response to probler On 2/8/22 at 8:30 pfearsIncrease cor resident/family/care careMonitor/docur response to probler On 2/8/22 at 8:30 pfearsIncrease cor resident/family/care careMonitor/docur response to probler On 2/8/22 at 8:30 pfearsIncrease cor resident/family/care careMonitor/docur response to probler On 2/8/22 at 8:30 pfearsIncrease cor resident/family/care careMonitor/docur response to probler On 2/8/22 at 8:30 pfearsIncrease cor resident/family/care careMonitor/docur response to probler On 2/8/22 at 8:30 pfearsIncrease cor resident/family/care careMonitor/docur response to probler On 2/8/22 at 8:30 pfearsIncrease cor resident/family/care care	ions to eliminate and/or ided, "Anticipate and meet is as orderedAdministerEncourage to try different ods i.e. positioning, relaxation is relaxation, bathing, heat and iscle r/record/report to Nurse any ins) of non-verbal report changes in usual report changes in usual reson and altered psychosocial chizoaffective disorder. In of care documented the ission and altered psychosocial chizoaffective disorder. In osocial well-being included, itions as orderedAllow the interest is and included in of care documented in osocial well-being included, itions as orderedAllow the interest is and included in of care documented included, itions as orderedAllow the interest is and included in order is an order in order in order is an order in order	F 60		
	unit left on 2/7/22 a stated after 7:30 p.r entire unit and he w stated he saw no nicheck on residents p.m. When asked i nurse during his shi #207 asked to see and Resident #257 about an earache.	round 7:30 p.m. CNA #1 m. there was no nurse on the ras the only CNA. CNA #1 urses come to the unit and from 7:30 p.m. until 11:00 f any residents needed a ft, CNA #1 stated Resident a nurse about her medications asked to see a nurse "I think" CNA #1 stated he told them a as soon as possible because,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495105	B. WING		R-C 02/10/2022	
	ROVIDER OR SUPPLIER	SILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	02/10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	
F 600	On 2/9/22 at 3:00 p again about medica administered with n unit. The DON stat only two nurses we nurses had to "split' stated she talked w LPN #3 by telephor 2/7/22. The DON s because she had to cart and LPN #3 wa only two nurses for stated she told then that they all had to DON stated nobody Resident #207 need residents not getting West. The DON stated were only two nurses	there was no nurse." .m., the DON was interviewed tions/treatments not onurse working the West ed LPN #3 was aware when re in the building that the the West unit. The DON ith unit manager LPN #2 and re during the evening on tated LPN #2 was upset work the East medication as upset because there were the night shift. The DON in everyone was frustrated and work together as a team. The realled or reported to her that ded pain medications or about g medications/treatments on atted she was aware there es working the building after ght the nurses knew to "split"	F 600			
	the unit left on 2/7/2 there were no nurse on 2/7/22 at 7:00 p. The clinical records unit were reviewed missed medications evening of 2/7/22 at when no nurse provunit. In addition to other residents on t #208 through #228	2 stated the two nurses on 22 at 7:00 p.m. CNA #2 stated as on West unit when she left				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495105	B. WING		,	R-C 02/10/2022	
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		521 10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	sugar checks for dia changes/site care refeedings/oxygen adurinary catheter. Me administered include and over-the counted diagnoses that include hyperlipidemia, glaus constipation/bowel mood disorder, prosinsomnia, pain, vitar neuropathy, seizure fibrillation and diabet treatments not proving fibrillation and diabet treatments on the everomorning of 2/8/22 in medications/creams pain, skin tears/wou prevention/care. Quality of care defict fifty-four West unit reprovided medication of 2/7/22 and early related deficiencies F690, F692, F693, Formulated deficiencies F690, F693, Formula	I tube feedings/flushes, blood betic management, tubing elated to enteral ministration, and care for a edications that were not ed a variety of prescriptions r medicines for treatment of ded hypertension, coma, muscle spasticity, management, congestion, tatic hyperplasia, depression, min/nutrition deficiencies, s, arthritis, dementia, atrial tes. Physician ordered ded to the West unit ening of 2/7/22 and early cluded topical for dry/chaffed skin, joint ands and pressure ulcer diencies were cited for the esidents that were not es/treatments on the evening morning of 2/8/22. Care were cited at F684, F686, F695 and F697. Ittled Ancillary Nursing Care ive 11/01/19) documented, will provide basic nursing care ng accepted standards of ecognized by state boards of by national nursing sevidenced by hiring duate from an approved or nurse aide curriculum and assed a licensing and/or	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495105	B. WING		R-C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	02/10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 684 SS=E	Patient Protection (et documented, "There mistreatment, abuse, property, or any crime of the Center have the verbal, sexual, mental employees are respointed in their absence, the Distribution and their absence, the City administrator, director nursing consultant or Quality of Care CFR(s): 483.25 § 483.25 Quality of Care Quality of care is a further applies to all treatments facility residents. Base assessment of a resident residents received accordance with profipractice, the compression of the compression of the compression and the resident in the REQUIREMENT by: Based on resident in	eglect prevention policy titled fective 1/23/20) is a zero tolerance for neglect, misappropriation of against a patientPatients e legal right to be free from all and physical abuseAll nsible for ng to the Administrator, or in rector of Nursing, or their any and all suspected or of patient abuse, neglect, l/or mistreatment" reviewed with the rof nursing and corporate a 2/9/22 at 3:00 p.m. are ndamental principle that not and care provided to ed on the comprehensive dent, the facility must ensure a treatment and care in essional standards of nensive person-centered sidents' choices. To is not met as evidenced the facility staff failed to	F 68	0	3/23/22	
	#202, #203, #205, #2	ey sample. Residents #201, 07 through #214, #216 hrough #225, #227, #228		attending Physician and Resident Representative were notified of resider not receiving their ordered	nts	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						R	-C
		495105	B. WING			02/	10/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LVNCUBLI	DO UEALTU O DEUADU	ITATION CENTER		5	615 SEMINOLE AVENUE		
LINCHBU	RG HEALTH & REHABIL	LITATION CENTER		L	YNCHBURG, VA 24502		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	e 18	F	684			
	· -	58 were not administered			medications/treatments for the 12 hrs.,		
		tments as ordered by the			the evening of 2/7/22 into the early		
	physician.	•			morning of 2/8/22. No new orders		
					received.		
	The findings include:				Current residents in the center have the	е	
		5.11			potential to be affected.		
		our of the facility on 2/8/22 at			Licensed will be educated by the Region		
		#205 stated he did not get evening (2/7/22). Resident			Director of Clinical Services/designee of the center □s policy on administration a		
	#205 stated he took a			documentation of medications/treatment			
	each evening at bedt				provided to the resident. The educati		
		ood pressure. When asked			will include ensuring residents receive		
	_	s medications, Resident			their scheduled medications and		
	#205 stated, "There v	wasn't no nurse here."			treatments as per MD orders. In additi	on,	
		I "some nurse" did not show			the DON/Nursing		
		nedicines were not given			Leadership/Administrator will be educa	ted	
		stated he wanted to get his			by the Regional Director of Clinical		
		nd was concerned about			Services/designee on the emergency	ata .	
	getting his blood pres	ssure medicine.			preparedness policies to ensure adequestaffing in the center. The DON	ale	
	Resident #205 was a	dmitted to the facility on			/designee will contact the Regional		
		es that included cerebral			Director of Clinical Services when the		
	infarction with hemipl				emergency preparedness policies have)	
		communication deficit,			been activated to ensure there is		
	hyperlipidemia, gastro	oesophageal reflux disease			adequate staffing in the center.		
		minimum data set (MDS)			The DON/designee will interview 5 aler		
		ssed Resident #205 with			and oriented residents weekly to ensur	е	
	moderately impaired	cognitive skills.			the residents are receiving their		
	Desident #205's elinia	and record decrimented			medications as per MD orders. The EMAR/ETAR will be reviewed 5x week	l. ,	
	current physician ord	cal record documented			to ensure medications have been giver	•	
	following medications				and documented as given on the	•	
	Tonowing modications	•			EMAR/ETAR. In addition, The		
	Atorvastatin calcium	80 mg (milligrams) at			DON/Administrator/Nursing		
	bedtime for treatment	-, -,			Leadership/designee will review staffin	g	
		at bedtime for hyperlipidemia			daily to ensure there is adequate staffing	-	
		.004% eye drops, instill 1			in the center. The DON/Nursing		
		pedtime for treatment of			Leadership will be notified when there	are	
	glaucoma				call offs to determine if the emergency		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDIN		R-C
		495105	B. WING _		02/10/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	
				5615 SEMINOLE AVENUE	
LYNCHBU	RG HEALTH & REHABI	LITATION CENTER		LYNCHBURG, VA 24502	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 684	Continued From pag	e 19	F 6	84	
F 684	Dantrolene sodium 2 spasticity Docusate sodium 10 constipation Baclofen 10 mg three Hydralazine 75 mg th hypertension Resident #205's med (MAR) documented to not administered on p.m. as scheduled. 2. Resident #201 was 6/28/19 with a readmoniagnoses for Resident Alzheimer's, pneumon hypertension, mood of hyperplasia, atherose anxiety, depression and MDS dated 1/19/22 as severely impaired concept impaired concept impaired concept following medications Guaifenesin extende hours for congestion Seroquel 75 mg at be a transulosin 0.4 mg and hyperplasia Trazadone 50 mg at Memantine 10 mg two Alzheimer's Melatonin 10 mg at each of the spanning to the sp	5 mg two times per day for 0 mg two times per day for etimes per day for spasms here times per day for dication administration record the above medications were the evening of 2/7/22 at 9:00 s admitted to the facility on hission on 1/12/21. Hent #201 included Honitis, dysphagia, (affective) disorder, prostatic heart disease, hand atrial fibrillation. The hassessed Resident #201 with highlity skills. cal record documented hers that included the his: d release 600 mg every 12 for 10 days hedtime for mood disorder hedtime for depression to times per day for heach bedtime for insomnia	F 6	preparedness policies ne implemented. The results of the review at the monthly QAPI mee QAPI committee determin no longer exists, the revie conducted on a random to The Administrator/Director responsible for implement of correction. Date of compliance-3/23/	will be discussed ting. Once the nes the problem ews will be pasis. or of Nursing are tation of the plan
	Aspirin 81 mg each r	times per day for pain norning units 2 tablets each day for			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495105	B. WING			R-C 02/10/2022	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	<u> </u>	02/10/2022	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	8:00 p.m. (guaifenes at 6:00 a.m. (aspirin, scheduled. 3. Resident #203 wa 9/11/18 with diagnos pressure ulcer, morb infection, encephalor hypertension, anemin hypothyroidism. The assessed Resident #203's clinic current physician or following medications. Atorvastatin 20 mg and Gabapentin 300 mg Buspirone 5 mg three depression Tylenol 650 mg three depression Tylenol 650 mg three Resident #203's MAI medications were no 9:00 p.m. as schedur 4. Resident #207 wa 6/13/20 with diagnos obesity, hypertension schizoaffective disorstenosis, intervertebrand gastroesophage	R documented these t administered on 2/7/22 at in), at 9:00 p.m. or on 2/8/22 cholecalciferol) as s admitted to the facility on es that included sacral id obesity, urinary tract bathy, atrial fibrillation, a, anxiety, osteoarthritis and a MDS dated 1/24/22 d203 as cognitively intact. cal record documented lers that included the second at bedtime for cholesterol at bedtime for pain e times per day for eatime per day for pain R documented the above t administered on 2/7/22 at	F 6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED		
		495105	B. WING			R-C 02/10/2022	
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	current physician of following medication. Doxepin 150 mg at Gabapentin 900 m neuropathy. Methadone 2.5 mg Morphine sulfate 3 pain. Aquaphor diaper rainner thighs topical for chaffing. Resident #207's M medications were revening of 2/7/22 at 12:00 a.m morphine sulfate a 2/8/22 at 12:00 a.m. On 2/8/22 at 5:35 ginterviewed about a evening of 2/7/22. not get any of her rainterviewed about a evening of 2/7/22. not get any of her rainterviewed about a evening of 2/7/22. not get any of her rainterviewed about a evening of 2/7/22. not get any of her rainterviewed about a evening of 2/7/22. not get any of her rainterviewed about a evening of 2/7/22. not get any of her rainterviewed about a evening of 2/7/22. not get any of her rainterviewed about a evening of 2/7/22. not get any of her rainterviewed about a evening of 2/7/22 at 3:35 ginterviewed about a evening of	inical record documented orders that included the ons and treatments: It bedtime for depression g three times per day for It every 8 hours for pain It omeg four times per day for It every 8 hours for pain It omeg four times per day for It every 8 hours for pain It omeg four times per day for It every 8 hours for pain It omeg four times per day for It of the early morning of 2/8/22 at It of the early mornin	F 6	84			
	2/2/18 with a readr	vas admitted to the facility on mission on 5/9/21. Diagnoses included atrial fibrillation,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
		495105	B. WING			R-C 02/10/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	DE	02/10/2022	
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F 684	Continued From page	_	F	684			
	hemiplegia, diabete disorder, hyperkaler dysphagia, asthma, morbid obesity and dated 11/10/21 asse moderately impaired. Resident #211's clir current physician or following: Atorvastatin 10 mg hyperlipidemia Ergocalciferol 1.25 Thursday for vitamin Senexon-S 8.6-50 regulation Thera-M multivitami Potassium Chloride (milliequivalents) twhypokalemia Buspirone 10 mg th Morphine sulfate Effor pain Artificial tears 1% of per day for dry eyes Gabapentin 600 mg neuropathy Eucerin cream apple evening shift for dry Voltaren gel 1% cre transdermal every serioder and the state of the substantial every serioder and s	s, chronic pain, bipolar mia, hyperlipidemia, mood disorder, hypertension, osteoarthritis. The MDS essed Resident #21 with d cognitive skills. Inical record documented ders that included the at each bedtime for mg every Monday and heliciency mg at bedtime for bowel in each day for wound healing extended release 20 meq to times per day for ree times per day for ree times per day for the drop in both eye four times of four times per day for y to both legs every day and eskin am apply 4 grams shift for leg pain					
	above medications/ administered on the medications were so at 9:00 p.m. except	nical record documented the treatments were not evening of 2/7/22. These cheduled to be administered for the buspirone and at were scheduled for 8:00					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495105	B. WING _			R- 02/1	C 1 0/2022	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	DE	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU		N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE	
F 684	1/6/21 with readmiss Resident #212 include vascular disease, chi hyperlipidemia, benig dementia, anxiety, de MDS dated 1/5/22 as moderately impaired. Resident #212's clini current physician ord following: Atorvastatin 80 mg a hyperlipidemia Doxazosin Mesylate benign prostatic hyper Risperidone 0.75 mg agitation/sleep Trazadone 100 mg a Hydrocodone-acetantimes per day for chrotriple antibiotic plus or right ear topically ear wound care Resident #212's MAR medications and the administered on the administered on the administered on the administered for 8:00 p.m. wand hydrocodone-acescheduled for 8:00 p.m.	s admitted to the facility on ion on 4/2/21. Diagnoses for led hypertension, peripheral ronic kidney disease, gn prostatic hyperplasia, epression and insomnia. The isessed Resident #212 with cognitive skills. cal record documented lers that included the it each bedtime for explasia at each bedtime for the each bedtime for insomnia ininophen 10-325 mg four onic back pain ointment 1% apply to top of ich day and evening shift for insomnia explain ointment in the each bedtime for insomnia ininophen 10-325 mg four onic back pain ointment 1% apply to top of ich day and evening shift for insomnia explain ointment in the explain ointment in the each bedtime for insomnia ointment 1% apply to top of ich day and evening shift for insomnia in the exception of risperidone etaminophen that were im.	Fé	584				
	11/1/17 with diagnos	s admitted to the facility on es that included cerebral legia, polyosteoarthritis, atrial						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
495105 B. WING			B. WING			R-C 02/10/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFII TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 684	fibrillation, dysphagia failure, hypertension disease. The MDS d Resident #213 with m skills. Resident #213's clinic physician orders that medications: Atorvastatin 20 mg at hyperlipidemia Hydrocodone-acetam times per day for poly Resident #213's MAF atorvastatin and hydr were not administer oscheduled. 8. Resident #218 was 1/29/19 with diagnost atrial fibrillation, hyperfracture, osteoporosis depression and gastr (GERD). The MDS depression and gastr (GERD). The MDS depression and gastr (GERD). The MDS depression and gastr (GERD) are skills. Resident #218's clinic current physician ord following medications. Famotidine 20 mg at Mirtazapine 15 mg a	cardiomyopathy, heart and gastroesophageal reflux ated 11/10/21 assessed noderately impaired cognitive cal record documented included the following teach bedtime for ninophen 5-325 mg three costeoarthritis and documented the cocodone-acetaminophen on 2/7/22 at 8:00 p.m. as admitted to the facility on the sthat included anemia, artension, seizures, hips, dementia, anxiety, oesophageal reflux disease lated 10/27/21 assessed everely impaired cognitive cal record documented the state included the state to depression bedtime for GERD bedtime for depression	F	684			
	(GERD). The MDS of Resident #218 with s skills. Resident #218's clinic current physician ord following medications Famotidine 20 mg at Mirtazapine 15 mg at Levetiracetam (Kepp (milliliter) give 5 ml tw	lated 10/27/21 assessed everely impaired cognitive cal record documented ers that included the statement of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495105 B. WING					R-C	
NAME OF D	ROVIDER OR SUPPLIER	495105	B. WING_		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	10/2022
NAME OF FI	ROVIDER OR SUFFLIER				6615 SEMINOLE AVENUE		
LYNCHBU	LYNCHBURG HEALTH & REHABILITATION CENTER				YNCHBURG, VA 24502		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	÷ 25	F	684			
		R documented the above administered on 2/7/22 at					
	11/4/20 with diagnose cerebrovascular accid fibrillation, hypertensi dysphagia, dysarthria						
	Resident #219's clinical record documented current physician orders that included the following:						
	Atorvastatin 80 mg at each bedtime for hypertension Peridex solution give 15 ml by mouth after meals and at bedtime for dental hygiene						
	Resident #219's MAR atorvastatin and Perio administered on the ep.m. as scheduled.						
	8/16/19 with diagnose COPD (chronic obstru depression, heart faile	220 with moderately					
	Resident #220's clinic current physician order following medications						

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495105	B. WING		R-C 02/10/2022
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	02/10/2022
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 684	Atorvastatin 40 mg Lexapro 10 mg at b Mirtazapine 15 mg Aspercreme lidocai topically every 12 h Simethicone capsu bedtime for abdomi Resident #220's Mi medications were n 9:00 p.m. as sched 11. Resident #221 v 1/12/21 with diagno cerebrovascular ac hypertension, chror hyponatremia, hypo depression. The M Resident #221 with problems and mode skills. Resident #221's cli current physician o following:	at bedtime for depression at bedtime for hyperlipidemia bedtime for depression at bedtime for depression ne patch 4% to right should fours for arthritis pain le 125 mg before meals and at inal discomfort/bloating AR documented the above not administered on 2/7/22 at uled. was admitted to the facility on oses that included cident (stroke), anemia,	F 684	,	
	120 ml three times loss. Resident #221's Mand Med Plus suppon 2/7/21 at 9:00 p 12. Resident #223	ement with instructions to give per day for history of weight AR documented the Tylenol element were not administered e.m. as scheduled. Was admitted to the facility on see that included anemia,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495105	B. WING		R-C 02/10/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	<u> </u>	02/10/2022
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	hypertension, renal ir infection, dementia, or glaucoma, cognitive or history of Covid-19. assessed Resident # cognitive skills. Resident #223's clinic current physician ord following medications Latanoprost solution both eyes at bedtime Rhopressa solution in bedtime for glaucoma Voltaren gel 1% applications were not evening of 2/7/22. The scheduled to be admitted to be admitt	resufficiency, urinary tract depression, urine retention, communication deficit and The MDS dated 12/28/21 223 with severely impaired cal record documented ers that included the s: 0.005% instill one drop in for glaucoma astill one drop in both eyes at a y 2 grams transdermal every to for pain, apply to bilateral a y 2 grams transdermal every to for pain, apply to bilateral a documented these to administered on the ne eye drops were inistered at 9:00 p.m. and to go the evening shift. as admitted to the facility on the est that included coronary in its congestive heart failure, mia, dementia, left arm and gastroesophageal reflux ated 11/10/21 assessed thort and long-term memory paired cognitive skills.	F 68	34		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C		
		495105	B. WING		02/10/2022	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION	
F 684	day for supplement Biofreeze gel 4% al every day and ever Resident #224's M/ supplements and the administered on 2/3 scheduled. 14. Resident #225 12/4/19 with a read for Resident #25 in accident (stroke), a GERD, diabetes, no dysphagia, obesity dated 10/29/21 ass moderately impaire. Resident #225's clir current physician of following: Atorvastatin 80 mg Accuchecks (blood and at bedtime for blood sugar is below Resident #225's M/ atorvastatin and the administered/obtain scheduled. 15. Resident #227 7/14/21 with diagnor renal cell carcinoma hypertension, hype	give 120 ml three times per pply to right knee topically hing shift for pain AR documented these he Biofreeze were not 7/22 at 9:00 p.m. as was admitted to the facility on mission on 2/3/22. Diagnoses cluded cerebrovascular trial fibrillation, hypertension, eurogenic bladder, depression, and hyperlipidemia. The MDS essed Resident #225 with d cognitive skills. hical record documented rders that included the at bedtime for cholesterol sugar check) before meals diabetes; notify physician if	F 68	4		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	(X3) DATE SURVEY COMPLETED	
		495105	B. WING		R-C 02/10/2022
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	02/10/2022
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC
F 684	current physician of following: Aricept 10 mg at b Latanoprost solution both eyes at bedting Pravastatin 20 mg Timolol Maleate so both eyes two times Med Plus 1.7 NSA weight maintenance. Resident #227's Mandications and sadministered on 2/2 scheduled. 16. Resident #228 5/21/21 with diagnorerebrovascular and hemiplegia, seizur disease, anemia, phypertension, renather MDS dated 12 with moderately in the	inical record documented orders that included the edtime for dementia on 0.005% instill one drop in me for glaucoma at bedtime for hyperlipidemia olution 0.5% instill one drop in es per day for glaucoma120 ml three times per day for ce	F 63	,	
	following: Eucerin eczema re topically every shift Resident #228's M cream was not app	elief cream 1% apply to skin It for dry skin AR documented the Eucerin Dilied on the evening shift of shift (11:00 p.m. to 7:00 a.m.)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495105	B. WING _	B. WING			R-C 02/10/2022	
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	, ZIP CODE	(12)	10/2022	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIV CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 684	8/19/21 with diagnose cancer, anemia, hyper pneumonia, Parkinson malnutrition, depressing schizophrenia. The Massessed Resident #2 impaired cognitive skill resident #230's clinic current physician order following medications: Atorvastatin 40 mg at Senna 8.6 mg two table constipation: Resident #230's MAR medications were not 9:00 p.m. as scheduled: 18. Resident #231 wat 4/11/18 with diagnosed depression, arthritis, deficiency. The MDS Resident #231 with sessibles. Resident #231's clinic current physician order following: Celexa 20 mg at bedt Mirtazapine 7.5 mg at services in the medical procession or the following:	as admitted to the facility on es that included colon retension, renal insufficiency, n's disease, protein-calorie on, psychosis and MDS dated 11/11/21 230 with moderately Ills. It record documented ers that included the : bedtime for cholesterol olets at bedtime for dementia, GERD and vitamin D dated 1/9/22 assessed everely impaired cognitive as a record documented dementia, GERD and vitamin D dated 1/9/22 assessed everely impaired cognitive as a record documented ers that included the impaired cognitive	Fé	584				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495105	B. WING _			R-C 02/10/2022		
	ROVIDER OR SUPPLIER	SILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	<u> </u>	02/10/2022		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 684	medications were n 9:00 p.m. as scheded 19. Resident #232 v 12/6/18 with diagnor hypertension, histor hyperlipidemia, hyp MDS dated 11/3/21 moderately impaired Resident #232's clir current physician or following medication Aricept 5 mg at bed Omeprazole delayer for GERD Simvastatin 20 mg Aggrenox extended (aspirin-dipyridamolhistory of stroke Gabapentin 600 mg Sennosides 8.6 mg constipation Artificial tears 1-0.3 four times per day for Resident #232's Mamedications were n 9:00 p.m. as scheded 20. Resident #233 v 2/4/21 with diagnos diabetes, hyperlipid and asthma. The North process of the schede in the schede i	AR documented these of administered on 2/7/2 at alled. was admitted to the facility on ses that included by of stroke, GERD, diabetes, onatremia and dementia. The assessed Resident #232 with diagram of cognitive skills. Inical record documented ders that included the final diagram of the for dementia diagram of the release 20 mg at bedtime for hyperlipidemia release 25-200 mg final two times per day for all two times per day for limit wo tablets twice per day for limit wo tablets twice per day for dry eyes AR documented these of administered on 2/7/22 at	F6	84				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		495105	B. WING			R-C 02/10/2022		
	ROVIDER OR SUPPLIER	SILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		02/10/2022		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE		
F 684	Continued From page 32 Resident #233's clinical record documented a		F	584				
		ders that included the						
	a stool softener	ry morning and at bedtime as se times per day for right knee						
	Resident #233's MAR documented the Colace and Tylenol were not administered on 2/7/22 at 9:00 p.m. as scheduled. 21. Resident #234 was admitted to the facility on 4/29/21 with diagnoses that included hypertension, diabetes, hyperlipidemia, Alzheimer's, depression and mood (affective) disorder. The MDS dated 11/15/21 assessed Resident #234 with severely impaired cognitive skills.							
		nical record documented ders that included the						
	hypertension Docusate sodium 11 constipation Donepezil 10 mg at Quetiapine Fumara mood Vanlafaxine ER 150	e 5 mg at bedtime for 00 mg at bedtime for bedtime for dementia te 100 mg at bedtime for mg at bedtime for depression ement 120 ml three times per eight loss						
	Resident #234's MA medications and su administered on 2/7							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495105	B. WING_			R-C 02/10/2022	
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	I	02/10/2022	
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 684	scheduled. 22. Resident #235 w 12/31/21 with diagnor obesity, chronic pair syndrome, atrial fibric borderline personality 12/6/21 assessed R intact. Resident #235's clinic current physician's devery morning and a Resident #235's MAR was not administere scheduled. 23. Resident #236 w 5/14/21 with diagnostibrillation, adult failure pilepsy, sleep aproceed to the pressive disorder dated 12/7/21 assess cognitively intact. Resident #236's clinic current physician or following: Aripiprazole 10 mg adepressive disorder Ergocalciferol 1.25 m for vitamin D deficie Reglan 5 mg three to tube feeds	vas admitted to the facility on oses that included morbid in GERD, restless leg llation, depression and by disorder. The MDS dated resident #235 as cognitively discal record documented a order for vitamin C 500 mg at bedtime for supplement. Redocumented the vitamin C do on 2/7/22 at 9:00 p.m. as vas admitted to the facility on rese that included atrial re-to-thrive, morbid obesity, rea, hypothyroidism, and diverticulosis, major and dysphagia. The MDS resed Resident #236 as rical record documented ders that included the research that included the research of the major response per day for nausea with response per day for nausea with respect to the facility on see that included the research of the major response per day for nausea with respect to the facility on see that included the research of the facility on see that included the response of the facility on the fa	F6	84			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495105	B. WING			R-C 02/10/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	, in the second second	02/10/2022
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORREC CROSS-REFEREN	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 684	Continued From page	e 34	F	684		
	Resident #236's MAF medications were no 9:00 p.m. as schedul	administered on 2/7/22 at				
	12/29/21 with diagno infarction, congestive (chronic obstructive pdiabetes, GERD, atrichronic kidney disease and peripheral vascu	oulmonary disease), al fibrillation, Alzheimer's, se, lung cancer, hypertension lar disease. The MDS dated sident #237 with severely				
	Resident #237's clinic current physician ord following:	cal record documented ers that included the				
	Donepezil 5 mg at be Famotidine 20 mg at Lipitor 80 mg at bedti Eliquis 5 mg every m atrial fibrillation Accuchecks (blood so	bedtime for GERD me for hyperlipidemia, orning and at bedtime for ugar check) before meals y physician for blood sugars				
	weight and an accucl morning of 2/8/22. T bedtime accucheck v each evening. The d					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495105 B. WING				R-C 02/10/2022
	OVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	1	OLI TOI LOLL
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	4/8/19 with diagnose: subarachnoid hemore glaucoma, convulsion GERD. The MDS da Resident #238 with makills. Resident #238's clinic current physician ord following medications: Atorvastatin 10 mg at Latanoprost solution both eyes at bedtime Keppra 500 mg two to seizures: Baclofen 10 mg give day for muscle relaxations and following medications: Baclofen 10 mg give day for muscle relaxations were not give day for muscle relaxations. We will be depression, os schedul at 202 with diagnoses cancer, COPD, vascu heart failure, morbid depression, osteopor The MDS dated 12/2 #202 with moderately Resident #202's clinic current physician's or	as admitted to the facility on a that included aphasia, thage with hemiplegia, as, hyperlipidemia and ted 12/10/21 assessed moderately impaired cognitive cal record documented the standard and	F	584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495105	B. WING		1	R-C 2/10/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		2/10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	8:00 a.m. Review of Resident for the hydrocodone no dose was remove a.m. dose on 2/7/22 sheet for hydrocodo the amount left on the constant of the amount left on the hydrocodone-acetar the 8:00 a.m. dose or administered. LP why the medication 27. Resident #208 v 10/02/2021 with the including but not liming hemiplegia, acute kingular hypertension. A quaset) with an ARD (as 12/20/2021, assessing problems with both land severely impaired skills. Resident #208's clinfollowing physician of Atorvastatin Calcium Give one tablet via Felipidemia	#202's narcotic count sheet -acetaminophen documented ed from the cart for the 8:00 . Resident #202's count ne-acetaminophen matched ne pharmacy supply card. m., LPN #6 caring for interviewed about the minophen not administered. The resident's MAR and minophen supply and stated on 2/7/22 was not signed out to the stated she did not know was not given as ordered. Was admitted to the facility on following diagnoses, ited to: dysphagia, dney failure, depression, and retrly MDS (minimum data assessment reference date) of the ded Resident #208 as having ong and short term memory and with daily decision making ical record included the orders: Tablets 40 mg (milligrams) PEG-Tube at bedtime for the 0.005% Instill 1 drop in both	F 6	34			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			R-C)2/10/2022	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		2110/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 684	Buspirone HCL Table PEG-tube three times Review of Resident (medication administ the above medication at 8:00 p.m. and 9:00 28. Resident #209 w 10/30/2020 with the including but not limi hemiplegia, aphasia, quarterly MDS with a assessed Resident # both long and short timpaired with daily d Resident #209's clinifollowing physician of Simethicone Tablet of three times a day for Aspirin Tablet chewatime a day for prophy Lactulose Solution 1 PEG-tube one time a Paroxetine HCL table PEG-tube two times Senexon-S Tablet 8. PEG-tube two times Review of Resident adocumented Simethicone Tablet one time a Review of Resident adocumented Simethicone Tablet Senexon-S Tablet 8.	nes a day for depression et 5 mg Give 1 tablet via s a day for anxiety #208's February MAR tration record) documented ns were not given as ordered 0 p.m. on 02/07/2022. ras admitted to the facility on following diagnoses, ted to: cerebral infarct, and hypertension. A an ARD of 12/23/2021, #209 as having problems with term memory and severely recision making skills. recal record included the reders: give 125 mg via PEG-tube or gas/bloating ble 81 mg via PEG-tube one ylaxis 0 gm/15 ml Give 30 ml via a day for constipation. ret 20 mg Give 1 tablet via a day for depression rablet 25 mg Vie 0.5 tablet via a day for hypertension 6-50 mgGive 2 tablets via a day for constipation #209's February MAR cone was not given as	F6	84			
	documented Simethi ordered at 8:00 p.m. medications were sc						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495105	B. WING _				-C 10/2022	
	ROVIDER OR SUPPLIER	LITATION CENTER	•	STREET ADDRESS, CI 5615 SEMINOLE AVE LYNCHBURG, VA	ENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	06/01/2019 with the fincluding but not limit Alzheimer's, adult fai A quarterly MDS with assessed Resident # both long and short to impaired with daily de Resident #210's clinic following physician of Amlodipine Besylate via PEG-tube in the repressure Aspirin EC Tablet De tablet by mouth one to prevention Carvedilol tablet 6.25 PEG-tube two times a pressure Lisinopril Tablet 30 m two times a day for her Review of Resident # documented the about given as ordered at 6 30. Resident #214 w 10/06/2021 with the fincluding but not limit hypothyroidism, and MDS with an ARD of Resident #214 as cog summary score of "15 and the sident #214 and the sident #214 as cog summary score of "15 and the sident #214 and the siden	as admitted to the facility on ollowing diagnoses, ed to: cerebral infarct, lure to thrive, and dysphagia. In an ARD of 11/29/2021, 210 as having problems with erm memory and severely ecision making skills. Cal record included the orders: Tablet 10 mg Give 1 tablet morning for high blood Layed release 81 mg Give 1 time a day for stroke Taming Give 1 tablet via a day for high blood The gray of t	Fé	884				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
		495105	B. WING			R-C 02/10/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	•	52/10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From pag		F 6	684			
	Atorvastatin Calcium tablet by mouth at be Levothyroxine Sodiu (micrograms) Give 7 day for THYROIDIS Review of Resident documented the Ato p.m. on 02/07/2022	n Tablets 20 mg Give one edtime for hyperlipidemia ım Tablet 75 mcg 75 mcgs by mouth one time a					
	01/23/2020 with the including but not lim peripheral vascular and protein/calorie r with an ARD of 11/1	vas admitted to the facility on following diagnoses,					
	following physician of	ical record included the orders: n Tablets 40 mg Give one					
	tablet by mouth at b Colace 100 mg Give a day for constipatio	edtime for hyperlipidemia e 100 mg by mouth two times in g Give 6.25 mg by mouth two					
	documented the abo	#216's February MAR ove medications were not 9:00 p.m. on 02/07/2022.					
		vas admitted to the facility on following diagnoses,					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495105	B. WING _			R-C 02/10/2022		
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	<u>\</u> _	02/10/2022		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 684	including but not lim retention, hypertens quarterly MDS with a assessed Resident in his cognitive statu "11". Resident #217's clin following physician of the company of	ited to: Atrial fibrillation, urine ion, and diabetes mellitus. A an ARD of 12/23/2021, #217 as moderately impaired is with a summary score of ical record included the orders: If Give 1 tablet by mouth at a ition 100 units/ml Inject 35 y at bedtime for diabetes ule 0.4 mg Give 1 capsule by r BPH (benign prostate each meal before meals for bs (blood sugar) below 60 or #217's February MAR ove medications were not 9:00 p.m. on 02/07/2022, nor completed at 6:00 a.m., on was admitted to the facility on gnoses including but not gia and hemiparesis, diabetes on, vascular dementia, and matic epilepsy and epileptic aplex partial seizures. A an ARD of 12/21/2021, #239 as severely impaired in with a summary score of "07".	F6	984				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	LE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		495105	B. WING			R-C 02/10/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	15 SEMINOLE AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 684	Continued From pa	ge 41	F 68	4			
	bedtime for dement Atorvastatin Calcium by mouth at bedtime Mitazapime Tablet 3 bedtime for ANTIDE Med Plus 2.0 three supplementation of mls (milliliters) Accuchecks AC (besleep) before meals be below 60 or about Review of Resident documented the aband Accucheck werp.m. on 02/07/2022 done on 02/08/2023 34. Resident #240 09/30/2020 with the including but not lindisorder, hypothyro and chronic kidney an ARD of 11/02/20	m Tablet 80 mg Give 1 tablet e for hyperlipdemia (sic) 30 mg Give 30 mg by mouth at EPRESSANT times per day for PO (by mouth) diet give 120 fore meals) and HS (hour of and at bedtime notify MD if we 400. #239's February MAR ove medications, supplement e not done as ordered at 9:00 The Accucheck as also not 2 at 6:00 a.m. as ordered. was admitted to the facility on following diagnoses, hited to: dementia, bipolar idism, chronic pain disorder, disease. A quarterly MDS with 21, assessed Resident #240 d in her cognitive status with a					
	Resident #240's clii following physician	nical record included the orders:					
	tablet by mouth at the Ramelteon Tablet 8 bedtime for sleep a Med Plus 2.0 three give 120 ml	Disintegrating 45 mg Give 1 pedtime for depression mg Give 1 tablet by mouth at id times a day for weight loss et 50 mg Give 1 tablet by					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	, ,	DATE SURVEY COMPLETED
		495105	B. WING			R-C 02/10/2022
	ROVIDER OR SUPPLIER	SILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	DDE	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 684	documented Mitarzanot given as ordered. The med plus was rp.m. on 02/07/2022 scheduled for midni 02/08/2022, neither ordered. 35. Resident #241 v 05/23/2017 with the including but not limhypertension, anxie convulsions and detan ARD of 01/23/20 as having problems memory as well as Idaily decision making Resident #241's clir following physician at Atorvastatin Calciur tablet by mouth at bonepezil HCL Tablemouth at bedtime re Levetiracertam Tablemouth two times at CONVULSIONS Hydralazine HCL Tamouth three times at	#240's February MAR apine and Ramelteon were d at 9:00 p.m. on 02/07/2022. not given as ordered at 8:00 . The Tramadol was ght and 6:00 a.m. on dose was administered as was admitted to the facility on following diagnoses, hited to: aphasia, ty, depressive disorder, mentia. A quarterly MDS with 22 assessed Resident #241 with both long and short term being severely impaired with ng skills nical record included the	F	684		
	documented the abo	#241's February MAR ove medications were not 9:00 p.m. on 02/07/2022.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495105	B. WING			R-C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	CODE	02/10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BI THE APPROPRIA	DATE	
F 684	05/23/2017 with the including but not lim schizoeffective disor and adult failure to the an ARD of 01/06/2020 as moderately impais score of "10". Resident #242's clin following physician of the Amitriptyline HCL Tamoth at bedtime for Benztropine Mesylar by mouth at bedtime Melatonin Give 3 mg insomnia Mitarzapine 30 mg Cobedtime for depress Perphenazine Table mouth at bedtime for Glycopyrrolate Table mouth three times a Carbidopa-Levodopatablet by mouth four disease Review of Resident documented the abordiven as ordered at 37. Resident #243 w 09/09/2011 with the including but not lim	vas admitted to the facility on following diagnoses, ited to: Parkinson's, ider, chronic kidney disease, hrive. A quarterly MDS with 22 assessed Resident #242 red with a cognitive summary ical record included the orders: blet 50 mg Give 1 tablet by depression to Tablet 1 mg Give 1 tablet for Parkinson's disease g by mouth at bedtime for Give 1 tablet by mouth at ion to 4 mg Give 1.5 tablet by a r schizoeffective disorder to 1 mg Give 0.5 tablet by day to decrease salivation a Tablet 25-100 mg Give 1.5 times a day for Parkinson #242's February MAR ove medications were not 9:00 p.m. on 02/07/2022.	F	584			
		essive disorder. An annual f 12/29/2021 assessed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495105	B. WING				-C 10/2022
	ROVIDER OR SUPPLIER	LITATION CENTER	•	5	TREET ADDRESS, CITY, STATE, ZIP CODE 615 SEMINOLE AVENUE YNCHBURG, VA 24502		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Resident #243's clinic following physician of Atorvastatin Calcium tablet by mouth at be heart disease Depakote Tablet Delatablets by mouth two Risperdal Tablet 1 mg time a day for mood of Vitamin B-1 100 mg of a day for supplement Review of Resident # documented the aborgiven as ordered at 8 38. Resident #244 ws 03/06/2020 with the fincluding but not limit respiratory failure, he dementia, and hemip an ARD of 01/08/202 as severely impaired score of "05". Resident #244's clinic following physician of Ascorbic Acid 1000 m bedtime for supplement Atorvastatin Calcium tablet by mouth at be Chlolecalciferol Table mouth at bedtime for	verely impaired with a core of "07". cal record included the reders: Tablets 20 mg Give one dtime for arterosclerotic ayed Release 125 mg Give 3 times a day for behavior g Give 1 tablet by mouth two disorder Give 1 tablet orally tow times a compared to the facility on collowing diagnoses, and to: Dysphagia, acute cart failure, vascular elegia. An annual MDS with 2 assessed Resident #244 with a cognitive summary cal record included the reders: ng Give 1 tablet by mouth at cent Tablets 40 mg Give one dtime for hyperlipidemia et 1000 unit Give 1 tablet by	F	684			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		NSTRUCTION	(X3) DATE	SURVEY PLETED
		495105	B. WING			1	I-C /10/2022
	ROVIDER OR SUPPLIER JRG HEALTH & REHABI			5615	ET ADDRESS, CITY, STATE, ZIP CODE SEMINOLE AVENUE CHBURG, VA 24502	1 021	10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 684	mouth three times a Med Plus 2.0 three tigive 120 mls Refresh Plus Solution eyes three times and days Review of Resident and documented the abost supplement were not p.m. and 9:00 p.m. of 39. Resident #245 w 05/03/2021 with the including but not limit dementia, major deposition of the cerebrovascular disease. ARD of 01/19/2022 and having problems with memory as well as a with daily decision of the cerebrovascular disease. Olopatadine HCL Solution of the cerebrovascular disease with daily decision of the cerebrovascular disease. ARD of 01/19/2022 and the cerebrovascular disease with daily decision of the cerebrovascular disease with daily decision of the cerebrovascular disease. ARD of 01/19/2022 and the cerebrovascular disease with daily decision of the cerebrovascular disease with decision of the cerebrovascular disease with decision of the cerebrovascular disease with daily decision of the cerebrovascular disease with decision of the cerebrovascular disea	day for pain imes a day for for nutrition imes a day for for nutrition in 0.05% Instill 1 drop in both ay for meibomiaanitis for 90 #244's February MAR ove medications and trigiven as ordered at 8:00 on 02/07/2022. #25 admitted to the facility on following diagnoses, ted to: hypertension, pressive disorder, and ease. A quarterly MDS with an easesed Resident #245 as in both long and short term reing moderately impaired taking skills #26 and included the orders: #26 button 1% Instill 1 drop in hours for irritation to 650 mg by mouth three parthritis lution Instill 1 drop in both ay for dry eyes #245's February MAR ove medications were not 8:00 p.m. and 9:00 p.m. on	F	584			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED
		495105	B. WING			R-C 02/10/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	TE, ZIP CODE	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	((EACH CORRECT CROSS-REFERENCE)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 684	including but not limit hypertension, major of dysphagia. A quarter 12/30/2021 assessed moderately impaired score of "09". Resident #246's clinic following physician of Escitalopram Oxlate bedtime for depression Buspirone HCL Table mouth two times a day Calcium Tablet 600 m two times a day for si	depressive disorder, and by MDS with an ARD of a Resident #246 as with a cognitive summary and record included the reders: Tablet 7.5 mg by mouth at an at 5 mg Give 1 tablet by any for anxiety any for anxiety any for anxiety any for any	F	584		
	documented the above given as ordered at 8 41. Resident #247 wa 06/15/2021 with the including but not limit disease, hypertension dysphagia. An annua 11/18/2021 assessed moderately impaired score of "10". Resident #247's clinic following physician of Levothyroxine Sodiur	ve medications were not :00 p.m. on 02/07/2022. as admitted to the facility on following diagnoses, ed to: Peripheral vascular n, hypothyroidism, and I MDS with an ARD of I Resident #247 as with a cognitive summary				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		DNSTRUCTION	(X3) DATE COMP	SURVEY
			B 14/11/0			l	-C
		495105	B. WING _			02/	10/2022
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
LYNCHBU	RG HEALTH & REHABI	LITATION CENTER		LYNCHBURG, VA 24502			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From pag		F 6	884			
	documented the abo	#247's February MAR ve medications was not 5:00 a.m. on 02/08/2022.					
	02/11/2020 with the including but not limi disorders due to kno dementia, delusional disorder and dementia ARD of 01/29/2022 a having problems with	ted to: Other mental wn physiological condition, I disorder, depressive ia. A quarterly MDS with an assessed Resident #248 as a both long and short term eing moderately impaired					
	Resident #248's clini following physician c	cal record included the orders:					
	500 mg Give 1 table mood disorder Olanzapine Tablet 10 at bedtime related to DISORDER Oxcarbazepine ER thour 600 mg Give 1 for mood disorder Trazadone HCL Table mouth at bedtime for Ziprasidone HCL Ca	psule 40 mg Give 40 mg by					
	PSYCHOSIS NOT DE KNOWN PHYSIOLO Depakote Tablet Del tablet by mouth two disorder Lactulose Solution 1 mouth three times a	ayed Release 250 mg Give 1 times a day for mood 0 Gm/15 Ml Give 30 ml by					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495105	B. WING				-C	
	ROVIDER OR SUPPLIER			561	REET ADDRESS, CITY, STATE, ZIP CODE 15 SEMINOLE AVENUE NCHBURG, VA 24502	1 0 <i>21</i>	10/2022	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From pag a day for PAIN MGT		F	684				
	documented the abo	#248's February MAR ve medications were not 9:00 p.m. and 10:00 p.m. on						
	02/11/2021 with the fincluding but not limit protein/calorie malnu (transient ischemic athrive. An annual ME 12/15/2021 assessed	ted to: dementia, dysphagia, utrition, history of TIA ttacks) and adult failure to OS with an ARD of						
	Resident #249's clinical record included the following physician orders:							
	by mouth at bedtime Olopatadine HCL So both eyes every 12 h is symptoms worsen Med Plus 2.0 three ti malnutrition and wou Midodrine HCL Table three times a day for Quetiapine Fumarate by mouth three times Review of Resident a documented the abo	lution 0.1% Instill 2 drop in hours for irritation notify HOV Imes a day for protein calorie and healing give 120 mls at 5 mg Give 10 mg by mouth hypotension at Tablet 50 mg Give 1 tablet as a day for dementia #249's February MAR we medications and t given as ordered at 8:00						
		as admitted to the facility on						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		495105	B. WING _				-C 10/2022
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	, CODE	1 021	10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
F 684	Continued From pag including but not limi (chronic obstructive phypertension, and ar an ARD of 11/11/202 as cognitively intact w"14". Resident #250's clini following physician of Latanoprost Solution eyes at bedtime for Comparastatith Sodium by mouth at bedtime Atrovent HFA Aeroscinhale orally three time. Review of Resident #250 with the about given as ordered at 8 02/07/2022. 45. Resident #251 w 01/15/2019 with the including but not limit flutter, glaucoma, hy	ted to: emphysema, COPD coulmonary disease), inxiety. A quarterly MDS with 1 assessed Resident #250 with as summary score of cal record included the orders: 0.005% Instill 1 drop in both Glaucoma Tablet 20 mg Give 1 tablet for hyperlipidemia of Solution 17 mcg/ACT 1 puffines a day for COPD #250's February MAR ve medications were not 3:00 p.m., and 9:00 p.m. on following diagnoses, ted to: dysphagia, Atrial pertension, and metabolic annual MDS with an ARD of		584	NCY)		
	moderately impaired score of "08". Resident #251's clini following physician of the physic	with a cognitive summary cal record included the rders: et 10 mg Give 1 tablet by mood disorder o mg Give 1 tablet at bedtime					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495105	B. WING		R-C	;)/2022
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	02/10	112022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	documented the abgiven as ordered at Accuchecks were a on 02/07/2022 and 46. Resident #252 v 06/17/2021 with the including but not lim hypertension, Atrial cognitive impairmer ARD of 01/14/2022 moderately impaired score of "08". Resident #252's clir following physician Lantoprost Solution eyes at bedtime for Eliquis Tablet 5 mg day for afib Review of Resident documented the abgiven as ordered at 02/07/2022. 47. Resident #253 v 11/22/2021 with the including but not lim disorder, hemiplegia	#251's February MAR ove medications were not 9:00 p.m. on 02/07/2022. The Iso not completed at 9:00 p.m. 6:00 a.m. on 02/08/2022. was admitted to the facility on following diagnoses, nited to: autistic disorder, fibrillation, obesity, and mild at. A quarterly MDS with an assessed Resident #252 as d with a cognitive summary nical record included the orders: 0.005% Instill 1 drop in both	F 68	34		
	11/22/2021 with the including but not lim disorder, hemiplegia cerebral infarction. of 12/12/2021 asset	e following diagnoses, nited to: hypertension, mood a, insomnia, seizures, and				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	_		LETED
		495105	B. WING			R.	-C 10/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 5615 SEMINOLE AVENUE LYNCHBURG, VA 2450		<u> U2/</u>	10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRI	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	following physician of Levothyroxine Sodius tablet by mouth one Prednisone 2.5 mg of bedtime for inflammar Rosuvastatin Calcium tablet by mouth at bed Topiramate Tablet 10 at bedtime for seizur Calcium Carbonate of mouth two times a dispersion of Divalproex Sodium of Sprinkle 125 mg Giv morning and at bedt Risperdone Tablet 0 two times a day for Martificial Tear Solution three times a day for Review of Resident adocumented the aborgiven as ordered. The given at 6:00 a.m. or medications were not p.m. as scheduled of 48. Resident #254 w 06/28/2019 with the including but not limit hypertension, dysphologolar cancer. A qualification of 1/11/2021 assessed moderately impaired score of 1/109".	ical record included the orders: Im Tablet 50 mcg Give 1 time a day for hypothyroidism Give 1 tablet by mouth at ation Im Tablet 40 mg Give one editime for hyperlipidemia 00 mg Give 2 tablet by mouth these for hypocalcemia capsule Delayed Release to 1 capsule by mouth every ime for seizures for give 1 tablet by mouth food disorder in Instill 1 drop in both eyes for dry eyes #253's February MAR eve medications were not the Levothyroxine was not in 02/08/2022. The other of given at 8:00 p.m. and 9:00 in 02/07/2022. It is admitted to the facility on following diagnoses, ted to: diabetes, agia, history of TIAs, and terly MDS with an ARD of dia Resident #254 as with a cognitive summary	F	84			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	ATE SURVEY OMPLETED
		495105	B. WING			R-C 02/10/2022
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	'	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	ge 52	F 68	34		
	eyes at bedtime for Ferrous Sulfate Tablet by mouth thre deficiency anemia Review of Resident documented the aborgiven as ordered at 02/07/2022. 49. Resident #255 w 10/22/2020 with the including but not lim protein-calorie malnosteoporosis, and hywith an ARD of 11/1	et 325 (65 Fe) mg Give 1 e times a day for iron #254's February MAR ove medications were not 8:00 p.m. and 9:00 p.m. on vas admitted to the facility on following diagnoses, ited to: rheumatoid arthritis, utrition, adult failure to thrive, ypertension. A quarterly MDS 0/2021 assessed Resident impaired with a cognitive				
	Resident #255's clin following physician o	ical record included the orders:				
	Med Plus 2.0 three t protein-calorie maln	_				
		#255's February MAR ove supplement was not given .m. on 02/07/2022.				
	06/23/2020 with the including but not lim multiple sclerosis, al disease. A significar of 12/17/2021 asses	vas admitted to the facility on following diagnoses, ited to: legal blindness, and gastro-esophageal reflux at change MDS with an ARD used Resident #256 as the a summary score of "13".				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRU		(X3) DATE SURVEY COMPLETED		
		495105	B. WING _			1	I-C /10/2022
	ROVIDER OR SUPPLIER	LITATION CENTER		5615 SEMIN	ORESS, CITY, STATE, ZIP CODE OLE AVENUE RG, VA 24502	1 02/	10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684			F 6	884			
	Resident #256's clini following physician o	cal record included the rders:					
	tablet by mouth two t	ablet 600-400 mg-unit Give 1 imes a day for supplement 1 tablet by mouth three le spasms					
	documented the abo	Review of Resident #256's February MAR documented the above medications were not given as ordered at 9:00 p.m. on 02/07/2022. 51. Resident #257 was admitted to the facility on					
	51. Resident #257 was admitted to the facility on 02/21/2019 with the following diagnoses, including but not limited to: dysphagia, major depressive disorder, hydrocephalus, unspecified psychosis, and hypertension. An annual MDS with an ARD of 12/08/2021 assessed Resident #257 as moderately impaired with a cognitive summary score of "09".						
	Resident #257's clini following physician o	cal record included the rders:					
	Gabapentin Capsule times a day for osteo	Give 300 mg by mouth three arthritis					
		‡257's February MAR ve medication was not given m. on 02/07/2022.					
	01/05/2022 with the tincluding but not limit fibrillation, morbid ob infarction,epilepsy, a	ted to: Diabetes, Atrial esity, myocardial nd heart failure. A quarterly 12/17/2021 assessed gnitively intact with a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495105	B. WING			02/	10/2022
NAME OF P	ROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE		
IVNCHBII	RG HEALTH & REHABIL	ITATION CENTER			5615 SEMINOLE AVENUE		
LINCHBU	RG REALIN & RENABIL	ITATION CENTER			LYNCHBURG, VA 24502		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	NIE.	DATE
			1		,		
F 684	Continued From page	s 5 <i>1</i>	_	684			
1 00-	Continued From page	5 34	-	004			
	Posidont #258's clinic	cal record included the					
	following physician or						
	lollowing priyaician or	uers.					
	Atorvastatin Calcium	Tablets 80 mg Give one					
		dtime for hyperlipidemia					
	,	ablet Delayed Release 125					
	mg Give 1 tablet	,					
	by mouth at bedtime	for epilepsy					
	Gabapentin Capsule	300 mg Give 1 capsule by					
	mouth three times a c	day for neuropathy					
		t 5 mg Give 1 tablet by					
	mouth three times a c						
		HS before meals and at					
	bedtime for bs monitor	pring					
	Review of Resident #	258's February MAP					
	documented the above						
		given/completed as ordered					
	at 9:00 p.m. on 02/07						
	On 2/8/22 at 3:35 p.m	n., the administrator, DON					
	and corporate consul	tant (administration staff #3)					
		eam and reported that no					
	physician ordered me	edications and/or treatments					
		any of the residents on the					
		at 7:00 p.m. until 2/8/22 at					
		stated LPN #2 was the					
		at evening and could have					
	_	s working on the facility's					
		uth and West). The DON #3 and LPN #4 worked in the					
	,	ng of 2/7/22 until 11:00 p.m.					
	•	#2 and LPN #4 left on					
		with two nurses scheduled					
	•	ig at 11:00 p.m. The DON					
	_	n the East unit, LPN #5 was					
		it and the two nurses were					
	supposed to "split" the						

STATEMENT OF AND PLAN OF (DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495105	B. WING _			R-C 02/10/2022
	OVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	ODE	02/10/2022
(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 (X (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TIVE DEFICIENCY	ON SHOULD BE HE APPROPRIAT	
	and corporate consulsurvey team. The Do that two nurses (LPN only nurses in the bu 2/8/22 at 7:00 a.m. To two nurses worked the (nurses) knew" to spistated there was no night shift. On 2/8/22 at 5:10 p.m. all prescribed medical not administered on 7:00 p.m. until 2/8/22 stated, "There was a change." The Lippincott Manual edition documents or common departures nursing care, "Legal made against profess following departures failure to assess the fashion, follow physical appropriate nursing rinformation about the policy or procedure, of information in the memedications as order orders that should has all of the above information the director of nursing the policy of procedure, of the director of nursing the director of	n., the administrator, DON that met again with the DN stated last night (2/7/22) at 3 and LPN #5) were the ilding from 11:00 p.m. until The DON stated when only the building that "they lit the West unit. The DON thouse supervisor" on the characteristic and treatments were west unit on the 2/7/22 from at 7:00 a.m. The DON miscommunication at shift all of Nursing Practice 11th an page 15 concerning from the standards of claims most commonly sional nurses include the from appropriate care: patient properly or in a timely cian orders, follow measures, communicate a patient, adhere to facility document appropriate adical record, administer red, and follow physician 's live been questioned" (1) armation was discussed with ag, the administrator, and ts, during a meeting on	F	584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495105	B. WING			l	-C 10/2022
NAME OF PRO	OVIDER OR SUPPLIER		l	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2022
LYNCHBUR	G HEALTH & REHABIL	ITATION CENTER			615 SEMINOLE AVENUE YNCHBURG, VA 24502		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(exit conference on 02 (1) Nettina, Sandra Nursing Practice. Phi Health/Lippincott Willi	was provided prior to the /10/2022. M. Lippincott Manual of iladelphia: Wolters Kluwer ams & Wilkins, 2019.		684			
SS=É (CFR(s): 483.25(b)(1)(5)(483.25(b) Skin Integ §483.25(b)(1) Pressure Based on the compression of the professional standard pressure ulcers and dulcers unless the individemonstrates that the fine professional standard pressure ulcers are ulcers and dulcers unless the individemonstrates that the fine professional standard pressure ulcers are the professional standard pressure ulcers from deveronce healing, prevents REQUIREMENT by: Based on observation record review, the fact interventions for the professional standard professional standard pressional standard preventions from deveronce and the pression of the profession of the professio	rity re ulcers. hensive assessment of a fust ensure that- is care, consistent with s of practice, to prevent loes not develop pressure vidual's clinical condition bey were unavoidable; and ressure ulcers receives and services, consistent dards of practice, to rent infection and prevent loping. The is not met as evidenced an, staff interview, and clinical condition and prevent loping. The is not met as evidenced and services and clinical condition and prevent loping. The is not met as evidenced and services and clinical condition and prevent loping. The is not met as evidenced and the interview and clinical condition and prevent loping. The is not met as evidenced and clinical condition and prevent loping. The is not met as evidenced and clinical condition and prevent loping. The is not met as evidenced and clinical condition and prevent loping. The is not met as evidenced and clinical condition and prevent loping. The is not met as evidenced and clinical condition and prevent loping. The is not met as evidenced and clinical condition and prevent loping. The is not met as evidenced and clinical condition and prevent loping. The is not met as evidenced and clinical condition and prevent loping. The is not met as evidenced and clinical condition and prevent loping. The is not met as evidenced and clinical condition and prevent loping. The is not met as evidenced and clinical condition and prevent loping. The is not met as evidenced and clinical condition and prevent loping. The is not met as evidenced and clinical condition and prevent loping. The is not met as evidenced and condition and	{F 6	886}	F686 Resident #214, 215, and #216 are currently receiving skin prep to heels. Resident #203 is currently having barric cream applied to ordered areas (glutea folds and perineum). Current residents in the center with the potential for skin impairment have the potential to be affected. Licensed will be educated by the Region Director of Clinical Services/designee of the center □s policy on administration a documentation of medications/treatments.	nal onal on	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495105	B. WING			R-C // 10/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		11012022	
				5615 SEMINOLE AVENUE			
LYNCHBU	RG HEALTH & REHABII	LITATION CENTER		LYNCHBURG, VA 24502			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
{F 686}	Continued From page	e 57	{F 68	6}			
	but not limited to: Mo and hypothyroidism.	ollowing diagnoses including orbid Obesity, Hypertension,	,	provided to the resident. Twill include ensuring resider their scheduled treatments orders. In addition, the DOI	nts receive as per MD N/Nursing		
	(assessment reference	nimum data set) with an ARD ce date) of 01/20/2022 214 as cognitively intact with		Leadership/Administrator will by the Regional Director of Services/designee on the el	Clinical		
	a summary score of 'Activities of Daily Livi assessed as "3/2"- ne assistance" with "One bed mobility. Section Ulcers/Injuries", the crisk of developing pre answered as "Yes". On 02/09/2022 at app Resident #214's clinic The current physiciar	mmary score of "15". Under section "GO 110 vities of Daily Living", Resident #214 was essed as "3/2"- needing "extensive stance" with "One person physical assist" for mobility. Section "MO150 Risk of Pressure rs/Injuries", the question, "Is this resident at of developing pressure ulcers/injuries?" was wered as "Yes". 12/09/2022 at approximately 10:00 a.m., dent #214's clinical record was reviewed. current physician orders contained the wing: "Skin prep to left heel every shift". The		preparedness policies to en staffing in the center. The /designee will contact the R Director of Clinical Services emergency preparedness p been activated to ensure the adequate staffing in the cen The DON/designee will revisors weekly to ensure treatmed been completed as ordered documented as completed of In addition, The DON/Administrator/Nursing	sure adequate DON egional when the olicies have ere is ter. ew the ETAR ents have and		
	order was written on The care plan was re following: "The resid ulcers related to adva conditions, fragile ski and reposition indepen	10/10/2021. viewed and contained the ent is at risk for pressure ance age, chronic health n, immobility, inability to turn endently, incontinence."		Leadership/designee will re daily to ensure there is adec in the center. The DON/Nu Leadership will be notified w call offs to determine if the e preparedness policies need implemented. The results of the review will redaily to ensure the content of the review will redaily to ensure the content of the review will redaily to ensure the content of the review will redaily to ensure the content of the review will redaily to ensure the content of the review will redaily to ensure the content of the review will redaily to ensure the content of the content of the review will redaily to ensure the content of the content of the review will redaily to ensure the content of the cont	quate staffing ursing when there are emergency to be Il be discussed		
	record) was reviewed prep was not applied by the physician duril 02/07/2022. 2. Resident #215 was 02/12/2021 with the fincluding but not limit	s admitted to the facility on following diagnoses, red to: Dementia, egia, and chronic peripheral		at the monthly QAPI meetin QAPI committee determines no longer exists, the review conducted on a random bas The Administrator/Director or responsible for implementat of correction. Date of compliance-3/23/20	s the problem s will be sis. of Nursing are tion of the plan		

NAME OF PROVIDER OR SUPPLIER LYNCHBURG HEALTH & REHABILITATION CENTER SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREEIX TAG PROVIDER PLAN OF CORRECTION AND HOLD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREEIX TAG PROVIDERS PLAN OF CORRECTION COMPRETION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREEIX TAG PROVIDERS PLAN OF CORRECTION COMPRETION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREEIX TAG PROVIDERS PLAN OF CORRECTION CONSTRUCTION HOLD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREEIX TAG PROVIDERS PLAN OF CORRECTION COMPRETION HOLD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREEIX TAG PROVIDERS PLAN OF CORRECTION COMPRETION HOLD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREEIX TAG PROVIDERS PLAN OF CORRECTION AND HOLD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION TAG PROVIDERS PLAN OF CORRECTION AND HOLD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY CROSS-REFERENCE TO THE APPROPRIATE DEFICIE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONS	STRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER LYNCHBURG HEALTH & REHABILITATION CENTER (A) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 686) Continued From page 58 An annual MDS with an ARD of 12/01/2021, assessed Resident #215 as moderately impaired with a cognitive summary core of "10". Under section "GO110 Activities of Daily Living", Resident #214 was assessed as needing "extensive assistance" with "Two + (plus) persons physical assist" for bed mobility and transfers. Section "MO150 Risk of Pressure Ulcers/Injuries", the question, "Is this resident at risk of developing pressure ulcers/Injuries?" was answered as "Yes". On 02/09/2022 at approximately 10:15 a.m., Resident #215 clinical record was reviewed. The current physician orders contained the following: "Skin prep to bilateral heels every shift for prevention". The order was written on 03/15/2021. The care plan was reviewed and contained the following: "The resident is at risk for pressure ulcers related to immobility", also "Potential for skin impairment". Interventions included but were			495105	B. WING			1	
FREFIX TAG REGULATORY OR LSC (IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCEDE TO THE APPROPRIATE CROSS-REFERENCEDE TO THE APPROPRIATE DEFICIENCY) F 686 Continued From page 58 (F 686)					5615 SE	EMINOLE AVENUE	<u>1 02/</u>	10/2022
An annual MDS with an ARD of 12/01/2021, assessed Resident #215 as moderately impaired with a cognitive summary core of "10". Under section "GO110 Activities of Daily Living", Resident #214 was assessed as needing "extensive assistance" with "Two + (plus) persons physical assist" for bed mobility and transfers. Section "MO150 Risk of Pressure Ulcers/Injuries", the question, "Is this resident at risk of developing pressure ulcers/injuries?" was answered as "Yes". On 02/09/2022 at approximately 10:15 a.m., Resident #215's clinical record was reviewed. The current physician orders contained the following: "Skin prep to bilateral heels every shift for prevention". The order was written on 03/15/2021. The care plan was reviewed and contained the following: "The resident is at risk for pressure ulcers related to immobility", also "Potential for skin impairment". Interventions included but were	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
The February TAR (treatment administration record) was reviewed and documented that skin prep was not applied to Resident #215's bilateral heels as ordered by the physician during the night shift on 02/07/2022. 3. Resident #216 was admitted to the facility on 01/23/2020 with the following diagnoses, including but not limited to: Hemiplegia, peripheral vascular disease, diabetes mellitus and protein-calorie malnutrition. An annual MDS with an ARD of 11/10/2021,	{F 686}	An annual MDS with assessed Resident # with a cognitive sums section "GO110 Actives Resident #214 was a "extensive assistance physical assist" for be Section "MO150 Risk Ulcers/Injuries", the crisk of developing preanswered as "Yes". On 02/09/2022 at ap Resident #215's clini The current physicial following: "Skin prepfor prevention". The 03/15/2021. The care plan was refollowing: "The residulcers related to imm skin impairment". Intenot limited to: "Skin The February TAR (trecord) was reviewed prep was not applied heels as ordered by shift on 02/07/2022. 3. Resident #216 was 01/23/2020 with the fincluding but not limit peripheral vascular dand protein-calorie manufactured in the second seco	an ARD of 12/01/2021, t215 as moderately impaired mary core of "10". Under vities of Daily Living", assessed as needing e" with "Two + (plus) persons ed mobility and transfers. A of Pressure question, "Is this resident at essure ulcers/injuries?" was proximately 10:15 a.m., cal record was reviewed. In orders contained the order was written on eviewed and contained the lent is at risk for pressure probility", also "Potential for erventions included but were prep bilateral per MD order." The areatment administration defined and documented that sking to Resident #215's bilateral the physician during the night admitted to the facility on following diagnoses, ted to: Hemiplegia, lisease, diabetes mellitus nathurition.	{F 6	86}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495105	B. WING _				-C 10/2022	
	ROVIDER OR SUPPLIER JRG HEALTH & REHABII	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	DE	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE	
{F 686}	a summary core of "1 Activities of Daily Livi assessed as needing "Two + persons phys and "Total dependent persons" for transfers On 02/09/2022 at app Resident #215's clinic The current physiciar following: "11/11/202 before and after weat to maintain skin integ for s/s (signs/symptot pain"; and "02/19/202 bilateral legs and fee evening shift for dry s The care plan was refollowing: "The residulcers related to advacenditions, dry fragile incontinence". Intervent limited to: "Skin at The February TAR (trecord) was reviewed following intervention the night shift on 02/0 checks before and af in order to maintain smonitor for s/s redner Wipesapply to left herevention." On the evening shift, Apply to bilateral legs	216 as cognitively intact with 4". Under section "GO110 ng", Resident #216 was "extensive assistance" with ical assist" for bed mobility be on staff with two + 5. proximately 10:45 a.m., cal record was reviewed. In orders contained the Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness, edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness, edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness, edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness, edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness, edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness, edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness, edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness, edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness, edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness, edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness, edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness, edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness edema, Interest Complete skin checks ring extension brace in order rity, every shift for monitor ms) of redness edema, Inter	{F 6	36}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X	3) DATE SURVEY COMPLETED
		495105	B. WING			R-C
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	ı	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 686}	DON (director of no consultant (administered to any ordered medication administered to any (which included Refrom 7:00 p.m. on 002/08/2022. 4. Resident #203 v. 9/11/18 with diagnor pressure ulcer, mo infection, encephal hypertension, anem hypothyroidism. The assessed Resident Resident #203's cli resident had currer treatment of a stag sacrum. The clinic physician's order do be applied arour folds and perineum Resident #203's tre (TAR) documented applied as ordered (11:00 p.m. to 7:00)	8:35 p.m. the administrator, ursing), and corporate nurse strative staff #3) met with the eported that no physician as or treatments were are residents on the West unit sidents #214, #215, and #216) 02/07/2022 until 7:00 a.m. on was admitted to the facility on oses that included sacral ribid obesity, urinary tract opathy, atrial fibrillation, nia, anxiety, osteoarthritis and the MDS dated 1/24/22 are #203 as cognitively intact. Inical record documented the physician orders for the 4 pressure ulcer on her all record documented a ted 1/28/22 for barrier cream and the sacral wound, gluteal are every shift for skin protection.	{F 68	<u> </u>		
	documented the re ulcer and was at ris ulcers or the develoulcers due to advan conditions, cognitive	sident had a sacrum pressure sk of worsening pressure opment of additional pressure need age, chronic health re impairment, dry/fragile skin erventions to promote healing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUILDI	FIPLE CONSTRUCTION NG	(X:	(X3) DATE SURVEY COMPLETED	
		495105	B. WING			R-C 02/10/2022
	ROVIDER OR SUPPLIER	ILITATION CENTER	•	STREET ADDRESS, CITY, STATE, 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	, ZIP CODE	OL/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
{F 686}	"Treatment per TAR On 2/8/22 at 3:35 p. and corporate consumet with the survey physician ordered m were administered to West unit from 2/7/27:00 a.m. The DON "house supervisor" treassigned the nurse three units (East, Sc stated LPN #2, LPN building on the even The DON stated LPI 2/7/22 at 11:00 p.m. for the building startistated LPN #3 was cassigned to South usupposed to "split" to On 2/8/22 at 4:45 p. and corporate consusurvey team. The Don that two nurses (LPI only nurses in the building startistated LPN #3 was cassigned to South usupposed to "split" to On 2/8/22 at 4:45 p. and corporate consusurvey team. The Don't that two nurses (LPI only nurses in the building startistated there was no night shift. On 2/8/22 at 5:10 p. all prescribed medicinot administered on	m., the administrator, DON altant (administration staff #3) team and reported that no edications and/or treatments of any of the residents on the 2 at 7:00 p.m. until 2/8/22 at stated LPN #2 was the hat evening and could have es working on the facility's buth and West). The DON #3 and LPN #4 worked in the ing of 2/7/22 until 11:00 p.m. N #2 and LPN #4 left on with two nurses scheduled ing at 11:00 p.m. The DON on the East unit, LPN #5 was nit and the two nurses were he West unit. m., the administrator, DON altant met again with the ON stated last night (2/7/22) N #3 and LPN #5) were the uilding from 11:00 p.m. until The DON stated when only he building that "they olit the West unit. The DON "house supervisor" on the	{F €	86}		
	that two nurses (LPN #3 and LPN #5) were the only nurses in the building from 11:00 p.m. until 2/8/22 at 7:00 a.m. The DON stated when only two nurses worked the building that "they (nurses) knew" to split the West unit. The DON stated there was no "house supervisor" on the night shift. On 2/8/22 at 5:10 p.m., the DON again stated that all prescribed medications and treatments were not administered on West unit on the 2/7/22 from 7:00 p.m. until 2/8/22 at 7:00 a.m. The DON stated, "There was a miscommunication at shift change."					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495105	B. WING			l	-C 10/2022
	ROVIDER OR SUPPLIER	ITATION CENTER		56	TREET ADDRESS, CITY, STATE, ZIP CODE 615 SEMINOLE AVENUE YNCHBURG, VA 24502		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	Continued From page These findings were administrator, directo		{F 6	86}			
F 690 SS=D	consultant during a m p.m. Bowel/Bladder Incont CFR(s): 483.25(e)(1).		F	690			3/23/22
	resident who is continuadmission receives somaintain continence u	cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is					
	ensure that- (i) A resident who ent indwelling catheter is resident's clinical con	on the resident's ssment, the facility must ers the facility without an not catheterized unless the dition demonstrates that					
	indwelling catheter or is assessed for remov as possible unless the demonstrates that car and (iii) A resident who is receives appropriate	ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to nfections and to restore					
	§483.25(e)(3) For a reincontinence, based comprehensive assess						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			R-C 02/10/2022	
	ROVIDER OR SUPPLIER	BILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE CO			
F 690	receives appropriated restore as much not possible. This REQUIREMENT by: Based on staff intereview, the facility scare for one of 58 m. Foley catheter care physician order dur 02/07/2022. Findings were: Resident #252 was 06/17/2021 with the including but not limely hypertension, Atrial neuropathic bladded impairment. A quarterly MDS with assessed Resident with a cognitive sur Resident #252's climely complete the comp	ent who is incontinent of bowel ent who is incontinent of bowel entereatment and services to sermal bowel function as NT is not met as evidenced review and clinical record staff failed to provide catheter esidents, Resident #252. Was not provided per ing the night shift on admitted to the facility on entered for autistic disorder, fibrillation, obesity, flaccider, and mild cognitive th an ARD of 01/14/2022 #252 as moderately impaired numary score of "08". Inical record was reviewed on eximately 8:30 a.m. The cluded: Check Foley anchor shift, and Foley care q shift	F 6	F690 Resident # 252 is currently is catheter care as ordered by Current residents in the cen catheters have the potential affected. Licensed Nurses will be educed. Regional Director of Clinical Services/designee on the center of providing catheter care adocumentation as complete ETAR. The education will intensuring residents receive the treatments as per MD order the DON/Nursing Leadership/Administrator will by the Regional Director of Services/designee on the enterpreparedness policies to enstaffing in the center. The Idesignee will contact the Redirector of Clinical Services emergency preparedness policies to enstaffing in the center. The Idesignee will contact the Redirector of Clinical Services emergency preparedness policies to ensure the adequate staffing in the center the DON/designee will revied to ensure the adequate staffing in the center the DON/designee will revied to ensure the adequate staffing in the center that the catheter care has been contended and documented as on the ETAR. In addition, IDON/Administrator/Nursing	the physician. Iter with I to be I to		
		iew date " Interventions		Leadership/designee will rev	•		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
				_		R	-C
		495105	B. WING _			02/	10/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LYNCHBU	RG HEALTH & REHABIL	ITATION CENTER	5615 SEMINOLE AVENUE				
LINGIIDO	NO HEALING KENADIL	ENTER SERVER		Ľ	YNCHBURG, VA 24502		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BY TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 690	ordered; Monitor and as ordered; Monitor/d due to catheter" Review of Resident # (treatment administra above interventions a provided as ordered of 02/07/2022. On 02/08/2022 at 3:3 DON (director of nurs consultant (administra survey team and reported medications administered to any received medications. The above information	document intake and output ocument for pain/discomfort 252's February TAR tion record) documented the nd treatments, were not during the night shift on 5 p.m. the administrator, ing), and corporate nurse ative staff #3) met with the orted that no physician or treatments were esidents (which included a West unit from 7:00 p.m. 1:00 a.m. on 02/08/2022.	F	690	in the center. The DON/Nursing Leadership will be notified when there a call offs to determine if the emergency preparedness policies need to be implemented. The results of the review will be discuss at the monthly QAPI meeting. Once th QAPI committee determines the proble no longer exists, the reviews will be conducted on a random basis. The Administrator/Director of Nursing a responsible for implementation of the p of correction. Date of compliance-3/23/2022	sed e m	
F 692 SS=G	nurse consultants, du approximately 12:15 p No further information exit conference on 02 Nutrition/Hydration St CFR(s): 483.25(g)(1)- §483.25(g) Assisted r (Includes naso-gastric both percutaneous er percutaneous endoscenteral fluids). Based	n was obtained prior to the 1/10/2022. In was	F	692			3/23/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495105	B. WING		R-C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 692	§483.25(g)(1) Mainta of nutritional status, significant desirable body weigh balance, unless their demonstrates that the preferences indicate §483.25(g)(2) Is offer maintain proper hydromaintain proper hydromaintaintaintaintaintaintaintaintaintaint	such as usual body weight or at range and electrolyte esident's clinical condition is is not possible or resident otherwise; red sufficient fluid intake to ation and health; red a therapeutic diet when problem and the health care rapeutic diet. Γ is not met as evidenced view, clinical record review, iew, and in the course of a pon, the facility failed to ght residents in the survey a significant weight loss, and if fifty eight residents g and flushes for hydration ysician. total of 57.7 pounds the of admission on an opiticant weight loss was not taff and no nutrition ut into place to prevent in harm. Residents #208, 201 and #222 did not receive thes for hydration from 7:00	F 69	F692 Resident #204 is no longer a residenthe center. Residents # 208, 209, 210, 247, 201 222 are currently receiving their tube feedings and/or flushes as ordered. A review of weights for the last 60 da was reviewed to ensure significant well losses have been addressed with interventions implemented. Current residents in the center receive tube feedings have the potential to be affected. The DON/Nursing Leadership/RD will educated by the Regional Director of Clinical Services/designee on the center spolicy for weights and weight management. The education will incomply to document these weights in the EH The DON/designee will monitor weight both weekly and monthly. Significant weight changes will be discussed in the weekly high-risk meetings with	and ys eight ing e I be nt ude now R. nts

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495105	B. WING _			R-C
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502			02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	5.475
F 692	08/07/2021 with diagral limited to: syphilis, mencephalopathy, hyporal encephalopathy, hyporal encepha	noses including but not bultiple sclerosis, ertension, and dementia. Inimum data set) with an ARD be date) of 09/07/2021 204 as severely impaired mary score of "05". Under the and Weight" Resident the das "70 inches", no weight ection "K0300 Weight Loss" unknown." Cal record was reviewed on grat approximately 2:00 p.m. owing: Imment dated 08/07/2021 Indiac/Circulation" and 204's "Pulse" as "Regular so, under Section "F" were externa: "Edema present, Pitting", none of those end as present. Resident was documented as so than or equal to) 3 sections are the section of t	F 6	interventions implemented. The results of the monitori discussed at the monthly (Once the QAPI committee problem no longer exists, be conducted on a random The Administrator/Director responsible for implement of correction. Date of compliance-3/23/2	ing will be QAPI meeting e determines to the reviews we n basis. r of Nursing an ation of the pl	he rill re

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3)) DATE SURVEY COMPLETED
		495105	B. WING			R-C 02/10/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 692	(diagnoses), theraphypertension) and "Resident will avoid through next review "Weights per proto PRN (as needed) swallowing)" The following weig 08/07/2021 242.8 09/01/2021 241.2 10/04/2021 198.3 The weight from 10 through and a note dietitian) was writte "Incorrect Docume weights in the clinic A "Malnutrition Unicompleted for Resi 08/24/2021, and 09 documents were id weight from 08/07/assessed with a BI greater than 20, no past 3-6 months, a acutely ill and there nutritional intake fo "No". All three doct RD. There was no documentation by about the dining preferences. Dietal updated and IDT (i	deutic diet d/t HTN (due to edema, elevated BMI." Focus: d significant weight change w." Interventions included: col, Monitor/document/report s/sx of dysphagia (difficulty hts were recorded: B8 lbs (pounds) 2 lbs 3 lbs (pounds) 2 lbs 3 lbs (pounds) 2 lbs 3 lbs (pounds) 3 lbs (pounds) 4 lbs (pounds) 5 lbs (pounds) 6 los of the RD (registered en on 10/07/2021 indicating, notation". There were no other cal record. Sersal Screening Tool" was dent #204 on 08/09/2021, 20/06/2021. All three tools dentical using the admission 2021. Resident #204 was MI (body mass index) score of the unplanned weight loss in the notate the question "Is the patient the has been or is likely to be notate of the other nutrition assessment or	F 6	92		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495105	B. WING				-C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502			10/2022
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 692	92 Continued From page 68		F	692			
		ailable to follow up with od preferences as consulted					
	50% or less for 2 or r Offered a snack after	21/2021 documented, "Ate nore meals in one day. meal." There were no other ecord regarding meal/ fluid					
	DON (director of nurs the weight protocol us stated, "We weigh ev admission, weekly for is weighed at least m they refuse we docur notes. Then we notify	O p.m. on 02/08/2022, the sing) was interviewed about sed by the facility. She eryone within 24 hours of r four weeks, and everyone onthly unless they refuseif ment that in the progress of the physician and the RP and of course we try again					
	10/24/2021 after bein staff as "very lethargi breathing." A progres dated 10/25/2021 docadmitted for AKI (acu hypernatremia, septic	te kidney injury),					
	department note writt documented that Res kilograms (185.18 po the emergency room	e reviewed. The emergency ten on 10/24/2021 sident #204 weighed 84 unds) at the time of arrival to . A difference of 57.7 pounds mission to the facility on					
	On 02/10/2022 at 10:	45 a.m., the RD was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			R-C 02/10/2022	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	•	ZI IO/ZOZZ	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 692	asked why he had recorded in the cli stated, "I am sure marked through it someone would lo monthit was like weigh the residen on Thursdayshe before that meetin had asked for a restated, "No, I don' asked if he felt manurse's document "inaccurate" withow was appropriate. I weight was stable that he lost 50 por was informed of Rime of admission don't know that I will differentlythe poverified within five of five poundsno him." The RD was or not the weight is stated, "That's a good The nurse practitic #204 was intervied a.m. She was ask #204 losing weigh acutely when som August for behavious broke his glasses and again becaus October and I used didn't notice that he	ding Resident #204. He was I marked through the weight nical record on 10/04/2021. He we discussed that as a team. I because it is very unlikely that use that much weight in a ly to be inaccurate. We usually its on Monday and then we meet a should have been reweighed ug." The RD was asked if he eweigh on Resident #204. He that ask for reweights." He was arking through a licensed ation and labeling it as ut discussing it with the nurse he stated, "The resident's for the first month, it is unlikely unds in one month." The RD desident #204's weight at the to the hospital. He stated, "I would have done anything licy states the weight will be days when there is a variance ursing should have reweighed asked how he knew whether he struck was a reweight. He	F	592			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495105	B. WING			1	-C
NAME OF D	ROVIDER OR SUPPLIER	495105	B. WING _	CTDC	ET ADDRESS, CITY, STATE, ZIP CODE	02/	10/2022
NAIVIE OF PE	ROVIDER OR SUPPLIER						
LYNCHBU	RG HEALTH & REHABIL	ITATION CENTER			SEMINOLE AVENUE CHBURG, VA 24502		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 692	Continued From page	÷ 70	F	692			
		ttention by the nursing staff ember anyone mentioning					
	with the DON, the addicorporate nurse consinformation was discussified white at the obtained per facility problem marked through RD without follow-up, documentation in the Resident #204 refusing weighed, or any interweight and/or prevent asked what should has "He should have been reweight should have be	ultants, the above ussed. Concerns were #204 had lost 23.8% of his the facility; weights were not rotocol; and weights had in the clinical record by the There was no clinical record regarding ag to eat, refusing to be ventions to monitor his to weight loss. The DON was ave happened. She stated, in weighed per our policy, a been obtained." Inted the weight on marked through by the RD 2/10/2022 at approximately sked if she remembered confirmed that she did. She					
	On 02/20/2022, at ap (certified nursing assi about Resident #204. care of himbut I ren	proximately 2:45 p.m., CNA stant) #2 was interviewed She stated, "I never took nember him. He drank his refused to eat." She was					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			R-C 02/10/2022	
	ROVIDER OR SUPPLIER	LITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CO 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		2710/2022	
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 692	he refused to eat and She stated, "I'm not so don't know if anyone At 3:00 p.m. on 02/10 were interviewed about stated that she had to "He fed himself, he he "He was mean, he at "The policy "Weight M dated 11/01/2019 condition Director of Nursing is patients are weighed staff is responsible for patient medical reconveighed on admission 4 weeks, or until the determines weight is thereafter if weight is verified within five dates the state of the pounds of the state of	staff had been notified that I how often that happened. Sure how often it happened, I told the nurses or not." 0/2022 two additional CNAs but Resident #204. CNA #4 aken care of Resident #204, ardly ate" CNA #5 stated, a lot of fruit." Ionitoring and Tracking" The responsible for ensuring in a timely mannerNursing or recording weight in the d; All patients will be in/readmission and weekly X interdisciplinary team stable, then monthly stable; Weights will be ys when a weight variance of st weight and/or significant intified." In was obtained prior to the 2/10/2022.	F	992			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	, ,	ATE SURVEY DMPLETED	
		495105	B. WING			R-C 02/10/2022	
	ROVIDER OR SUPPLIER	ILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 692	Enteral Feed Order flush via PEG tube Enteral Feed Order 237 ml bolus feed v The care plan was r resident requires tul dysphagia, swallow aspiration with lowe Interventions includifeeding) per order; order." Review of Resident (medication adminis water flushes were 02/07/2022, or at m 02/08/022, for a tota Resident #208 also bolus feedings at 8: midnight and 4:00 a of 711 cc (1066.5 ca provided. 3. Resident #209 wa 10/30/2020 with the including but not lim hemiplegia, aphasia quarterly MDS with assessed Resident both long and short impaired with daily of the control or the control of the control	every 4 hours 220 ml H2O every 4 hours Osmolite 1.5 @ ia PEG tube eviewed and included, "The be feeding r/t (related to) ing problem. He is at risk for ring HOB (head of bed)" ed: "Provide TF (tube Provide water flushes per MD #208's February MAR stration record) documented not provided at 8:00 p.m. on idnight and 4:00 a.m. on al of 660 cc of water not given. did not receive Osmolite 1.5 00 p.m. on 02/07/2022, or at .m. on 02/08/2022, for a total alories) of tube feeding not as admitted to the facility on following diagnoses, ited to: cerebral infarct, a, and hypertension. A an ARD of 12/23/2021, #209 as having problems with term memory and severely decision making skills.	F 69	92			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3	OMPLETED	
		495105	B. WING			R-C 02/10/2022	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	S, CITY, STATE, ZIP CODE AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 692	flush via PEG tube Enteral Feed Orde 237 ml bolus feed The care plan was resident requires to Interventions incluing Provide water flush Review of Resider documented water 8:00 p.m. on 02/07 a.m. on 02/08/022 not given. Resident Osmolite 1.5 bolus 02/07/2022, or at ro 02/08/2022, for at of tube feeding not 4. Resident #210 w 06/01/2019 with the including but not lin Alzheimer's, adult A quarterly MDS wassessed Resident both long and short impaired with daily Resident #210's of following physician Enteral Feed Orde flush via PEG tube Enteral Feed Orde	r every 4 hours 200 ml H2O r every 4 hours Osmolite 1.5 @ via PEG tube reviewed and included, "The ube feeding r/t dysphagia." ded: "Provide TF per order; nes per MD order." It #209's February MAR flushes were not provided at r/2022, or at midnight and 4:00 for a total of 600 cc of water t #208 also did not receive reedings at 8:00 p.m. on nidnight and 4:00 a.m. on otal of 711 cc (1066.5 calories) reprovided. It was admitted to the facility on the following diagnoses, mited to: cerebral infarct, failure to thrive, and dysphagia. It with an ARD of 11/29/2021, tt #210 as having problems with tt term memory and severely decision making skills. Inical record included the torders: r every 4 hours 300 ml H2O	F 69	92			
	The care plan was	reviewed and included,"The ube feeding r/t inability to					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED
		495105	B. WING _			R-C 02/10/2022
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	•	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 692	weight, and adequato) feeding problems multiple CVA (cereb slightly elevate BMI. "Provide TF per ordorder." Review of Resident documented water f 10:00 p.m. on 02/07 4:00 a.m. on 02/08/water not given. Resident not given. Resident eceive Jevity 1.5 C and 6:00 a.m. on 02 (711 calories) of tub 5. Resident #247 wa 06/15/2021 with the including but not lim disease, hypertensid dysphagia. An annual 11/18/2021 assesses moderately impaired score of "10".	po (by mouth) to maintain the nutritional status d/t (due is r/t dx (diagnoses) dementia, ral vascular accidents), "Interventions included: er; Provide water flushes per #210's February MAR flushes were not provided at r/2022, or at 2:00 a.m. and 022, for a total of 900 cc of sident #210 also did not all bolus feedings at midnight r/08/2022, for a total of 474 cc e feeding not provided. The sadmitted to the facility on the following diagnoses, ited to: Peripheral vascular fon, hypothyroidism, and all MDS with an ARD of	F6	92		
	following physician of every 6 hours 275 m. The care plan was resident requires tult problem." Interventing flushes per MD order. Review of Resident documented water from the every flushes.	eviewed and included,"The be feeding r/t swallowing ons included: "Provide water er." #247's February MAR lushes were not provided at n. on 02/08/2022, for a total of				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		495105	B. WING			R-C 02/10/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	5.475
F 692	Continued From pa	age 75	F 6	92		
	director of nursing, nurse consultants, approximately 12:1	tion was discussed with the the administrator, and both during a meeting at 5 p.m. on 02/10/2022.				
	No further informat exit conference on	ion was obtained prior to the 02/10/2022.				
	6/28/19 with a read Diagnoses for Resi Alzheimer's, pneun hypertension, moor hyperplasia, athero anxiety, depression	vas admitted to the facility on Imission on 1/12/21. Ident #201 included monitis, dysphagia, d (affective) disorder, prostatic esclerotic heart disease, a and atrial fibrillation. The 2 assessed Resident #201 with				
	current physician o	nical record documented rders for the following enteral meet the resident's nutritional ds:				
	(milliliters) bolus th 7/10/21 - Flush fee every 4 hours 1/13/21 - Flush fee	eed order - Jevity 1.5 @ 474 ml ree times per day d tube with 250 ml of water d tube with 20 to 30 ml of fter each medication pass				
	(MAR) documented was not administer as scheduled. This resident's daily fee	edication administration record the Jevity bolus (474 mls) ed on the 2/7/22 at 8:00 p.m. amount was 1/3 of the ding formula requirement (711 R documented water flushes ur hours were not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495105	B. WING _			R-C 02/10/2022
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	CODE	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 692	8:00 p.m., 2/8/22 at 1 a.m. resulting in 750 flushes (50%) not profuse (50%) not pro	feeding tube on 2/7/22 at 2:00 a.m. and 2/8/22 at 4:00 ml of the 1500 ml daily water ovided. And for 2/7/22 at 8:00 p.m., a 6:00 a.m. were not refore no water was tion passes. Of care (revised 2/1/22) dent was at risk of autritional risk due NPO atus and requirement for ysphagia and esophageal ions to prevent dehydration, and avoid tube feeding and, "Monitor/document as/symptoms) of B (head of bed) elevated imesCheck for tube are contents/residual volume and record. Hold feed if cument/report PRN (as irationProvide TF (tube a.Provide water flushes per ube Feeding and water se admitted to the facility on the se that included persistent matic cerebral edema,	F6	592		
	joint contractures. The assessed Resident # cognitive skills unable	dent (stroke) diabetes and ne MDS dated 11/19/21 222 as comatose with e to be assessed.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495105	B. WING _			R-C 02/10/2022
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	CODE	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	
F 692	feedings/flushes to mand hydration needs: 12/2/20 - Enteral feed ml/hour via PEG (per gastrostomy) 6/18/20 - Water flush PEG tube Resident #222's MAR Osmolite administeres shift of 2/7/22. The Market flushes were adminis 2/8/22 at 12:00 a.m. as scheduled. This mordered 900 ml daily administered. Resident #222's plant documented the residehydration due to to be dehydration due to to be dehydration due to to dependence upon to prevent dehydratic complications from to "Administer medical orderedMonitor/docof dehydrationobsevomiting and observed HOB elevated 30-45 minutes after tube fee placement and gastriper facility protocol a flushes as ordered"	ding of Osmolite 1.0 at 70 reutaneous endoscopic es 150 ml every 4 hours via R documented no amount of ed on the evening or night MAR documented no water stered on 2/7/22 at 8:00 p.m., and on 2/8/22 at 4:00 a.m. resulted in 450 ml out of the water (50%) not of care (revised 12/2/21) dent was at risk of libe feeding, required tube ragia, had a history of weight of nutrition/dehydration due tube feedings. Interventions on, weight loss and libe feeding included, ations as cument/report PRN any s/sx erve for further episodes of e for signs of aspirationthe degrees during and thirty ledCheck tube for it contents/residual volume and recordProvide TF and	F	592		
		n., the administration, DON Itant (administration staff #3)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495105	B. WING _			l	-C 10/2022
	ROVIDER OR SUPPLIER	BILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP COD 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	E		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI		(X5) COMPLETION DATE
F 692	physician ordered in were administered in were unit from 2/7/2 in a.m. The DON "house supervisor" reassigned the nurs three units (East, S stated LPN #2, LPN building on the ever The DON stated LF 2/7/22 at 11:00 p.m for the building star stated LPN #3 was assigned to South usupposed to "split" On 2/8/22 at 4:45 p and corporate consurvey team. The I that two nurses (LP only nurses in the building star two nurses worked (nurses) knew" to stated there was not night shift. On 2/8/22 at 5:10 p all prescribed medianot administered or 7:00 p.m. until 2/8/2 stated, "There was change."	team and reported that no nedications and/or treatments to any of the residents on the 22 at 7:00 p.m. until 2/8/22 at N stated LPN #2 was the that evening and could have sees working on the facility's outh and West). The DON M #3 and LPN #4 worked in the ning of 2/7/22 until 11:00 p.m. PN #2 and LPN #4 left on with two nurses scheduled ting at 11:00 p.m. The DON on the East unit, LPN #5 was unit and the two nurses were the West unit. .m., the administrator, DON ultant met again with the DON stated last night (2/7/22) N #3 and LPN #5) were the building from 11:00 p.m. until The DON stated when only the building that "they plit the West unit. The DON or "house supervisor" on the .m., the DON again stated that cations and treatments were a West unit on the 2/7/22 from 22 at 7:00 a.m. The DON a miscommunication at shift	F	692			
	consultant during a	meeting on 2/9/22 at 3:00 rmation was provided to the					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495105	B. WING		R-C 02/10/2022	
	ROVIDER OR SUPPLIER	ILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		02/10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 692	Continued From pag	ge 79	F 69	92		
F 693 SS=E	feedings and flushes	/Restore Eating Skills	F 69	93	3/23/22	
	both percutaneous e percutaneous endos enteral fluids). Base comprehensive asse ensure that a reside §483.25(g)(4) A resi eat enough alone or enteral methods unl condition demonstra clinically indicated a	ric and gastrostomy tubes, endoscopic gastrostomy and ecopic jejunostomy, and d on a resident's essment, the facility must				
	means receives the services to restore, and to prevent compincluding but not limited diarrhea, vomiting, cabnormalities, and rathis REQUIREMEN by: Based on staff interreview, the facility services for gastrost residents in the survivide Residents ##222, #226 and #24 and/or monitoring for	dent who is fed by enteral appropriate treatment and if possible, oral eating skills blications of enteral feeding ited to aspiration pneumonia, dehydration, metabolic resal-pharyngeal ulcers. T is not met as evidenced eview and clinical record raff failed to provide care and romy tubes for eight of 58 rey sample. Nurses failed to 201, #208, #209, #210, #219, 7 tube feeding site care r tube feeding complications sired in the plan of care.		F693 Residents #201,208, 209, 210, 219, 226, and 247 are currently receivin feeding site care and and/or monitor for tube feeding complications as of Current residents in the center who receiving tube feeding has the potential be affected. Licensed Nurses will be educated by	g tube oring rdered. o are ential to	

CENTER	3 FOR MEDICARE &	MEDICAID SERVICES				CIVID INC	7. 0930 - 0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						R	-C
		495105	B. WING _			02/	10/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S1	FREET ADDRESS, CITY, STATE, ZIP CODE		
LVNCUDII	DC UEALTH & DEHADI	LITATION CENTED		56	615 SEMINOLE AVENUE		
LINCHBU	RG HEALTH & REHABI	LITATION CENTER		LY	YNCHBURG, VA 24502		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 693	Continued From pag	e 80	F	593			
	The findings include:				Regional Director of Clinical		
	Trio ilitalingo ilitolado.				Services/designee on the center □s pol	icv	
	1. Resident #201 wa	s admitted to the facility on			for providing tube feeding site care and		
	6/28/19 with a readm				monitoring for tube feeding complication		
	Diagnoses for Resid	ent #201 included			as ordered with documentation as		
	Alzheimer's, pneumo				completed on the ETAR. In addition,	the	
		(affective) disorder, prostatic			DON/Nursing Leadership/Administrator		
		clerotic heart disease,			will be educated by the Regional Direct	tor	
		and atrial fibrillation. The			of Clinical Services/designee on the		
		IDS) dated 1/19/22 assessed			emergency preparedness policies to		
		severely impaired cognitive			ensure adequate staffing in the center.		
	skills.				The DON /designee will contact the Regional Director of Clinical Services		
	Resident #201's clini	cal record documented			when the emergency preparedness		
		ders regarding feeding tube			policies have been activated to ensure		
	care:	ioro rogaramig rocamig tazo			there is adequate staffing in the center		
					The DON/designee will review the ETA		
	1/13/21 - Check tube	placement before initiation			5x weekly to ensure treatments including		
		on administration and flushing			tube feeding site care and monitoring fe	or	
	tube or at least every	/ 8 hours			complications been completed as orde	red	
	1/13/21 - Observe ea	•			and documented as completed on the		
	_	, vomiting, distention,			ETAR. In addition, The		
		stipation and breaths sound			DON/Administrator/Nursing		
	each shift	idual agab abift and sentest			Leadership/designee will review staffin	-	
		idual each shift and contact			daily to ensure there is adequate staffing	ıy	
		ceeds 250 mls (milliliters) precautions every shift;			in the center. The DON/Nursing Leadership will be notified when there	are	
		30 to 45 degrees at all times			call offs to determine if the emergency	aic	
	during feeding	oo to 10 dogrood at all tillioo			preparedness policies need to be		
	9				implemented.		
	Resident #201's med	dication administration record			The results of the review will be discus	sed	
	(MAR) documented t	tube placement check,			at the monthly QAPI meeting. Once th	е	
	gastric residual meas				QAPI committee determines the proble	m	
		spiration precautions were			no longer exists, the reviews will be		
	-	7/22 on the night shift as			conducted on a random basis.		
	scheduled.				The Administrator/Director of Nursing a		
	D : 1 ("00 " :				responsible for implementation of the p	lan	
		n of care (revised 2/1/22)			of correction.		
	aocumented the resi	dent had a feeding tube due			Date of Compliance:3/23/2022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED R-C		
		495105	B. WING		1	K-C 2/10/2022	
	ROVIDER OR SUPPLIER	BILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		02/10/2022		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 693	tube complications the HOB (head of ball timesCheck for contents/residual varecord. Hold feed if aspirateMonitor/oneeded) any s/sx (stapiration-fever, Stapiration-fever, Stapiration-fever-fever, Stapiration-fever	ventions to prevent feeding included, "resident needs ped) elevated 30-45 degrees at a tube placement and gastric olume per facility protocol and f great than 500 cc document/report PRN (as signs/symptoms) of: OB (shortness of breath), Tube in at tube site, Self-extubation, in malfunction, Abnormal poide local care to G-tube site was admitted to the facility on poses that included incident (stroke), atrial insion, depression, heart failure, and tachycardia. The MDS it is sessed Resident #219 as a signal record documented in the dated 1/12/22 to provide it is care "every night shift and an it to ensure the PEG oscopic gastrostomy) tubing	F 69	3			
	site. Resident #219's pla	nd/or monitoring of the PEG an of care (revised 1/31/22) and a feeding tube due to					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495105	B. WING			R-C 02/10/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	ı	02/10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 693	dysphagia. Intervent complications related "Monitor/document. Aspiration-fever, SOE at tube site, Self-extural malfunction, Abnormal local care to G-tube sfor s/sx of infection" 3. Resident #222 was 4/21/18 with diagnost vegetative state, trauserebrovascular accipiont contractures. The assessed Resident #cognitive skills unable Resident #222's clinic current physician ord regarding care of the 8/8/18 - Every night stube set and label with resident name 4/21/18 - Check tube of formula, medication tube every 8 hours 4/21/18 - Complete to 4/21/18 - Complete to 4/21/18 - Check tube and hold tube feeding notification to MD/NP practitioner) Resident #222's MAF	ions to prevent to the tube included, freport PRN any s/x of: 3, Tube dislodged, Infection bation, Tube dysfunction or al breath soundsProvide site as ordered and monitor s admitted to the facility on es that included persistent matic cerebral edema, dent (stroke) diabetes and he MDS dated 11/19/21 222 as comatose with to to be assessed. cal record documented ters for the following resident's feeding tube. shift, change syringe and th time, date, formula and placement before initiation administration and flushing tube site care every shift to signs of dehydration, tention, diarrhea, reflux, ath sounds each shift the feed residual every shift to fig greater than 500 ml with to (physician/nurse) R documented no change of	F 69	93			
		g set, no checking of tube ite care, no checking of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495105	B. WING			R-C 02/10/2022	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	I_	02/10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 693	residual and no monicomplication on 2/7/2 Resident #222's plandocumented the residue to traumatic brain Interventions to preventhe tube feedings inch HOB elevated 30-45 tube for placement and volume per facility procedum. Monitor/doculof: Aspiration - fever Infection at tube site, dysfunction or malfur sounds Provide local ordered and monitor 4. Resident #226 was 4/2/21 with diagnose hyperlipidemia, aphal accident (stroke), depart and GERD (glisease). The MDS Resident #226 with sproblems and severe Resident #226's clinic physician's order date PEG site with wound each day until healed Resident #226's tread documented no PEG Resident #226's plandocumented the resident #226's plandocumented #22	toring for sign/symptoms of 22 during the night shift. of care (revised 12/2/21) dent required tube feeding in injury and dysphagia. Ent complications related to luded, "resident needs the degrees at all timesCheck and gastric contents/residual otocol and imment/report PRN any s/sx, SOB, Tube dislodged, Self-extubation, Tube and care to G-tube site as for s/sx of infection s admitted to the facility on that included hypertension, sia, cerebrovascular pression, history of breast astroesophageal reflux dared 1/6/22 assessed thort and long-term memory ly impaired cognitive skills. cal record documented a ded 12/15/21 to clean old cleanser, apply dry dressing l. timent administration record site care on 2/7/22. of care (revised 1/20/22) dent had an actual skin	F 69	93			
	Resident #226 with s problems and severe Resident #226's clinic physician's order date PEG site with wound each day until healed Resident #226's tread documented no PEG Resident #226's pland documented the resident maintenance related to	hort and long-term memory ly impaired cognitive skills. cal record documented a ed 12/15/21 to clean old cleanser, apply dry dressing l. tment administration record site care on 2/7/22. of care (revised 1/20/22)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			R-C 02/10/2022
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	•	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 693	5. Resident #208 w 10/02/2021 with the including but not lin hemiplegia, acute k hypertension. A quaset) with an ARD (a 12/20/2021, assess problems with both and severely impairs skills. Resident #208's clir following physician Enteral Feed Order resident residuals of physician if residuals of physician if residuals of physician with lower aspiration with lower aspiration with lower approached and gastric content protocol and record Review of Resident (medication administresiduals were not ordered during the 6. Resident #209 w 10/30/2020 with the including but not lin hemiplegia, aphasia quarterly MDS with assessed Resident	"Treatment as ordered." as admitted to the facility on following diagnoses, nited to: dysphagia, idney failure, depression, and arterly MDS (minimum data ssessment reference date) of ed Resident #208 as having long and short term memory red with daily decision making nical record included the orders: every shiftcheck and record (every) shift. Contact I exceeds 500 mls. reviewed and included, "The be feeding r/t (related to) ing problem. He is at risk for ering HOB (head of bed)" ed: "Check for tube placement is/residual volume per facility	F	593		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		495105	B. WING			R-C 02/10/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	I	02/10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 693	Continued From pa	•	F 6	93			
		decision making skills. nical record included the orders:					
	syringe daily. Chan date, formula and r Enteral Feed Order residuals Q shift. C exceeds 500 ml. Enteral Feed Order placement before in administration, and hours Enteral Feed Order 20-30 ml of water be administration of m Enteral Feed Order of dehydration, nau	revery shift. Check and record ontact physician if residual revery shift. Check tube nitiation of formula, medication flushing tube or at least q 8 revery shift. Flush tube with refore and after redication pass revery shift. Observe for signs revery shift. Observe for signs resea, vomiting, distention, instipation, and breath sounds					
	resident requires to Interventions include placement and gas per facility protocol greater than 200 co	reviewed and included, "The libe feeding r/t dysphagia." led: "Check for tube tric contents/residual volume and record. Hold feed if aspirate; Provide water er, Provide local care to red"					
	documented the sy residuals were not the PEG-tube was	t #209's February MAR ringe was not changed, obtained, placement of the of not checked, the tube was not esident #209 observed for s/sx					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495105	B. WING				-C
NAME OF P	ROVIDER OR SUPPLIER	455165		STREET ADDRESS	S, CITY, STATE, ZIP CODE	02/	110/2022
LYNCHBU	RG HEALTH & REHABII	LITATION CENTER		5615 SEMINOLE AVENUE LYNCHBURG, VA 24502			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD		BE	(X5) COMPLETION DATE
F 693	Continued From pag	e 86	F 6	93			
	02/07/2022 as ordered administration record	during the night shift on ed. The TAR (treatment I) documented the PEG tube ed during the night shift on					
	06/01/2019 with the fincluding but not limit Alzheimer's, adult fai A quarterly MDS with assessed Resident #	ted to: cerebral infarct, lure to thrive, and dysphagia. h an ARD of 11/29/2021, 1210 as having problems with erm memory and severely					
	Resident #210's clini following physician o	cal record included the rders:					
	syringe daily. Change date, formula, and na Enteral Feed Order or residuals q shift. Cor exceeds 500 mls. Enteral Feed Order or placement before initial administration, and fl hours. Enteral Feed Order or 20-30 ml of water be administration of med Enteral Feed Order of dehydration, nauson	every shift. Check and record intact physician if residual every shift. Check tube station of formula, medication ushing tube or at least q 8 every shift. Flush tube with fore and after dication pass every shift. Observe for signs ea, vomiting, distention, stipation, and breath sounds ery shift					
	_	eviewed and included, "The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495105	B. WING _		R-C			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		2/10/2022		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 693	consume adequate pweight, and adequate to) feeding problems multiple CVA (cerebralightly elevate BMI (Interventions include and gastric contents/protocol and record. cc aspirate; Provide provide local care to ordered" Review of Resident # documented the syrin residuals were not of the PEG-tube was not flushed, nor was Resof dehydration, etc., 02/07/2022 as ordere PEG tube had not be shift on 02/07/2022. 8. Resident #247 was 06/15/2021 with the fincluding but not limit disease, hypertension dysphagia. An annual 11/18/2021 assessed moderately impaired score of "10". Resident #247's clinifollowing physician of Enteral Feed Order esyringe daily. Changedate, formula, and nate of the strength of the syringe daily.	e feeding r/t inability to to (by mouth) to maintain to nutritional status d/t (due r/t dx (diagnoses) dementia, al vascular accidents), body mass index)." d: "Check for tube placement residual volume per facility Hold feed if greater than 500 water flushes per order, the Peg tube site as #210's February MAR nge was not changed, otained, placement of the of ot checked, the tube was not cident #210 observed for s/sx during the night shift on the TAR documented the teen anchored during the night as admitted to the facility on following diagnoses, teed to: Peripheral vascular n, hypothyroidism, and al MDS with an ARD of the Resident #247 as with a cognitive summary cal record included the refers: every night shift. Change the set daily and label for time, the set of the status of the set of t	F	93				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495105	B. WING _				-C 10/2022
	ROVIDER OR SUPPLIER	LITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TIVE DEFICIENCY	ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 693	exceeds 500 mls. Enteral Feed Order of placement before init administration, and fl hours. Enteral Feed Order of dehydration, naus diarrhea, reflux, conson Q shift Anchor PEG tube even Anchor tube feeding The care plan was reresident requires tube problem." Intervention placement and gastriper facility protocol and greater than 500 cc and flushes per order, Prosite as ordered" Review of Resident and documented the syring residuals were not of the PEG-tube was not flushed, nor was Resof dehydration, etc., of 02/07/2022 as ordered peg tube had not be shift on 02/07/2022. On 2/8/22 at 3:35 p.m. and corporate consumet with the survey to physician ordered med were administered to West unit from 2/7/22	every shift. Check tube iation of formula, medication ushing tube or at least q 8 every shift. Observe for signs ea, vomiting, distention, tipation, and breath sounds ery shift every shift every shift every shift every shift every shift experience (and included, "The effeeding r/t swallowing instinctions included: "Check for tube of contents/residual volume and record. Hold feed if itspirate; Provide water ovide local care to G-tube	Fé	593			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495105	B. WING			R-C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	l	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 693	"house supervisor" the reassigned the nurses three units (East, Soustated LPN #2, LPN # building on the evening The DON stated LPN 2/7/22 at 11:00 p.m. of or the building starting stated LPN #3 was or assigned to South unsupposed to "split" the On 2/8/22 at 4:45 p.m and corporate consults survey team. The DO that two nurses (LPN only nurses in the build 2/8/22 at 7:00 a.m. To two nurses worked the (nurses) knew" to split stated there was no "night shift. On 2/8/22 at 5:10 p.m all prescribed medical not administered on vortical to the consultation of the consultation of the consultant during a machinistrator, director consultant during a machinistrator, director consultant during a machinistrator.	at evening and could have s working on the facility's ath and West). The DON 43 and LPN #4 worked in the ag of 2/7/22 until 11:00 p.m. #2 and LPN #4 left on with two nurses scheduled g at 11:00 p.m. The DON at the East unit, LPN #5 was at and the two nurses were e West unit. In, the administrator, DON tant met again with the DN stated last night (2/7/22) #3 and LPN #5) were the liding from 11:00 p.m. until the DON stated when only the building that "they at the West unit. The DON thouse supervisor" on the line, the DON again stated that tions and treatments were livest unit on the 2/7/22 from at 7:00 a.m. The DON miscommunication at shift in was provided to the survey issed gastrostomy care. The event with the reference of 2/9/22 at 3:00 p.m. In was obtained prior to the	F	593		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495105	B. WING _			1	-C 10/2022	
	ROVIDER OR SUPPLIER	LITATION CENTER		56	TREET ADDRESS, CITY, STATE, ZIP CODE 615 SEMINOLE AVENUE YNCHBURG, VA 24502	1 02	10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFII TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 695 F 695 SS=D	Continued From page Respiratory/Trached CFR(s): 483.25(i) § 483.25(i) Respirate tracheostomy care at The facility must ensure and tracheal sucare, consistent with practice, the comprescare plan, the reside and 483.65 of this sure This REQUIREMEN by: Based on staff interreview, the facility strace/services related two of 58 residents in Resident #230 and #200.000 and for the findings include the findings include.	ge 90 Instomy Care and Suctioning Industry care, including Industry care, including Industry that a resident who Ine, including tracheostomy Industry including the service of the service of the survey sample. Industry including the service of the survey sample of the survey sample. Industry including the service of the survey sample of the survey s	F	695 695	F695 Resident #230 and 250 are currently receiving their oxygen as ordered along with tubing changes. Current residents in the center on 02 therapy have the potential to be affected. Licensed Nurses will be educated by the Regional Director of Clinical Services/designee on the center spot for ensuring the administration oxygen ordered along with tubing changes with	g ed. he iicy as	3/23/22	
	8/19/21 with diagnost cancer, anemia, hypp pneumonia, Parkins malnutrition, depress schizophrenia. The dated 11/11/21 assemoderately impaired Resident #230's clin current physician ord to oxygen administration.	minimum data set (MDS) ssed Resident #230 with cognitive skills. ical record documented ders for the following related			documentation as completed on the ETAR. In addition, the DON/Nursing Leadership/Administrator will be educated by the Regional Director of Clinical Services/designee on the emergency preparedness policies to ensure adequate staffing in the center. The DON /designee will contact the Regional Director of Clinical Services when the emergency preparedness policies have been activated to ensure there is adequate staffing in the center. The DON/designee will review the ETA 5x weekly to ensure the administration	aate e		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495105	B. WING			R-C	
NAME OF D	DOVIDED OD CUIDDUED	493103	B: Willo	CTDEET ADDRESS CITY STATE 7	•	2/10/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
LYNCHBU	RG HEALTH & REHAE	BILITATION CENTER		5615 SEMINOLE AVENUE			
				LYNCHBURG, VA 24502			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 695	Continued From pa	ge 91	F 6	95			
	shift every Monday	, Wednesday and Friday 2 liters per minute every shift		oxygen therapy and tubi per physician orders and completed on the ETAR	d documented as . In addition, The		
	(TAR) documented verification that oxy	eatment administration record no tubing change or gen was administered at 2 ring the night shift on 2/7/22.		DON/Administrator/Nurs Leadership/designee wil daily to ensure there is a in the center. The DON Leadership will be notified call offs to determine if the	ll review staffing adequate staffing I/Nursing ed when there are		
	Resident #230's plan of care (revised 2/4/22) documented the resident used oxygen at 2 liters per minute. Interventions to prevent poor oxygen absorption included, "O2 [oxygen] as orderedOxygen tubing change as indicated/as per md [physician] order" 2. Resident #250 was admitted to the facility on 02/18/2021 with the following diagnoses, including but not limited to: emphysema, COPD (chronic obstructive pulmonary disease), hypertension, and anxiety. A quarterly MDS with an ARD of 11/11/2021 assessed Resident #250 as cognitively intact with as summary score of "14".			preparedness policies no implemented. The results of the review at the monthly QAPI me QAPI committee determ no longer exists, the reviconducted on a random. The Administrator/Direct responsible for impleme of correction. Date of Compliance:3/23	eed to be v will be discussed eting. Once the ines the problem iews will be basis. tor of Nursing are ntation of the plan		
	02/09/2022 at approphysician orders ind Atrovent HFA Aeros inhale orally three t Oxygen Therapy-O via nasal cannula e breath] Oxygen tubing chainight shift every Mo	nical record was reviewed on eximately 10:30 a.m. The cluded the following: sol Solution 17 mcg/ACT 1 puff imes a day for COPD xygen at 3 liters continuously every shift for sob [shortness of inge weekly on 11-7 shift every enday, Wednesday, Friday					
	following focus area	reviewed and contained the as: "The resident has altered us r/t (related to) hypertension"					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			R-C)2/10/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	•	JZ/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 695	and "The resident had Respiratory illness and included but were not ordered; Monitor for respiratory distress a OXYGEN SETTING Review of Resident: (medication administ (treatment administreatment administreatment administreatment administreatment as ordered at 8:00 printerventions for oxy completed as ordered on 02/07/2022. On 2/8/22 at 3:35 put and corporate consumet with the survey physician ordered mover administered to West unit from 2/7/27:00 a.m. The DON "house supervisor" to reassigned the nurse three units (East, Sc stated LPN #2, LPN building on the even The DON stated LPN 2/7/22 at 11:00 p.m. for the building startistated LPN #3 was consumed assigned to South unsupposed to "split" to On 2/8/22 at 4:45 put and corporate consusurvey team. The DON survey team.	as oxygen therapy r/t and SOB". Interventions at limited to: "O2 (oxygen) as as/sx (signs and symptoms) of and report to MD as needed; S: O2 as ordered." #250's February MAR attation record) and TAR atton record) were reviewed. and for COPD was not given and on 02/07/2022. The agen therapy were also not ad during the night shift (11-7) m., the administrator, DON altant (administration staff #3) atteam and reported that no addications and/or treatments any of the residents on the attated LPN #2 was the attated LPN #2 was the attated LPN #4 worked in the and west). The DON #3 and LPN #4 worked in the and of 2/7/22 until 11:00 p.m. A #2 and LPN #4 left on with two nurses scheduled and at 11:00 p.m. The DON and the East unit, LPN #5 was anit and the two nurses were	F	695		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495105	B. WING _			R-C /10/2022
	ROVIDER OR SUPPLIER RG HEALTH & REHABIL	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	2/8/22 at 7:00 a.m. The two nurses worked the (nurses) knew to split stated there was no night shift. On 2/8/22 at 5:10 p.m. all prescribed medicanot administered on V7:00 p.m. until 2/8/22 stated, "There was a change." No further information team regarding the material treatments that including the material treatments that including a material treatment of the self-indings were administrator, director consultant during a material p.m. No further information exit conference on 02 Pain Management	ilding from 11:00 p.m. until The DON stated when only the building that "they it the West unit. The DON Thouse supervisor" on the In., the DON again stated that attions and treatments were West unit on the 2/7/22 from at 7:00 a.m. The DON miscommunication at shift In was provided to the survey hissed medications and ded oxygen administration. The provided with the ar of nursing and corporate meeting on 2/9/22 at 3:00 In was obtained prior to the	Fé			3/23/22
SS=G	provided to residents consistent with profes the comprehensive p and the residents' go. This REQUIREMENT by: Based on resident in clinical record review	ure that pain management is who require such services, ssional standards of practice, erson-centered care plan,		F697 Resident #202, 207, 211, 212, 213, 2 220, 221, 223, 224, 231, 233, 241, 24		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			D WING				-C	
		495105	B. WING _			02/	10/2022	
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
LYNCHBU	RG HEALTH & REHABII	LITATION CENTER			15 SEMINOLE AVENUE			
				LY	NCHBURG, VA 24502			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 697	Continued From page management for sixte survey sample. Resident #202, residing Residents #207, #21 #221, #223, #224, #2 and #257, residing or provided physician or treatments for pain or Resident #207 experiouses refused to admedications and failer assessment and/or reverbal requests for the harm. The findings include: 1. Resident #207 was 6/13/20 with diagnost obesity, hypertensions schizoaffective disords stenosis, intervertebrand gastroesophaged dated 12/20/21 assess cognitively intact. Resident #207's clinic current physician ord following medications. Methadone 2.5 mg ethalogous stenosis and several requests for the harm.	e 94 een of 58 residents in the ling on the East unit, and 1, #212, #213, #218, #220, 231, #233, #241, #246, #248, In the West unit, were not redered medications and/or lanagement on 2/7/22. lienced significant pain after minister scheduled pain led to provide any lesponse to the resident's lie medication, resulting in s admitted to the facility on les that included morbid la, chronic pain syndrome, ler, depression, spinal lal disc disorder, lumbago lal reflux disease. The MDS lased Resident #207 as cal record documented lers that included the les for pain management: levery 8 hours for pain		697	248 and 257 are currently receiving medications and/or treatments for pain management. LPN #3 who refused to administered particular medication to resident #207, was an outside agency employee and will not be allowed to work in the center. In additional this nurse was also reported to the Board Nursing for refusing to administer particular medication when a resident requested Current residents in center on pain management regimen have the potentiation be affected. Licensed will be educated by the Regional Director of Clinical Services/designee of the center spolicy on administration addocumentation of medications/treatment including those for pain management. In addition, the DON/Nursing Leadership/Administrator will be educated by the Regional Director of Clinical Services/designee on the emergency preparedness policies to ensure adequate staffing in the center. The DON /designee will contact the Regional Director of Clinical Services when the emergency preparedness policies have been activated to ensure there is adequate staffing in the center. The DON/designee will interview 5 alert and oriented residents weekly to ensure the residents are receiving their pain	ain pe on, ard ain it. al onal on and arts ted	DAIL	
	pain Resident #207's MAF	ng four times per day for R documented the phine sulfate were not			medications as per MD orders. The EMAR/ETAR will be reviewed 5x week to ensure pain medications have been given and documented as given on the EMAR/ETAR. In addition, The			
	administered on 2/8/2	22 at 12:00 a.m. and an			DON/Administrator/Nursing Leadership/designee will review staffin	a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495105	B. WING _				R-C 2/10/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	2/10/2022	
				56	615 SEMINOLE AVENUE			
LYNCHBU	IRG HEALTH & REHAI	BILITATION CENTER		Ľ	YNCHBURG, VA 24502			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 697	Continued From pa	nge 95	F6	697				
	scheduled. Resident #207's pladocumented the repain, low back pain disease and chronidisability. Interventinimize pain incluneedsMedication analgesia per ordepain relieving meth therapy, progressive cold application, mstimulationMonitos/sx (signs/symptotipainObserve and	or/record/report to Nurse any			daily to ensure there is adequate staffi in the center. The DON/Nursing Leadership will be notified when there call offs to determine if the emergency preparedness policies need to be implemented. The results of the review will be discus at the monthly QAPI meeting. Once the QAPI committee determines the problem to longer exists, the reviews will be conducted on a random basis. The Administrator/Director of Nursing responsible for implementation of the pof correction. Date of compliance-3/23/2022	are ssed ne em		
	by telephone about LPN #3 stated ther unit on 2/7/22 until was never assigned she was not aware unit until around 11 called her on the plant methodone pain	o.m., LPN #3 was interviewed at the evening/night of 2/7/22. The were two nurses on West 7:00 p.m. LPN #3 stated she do to West unit on 2/7/22 and there was no nurse on West 30 p.m. when Resident #207 mone and asked for her edication. LPN #3 stated, "I was no nurse back there (West PN #3 stated she told Resident do not give her the medication arcotic and she did not count at unit at shift change. LPN #3 comfortable giving narcotics e "it might come back on me" wrong. LPN #3 stated she did ents on the West unit because ast.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
				_		$\mid \mid$ R	-C
		495105	B. WING				10/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	10/2022
					615 SEMINOLE AVENUE		
LYNCHBU	RG HEALTH & REHA	BILITATION CENTER			YNCHBURG, VA 24502		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		COMPLETION DATE
F 697	Continued From p	age 96	F	697			
	On 2/8/22 at 5:35	p.m., Resident #207 was					
		any missed medications on the					
		Resident #207 stated she did					
		medications on 2/7/22 after					
		/22 at 11:00 a.m. Resident					
	#207 stated that o	n 2/7/22 she missed a 9:00					
		pentin, on 2/8/22 at 12:00 a.m.					
	missed a dose of r						
		and missed another dose of					
	morphine sulfate scheduled for 2/8/22 at 6:00 a.m. Resident #207 stated that on 2/7/22 around						
		ported to the CNA (certified					
		#5 that she needed a nurse to pain medications. Resident					
	_	#5 checked with the nurse on					
		rted to her that she "was out of					
		no nurse on the unit (West).					
		ted she called on her cell					
	phone to the East	unit and asked LPN (licensed					
		if she would come and give					
	her the pain medic	cations. Resident #207 stated					
	LPN #3 told her "n	o" and that she was not her					
		Resident #207 stated when she					
	asked who her ass	signed nurse was, LPN #3 told					
		ve a nurse this shift. Resident					
		nen called the other unit					
	` /	#207 stated whoever					
		ne on South stated the nurse					
		lent. Resident #207 stated she needed her pain, psych meds					
		nurse to call her when possible.					
		ted she did not know who					
		ne but that person told her if the					
	•	she would and "if not, she					
		esident #207 stated she never					
		from either nurse. Resident					
		was a CNA working the unit on					
		of 2/7/22 but she saw no nurse					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		ATE SURVEY OMPLETED
		495105	B. WING			R-C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	•	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 697	morning (2/8/22). Rein "a lot of pain" due methadone and mor she had pain in her a rated pain during the "9 almost 10" (on scipain). Resident #20 911 to go to the emenobody was here to stated she could not "up and down all nig corporate nursing coaround 2:00 a.m. ab medications. Reside a nurse (LPN #1) on did not see another 11:00 a.m. when the medications. On 2/8/22 at 8:30 p.unit was interviewed the West unit on the p.m. CNA #1 stated the unit and check ountil 11:00 p.m. When eeded a nurse during Resident #207 asked medications. CNA # #207 a nurse would because, "I didn't was nurse." On 2/9/22 at 3:00 p.1 again about medications administered with no unit. The DON state only two nurses were	the day shift reported the next esident #207 stated she was to missed doses of phine. Resident #207 stated arms and lower back and e early morning of 2/8/22 as a ale of 0 = no pain, 10 = worst 7 stated she almost called argency room because care for her. Resident #207 sleep due to the pain, was ht" and even emailed the ensultant (administration #3) out not getting her ent #207 stated she last saw 2/7/22 around 7:00 p.m. and nurse until 2/8/22 around day shift nurse brought her m., CNA #1 working on West . CNA #1 stated he worked evening of 2/7/22 until 11:00 he saw no nurses come to n residents from 7:30 p.m. an asked if any residents ing his shift, CNA #1 stated do to see a nurse about her est stated he told Resident come as soon as possible ant to say there was no	F6	97		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONS		(X3) DATE COMF	SURVEY PLETED
			5 14/110				t-C
		495105	B. WING _			02/	10/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
LYNCHRU	RG HEALTH & REHABIL	ITATION CENTER		5615 SE	MINOLE AVENUE		
LINGIIDO	NO HEALIN & KENADIL	HAHON GENTER		LYNCH	BURG, VA 24502		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page	e 98	F	697			
	stated she talked with LPN #3 by telephone 2/7/22. The DON stated because she had to we cart and LPN #3 was only two nurses for the stated she told them that they all had to we DON stated nobody of Resident #207 needed DON stated she was nurses working the bethought the nurses know thought the nurses know thought the nurses know thought the nurses know thought the nurses know the manager 948 of this reference nursing consideration "Don't stop abruptly individualize gradual and symptoms of with and psychological disadependent patients The Nursing 2022 Driescribes morphine signalgesic used for the pain requiring continuopioid. Page 1008 of regarding nursing commorphine sulfate, "I slowly and individuality prevent signs and synworsening pain, and physically dependent	n unit manager LPN #2 and during the evening on ted LPN #2 was upset work the East medication upset because there were le night shift. The DON everyone was frustrated and ork together as a team. The called or reported to her that ad pain medications. The aware there were only two uilding after 11:00 p.m. but new to "split" the West unit. The Handbook on page 945 as an opioid analgesic ment of severe pain. Page documents regarding as with use of methadone, rewithdraw slowly and taper plan to prevent signs and taper plan to prevent signs had awal, worsening pain, thress in physically "(1) The Handbook on page 1004 auditate as an opioid emanagement of severe lous, around-the-clock this reference documents insiderations with use of Don't stop abruptly; withdraw are gradual taper plan to mptoms of withdrawal, osychological distress in patients" (1)		59 <i>1</i>			
	worsening pain, and physically dependent (1) Woods, Anne Dak	osychological distress in					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495105	B. WING				-C 10/2022
	ROVIDER OR SUPPLIER	LITATION CENTER	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE 615 SEMINOLE AVENUE LYNCHBURG, VA 24502		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	2/2/18 with a readmiss for Resident #211 inchemiplegia, diabetes, disorder, hyperkalem dysphagia, asthma, norbid obesity and ordated 11/10/21 assess moderately impaired. Resident #211's clinic current physician ordated following medications. Morphine sulfate ER for pain Voltaren gel 1% creat transdermal every shallower medications/tradministered on the emorphine sulfate was and the Voltaren gel was and the voltaren	s admitted to the facility on sision on 5/9/21. Diagnoses sluded atrial fibrillation, chronic pain, bipolar ia, hyperlipidemia, mood disorder, hypertension, steoarthritis. The MDS seed Resident #21 with cognitive skills. cal record documented ers that included the for pain: 15 mg three times per day m apply 4 grams iff for leg pain cal record documented the eatments were not evening of 2/7/22. The scheduled for 8:00 p.m. was scheduled for 9:00 p.m. of care (revised 11/22/21) dent had leg pain. nize and/or eliminate pain erelaxation techniques and ctivitiesMedicate as or pain not relievedPosition Premedicate in anticipation"	F	697			
		ed hypertension, peripheral					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495105	B. WING		R-C 02/10/2022	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	02/10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLET	
F 697	Continued From pag	e 100	F 6	97		
	dementia, anxiety, d	on prostatic hyperplasia, epression and insomnia. The esessed Resident #212 with cognitive skills.				
	Resident #212's clini current physician ord following pain medic					
Hydrocodone-acetam times per day for chro	ninophen 10-325 mg four onic back pain					
	Resident #212's MAI hydrocodone-acetan administered on 2/7/ scheduled.	ninophen was not				
	documented the resi to decrease and/or e "Attempt non-pharma neededEncourage provide diversional a	of care (revised 2/1/22) dent had pain. Interventions liminate pain included, acological interventions as relaxation techniques and ctivitiesPosition resident for e in anticipation of painful				
	11/1/17 with diagnos infarction with hemip fibrillation, dysphagia failure, hypertension disease. The MDS of	s admitted to the facility on es that included cerebral legia, polyosteoarthritis, atrial a, cardiomyopathy, heart and gastroesophageal reflux lated 11/10/21 assessed noderately impaired cognitive				
		cal record documented included the following pain				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	' '	OMPLETED		
		495105	B. WING			R-C 02/10/2022		
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	'	,		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 697	times per day for per Resident #213's Manydrocodone-aceta administered on 2/scheduled. Resident #213's pladocumented the resolution in the Interventions to decomple the result or dered Position for the Intervention in the	aminophen 5-325 mg three olyosteoarthritis AR documented the aminophen was not 7/22 at 8:00 p.m. as an of care (revised 2/10/22) sident had pain due to arthritis. crease pain included, tion techniques and provide sMedicate as for comfort" In a sadmitted to the facility on coses that included anemia, pertension, seizures, hip sis, dementia, anxiety, stroesophageal reflux disease 6 dated 10/27/21 assessed in severely impaired cognitive inical record documented reders that included the	F 69					
	documented the re Interventions to de- included, "Encoura	an of care (revised 11/4/21) sident had potential for pain. crease and/or eliminate pain ge relaxation techniques and activitiesMedicate as						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	, ,	COMPLETED
		495105	B. WING _			R-C 02/10/2022
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	resident for comfor of painful procedure. 6. Resident #220 w 8/16/19 with diagnor COPD (chronic obsidepression, heart for hypertension, diabethyperlipidemia. The assessed Resident impaired cognitive. Resident #220's clicurrent physician of following pain treat. Aspercreme lidocal topically every 12 him. Resident #220's Manager Aspercreme was not good p.m. as scheduled the rest of decrease and/or "Encourage relaxated diversional activitie orderedNotify Manager Manager Painful procedure. 7. Resident #221 w 8/16/19 Manager Painful procedure.	of for pain not relievedPosition tPremedicate in anticipation es" was admitted to the facility on oses that included dementia, structive pulmonary disease), ailure, coronary artery disease, etes, renal insufficiency and the MDS dated 12/10/21 at #220 with moderately skills. mical record documented refers that included the ment: ine patch 4% to right should hours for arthritis pain AR documented the obtadministered on 2/7/22 at fulled. an of care (2/1/22) sident had pain. Interventions eliminate pain included, tion techniques and provide sMedicate as of for pain not relievedPosition tPremedicate in anticipation es"	F 6	97		
	hypertension, chroi hyponatremia, hypo	cident (stroke), anemia,				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		495105	B. WING		l	R-C 2/10/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	•	110/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	Continued From page	103	F 6	97		
		nort and long-term memory ately impaired cognitive				
	Resident #221's clinic current physician orde following pain medica					
	Tylenol 650 mg three generalized pain	times per day for				
		documented the Tylenol on 2/7/22 at 9:00 p.m. as				
	documented the resident interventions to decressincluded, "Attempt no interventions as need techniques and providuativitiesMedicate apain not relievedPo	edEncourage relaxation de diversional s orderedNotify MD for				
	8/3/21 with diagnoses hypertension, renal in infection, dementia, d glaucoma, cognitive of history of Covid-19.	admitted to the facility on that included anemia, sufficiency, urinary tract epression, urine retention, communication deficit and The MDS dated 12/28/21 223 with severely impaired				
	Resident #223's clinic current physician orde following pain medica					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495105	B. WING _			R-C 02/10/2022	
	ROVIDER OR SUPPLIER	SILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	E	02/10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 697	Continued From pag	ge 104	F 6	697			
		oly 2 grams transdermal every ift for pain, apply to bilateral rs					
		AR documented the Voltaren stered during the evening shift uled.					
	documented the res Interventions to dec included, "Encourage provide diversional orderedNotify MD	in of care (revised 1/31/22) sident experienced pain. irease and/or eliminate pain ge relaxation techniques and activitiesMedicate as for pain not relievedPositionPremedicate in anticipation es"					
	8/19/19 with diagno artery disease, anel diabetes, hyperlipid fracture, dysphagia disease. The MDS Resident #224 with	as admitted to the facility on ses that included coronary mia, congestive heart failure, emia, dementia, left arm and gastroesophageal reflux dated 11/10/21 assessed short and long-term memory npaired cognitive skills.					
		nical record documented decrease that included the ment:					
	Biofreeze gel 4% ap	oply to right knee topically ing shift for pain					
	**	AR documented the Biofreeze ed on the evening of 2/7/22.					
	documented the res	n of care (revised 1/31/22) sident had right knee pain. imize pain included,					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495105	B. WING			l	-C
	201/1252 02 01/221/52	493103	B. Wille		ATTEST ADDRESS SITV STATE TO SODE	02/	10/2022
	ROVIDER OR SUPPLIER RG HEALTH & REHABIL	ITATION CENTER		5	STREET ADDRESS, CITY, STATE, ZIP CODE 615 SEMINOLE AVENUE LYNCHBURG, VA 24502		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	relieved with medication 10. Resident #231 was 4/11/18 with diagnose depression, arthritis, deficiency. The MDS Resident #231 with so skills. Resident #231's clinic current physician order following pain medication was not an edication was	as admitted to the facility on as that included dementia, GERD and vitamin D dated 1/9/22 assessed everely impaired cognitive and record documented ers that included the attion: It is extended release one day for arthritis pain It documented this dministered on 2/7/22 at ed. If of care (revised 1/6/22) dent experienced pain, ease and/or eliminate pain relaxation techniques and ctivitiesMedicate as or pain not relievedPosition Premedicate in anticipation" It is admitted to the facility on a that included hypertension, mia, intellectual disabilities and coderately impaired cognitive and record documented a seal record documented a	F	697			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	, ,	DATE SURVEY COMPLETED
		495105	B. WING			R-C 02/10/2022
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	CODE	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 697	Continued From page	ge 106	F	697		
	following medication	n for pain:				
	Tylenol 650 mg thre pain.	e times per day for right knee				
		AR documented the Tylenol ed on 2/7/22 at 9:00 p.m. as				
	documented the resinterventions to decincluded, "Attempt rinterventions as need techniques and provactivitiesMedicate pain not relievedF	as orderedNotify MD for				
	2/1/20 with diagnos cancer, COPD, vasc heart failure, morbio depression, osteopo The MDS dated 12/	vas admitted to the facility on es that included endometrial cular dementia, congestive dobesity, hypertension, prosis and history of Covid-19. 29/21 assessed Resident assessed Resident cognitive skills				
	current physician's	nical record documented a order dated 5/10/21 for minophen 5-325 mg three nin.				
	8:00 a.m. Resident for the hydrocodone no dose was remov	AR documented this administered on 2/7/22 at #202's narcotic count sheet e-acetaminophen documented ed from the cart for the 8:00 P. Resident #202's count				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495105	B. WING _			R-C 02/10/2022
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	<u>I</u>	02/10/2022
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	sheet for hydrocodor the amount left on the amount left on the On 2/7/22 at 3:20 p.r. Resident #202 was in hydrocodone-acetan LPN #6 reviewed the of hydrocodone-acet 8:00 a.m. dose for 2/2 administered. LPN # why the medication was resident #202's plant documented the resingulated interventions to decrincluded, "Attempt no interventions as need techniques and provactivitiesMedicate pain not relievedPocomfortPremedicate procedures" 13. Resident #241 w 05/23/2017 with the including but not limit hypertension, anxiety convulsions and deman ARD of 01/23/202 as having problems was memory as well as bedaily decision making. Resident #241's clinifollowing physician of Tylenol Tablet 325 methods.	ne-acetaminophen matched e pharmacy supply card. m., LPN #6 caring for interviewed about the ninophen not administered. It resident's MAR and supply aminophen and stated the 17/22 was not signed out or 16 stated she did not know was not given as ordered. In of care (revised 1/12/22) dent experienced pain. ease and/or eliminate pain con-pharmacological dedEncourage relaxation ide diversional as orderedNotify MD for osition resident for the in anticipation of painful was admitted to the facility on following diagnoses, ted to: aphasia, y, depressive disorder, mentia. A quarterly MDS with 12 assessed Resident #241 with both long and short term eing severely impaired with g skills cal record included the order for pain: gGive 2 tablets by mouth	F 6	97		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	COMPLETED		
		495105	B. WING		R-C 02/10/2022	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	02/10/2022	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 697	as ordered at 9:00 The care plan was area "Pain". Interve ordered, Notify MD medication or with a 14. Resident #246 09/01/2021 with the including but not lin hypertension, major dysphagia. A quarte 12/30/2021 assess moderately impaire score of "09". Resident #246's clin following physician Tylenol 325 mg Giv times a day for pair Review of Resident documented the abas ordered at 8:00 The care plan was area "Pain". Interve ordered, Notify MD medication or with a 15. Resident #248 02/11/2020 with the including but not lin disorders due to know the care plan in the care plan was area "Pain". Intervented the abas ordered at 8:00 medication or with a 15. Resident #248 02/11/2020 with the including but not lin disorders due to know the care plan was area "Pain". Intervented the abas ordered at 8:00 medication or with a 15. Resident #248 02/11/2020 with the including but not lin disorders due to know the care plan was area "Pain". Intervented the abas ordered at 8:00 medication or with a 15. Resident #248 02/11/2020 with the including but not lin disorders due to know the care plan was area "Pain". Intervented the abas ordered at 8:00 medication or with a 15. Resident #248 02/11/2020 with the including but not lin disorders due to know the care plan was area 15 medication or with a 15 med	ove medication, was not given p.m. on 02/07/2022. reviewed and included a focus intions included: "Medicate as is pain is not relieved with new complaints of pain." was admitted to the facility on a following diagnoses, nited to: Breast cancer, or depressive disorder, and first part of the deep of the d	F 697			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495105	B. WING _			R-C 02/10/2022
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	, ZIP CODE	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)	D.**E
F 697	memory as well as a with daily decision in Resident #248's clin following physician of Tylenol 325 mgGin times a day for PAIN Review of Resident documented the about as ordered at 9:00 p. The care plan was rarea "Pain". Interver ordered, Notify MD is medication or with in 16. Resident #257 v 02/21/2019 with the including but not limit depressive disorder hydrocephalus, unsignification. An an 12/08/2021 assesses moderately impaired score of "09". Resident #257's clin following physician of Gabapentin Capsule times a day for oster Biofreeze Gel 4%1	h both long and short term being moderately impaired making skills ical record included the order for pain: We 2 tablet by mouth four I MGT (management). #248's February MAR ove medication, was not given out. on 02/07/2022. eviewed and included a focus included: "Medicate as spain is not relieved with ew complaints of pain." Was admitted to the facility on following diagnoses, ited to: dysphagia, major osteoarthritis, oecified psychosis, and inual MDS with an ARD of ad Resident #257 as I with a cognitive summary ical record included the orders: Be Give 300 mg by mouth three	F	697		
		#257's February MAR ove medication was not given				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SU COMPLE	
		495105	B. WING			R-C 02/10/2022	
NAME OF D	DOVIDED OD CURRUED	493103	B: Willo	CTDEET ADDRESS OFF STATE ZID	CODE	02/10	0/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
LYNCHBU	IRG HEALTH & REHABIL	ITATION CENTER		5615 SEMINOLE AVENUE LYNCHBURG, VA 24502			
				· ·			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BI THE APPROPRIA	_	(X5) COMPLETION DATE
F 697	Continued From page	e 110	F 6	597			
	the February TAR (tre	m. on 02/07/2022. Review of eatment administration the Biofreeze Gel was not uring the night shift on					
	focus area "Pain" with "Medicate as ordered relieved with medicat of pain." Also, "The re	viewed and included the n interventions that included: Notify MD is pain is not ion or with new complaints esident has pain r/t (related h the intervention: "Meds as					
	(DON) was interview administered to resid evening of 2/7/22 and The DON stated nurs and sign off a medica (MAR) or treatment a The DON had no exp did not receive medic	n., the director of nursing ed about medications not ents on the West unit on the dearly morning of 2/8/22. es had 24 hours to clarify tion administration record dministration record (TAR). lanation why the residents eations on the evening of e would research and clarify.					
	and corporate consulmet with the survey to physician ordered me were administered to West unit from 2/7/22 7:00 a.m. The DON "house supervisor" th reassigned the nurse three units (East, Sot stated LPN #2, LPN # building on the evenin The DON stated LPN	n., the administrator, DON tant (administration staff #3) eam and reported that no edications and/or treatments any of the residents on the eat 7:00 p.m. until 2/8/22 at stated LPN #2 was the at evening and could have as working on the facility's with and West). The DON #3 and LPN #4 worked in the ng of 2/7/22 until 11:00 p.m. #2 and LPN #4 left on with two nurses scheduled					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495105	B. WING			R-C 02/10/2022
	ROVIDER OR SUPPLIER	11.11		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	I	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 697	Continued From pag	e 111	F 6	597		
	stated LPN #3 was of assigned to South un supposed to "split" the					
	and corporate consusurvey team. The D that two nurses (LPN only nurses in the bu 2/8/22 at 7:00 a.m. two nurses worked to (nurses) knew" to sp	m., the administrator, DON Itant met again with the ON stated last night (2/7/22) I #3 and LPN #5) were the tilding from 11:00 p.m. until The DON stated when only the building that "they lit the West unit. The DON "house supervisor" on the				
	all prescribed medica not administered on 7:00 p.m. until 2/8/22	m., the DON again stated that ations and treatments were West unit on the 2/7/22 from 2 at 7:00 a.m. The DON miscommunication at shift				
F 725 SS=G	the director of nursin both nurse consultar approximately 12:15 further information w conference on 02/10 Sufficient Nursing St	aff	F7	725		3/23/22
	the appropriate comprovide nursing and resident safety and a	t Staff. The sufficient nursing staff with spetencies and skills sets to related services to assure attain or maintain the highest mental, and psychosocial				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY MPLETED
		495105	B. WING _		l ,	R-C)2/10/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	•	JZ/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 725	Continued From pag		F 7	25		
	resident assessmen and considering the diagnoses of the fac accordance with the at §483.70(e). §483.35(a)(1) The fa	ility's resident population in facility assessment required acility must provide services				
	types of personnel of nursing care to all re- resident care plans: (i) Except when wain this section, licensed	rsonnel, including but not				
	paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMEN by:	T is not met as evidenced				
	clinical record review provide sufficient nu services were provide in the survey sample West unit that include #205, #207 through were not provided pland/or treatments do hours starting on the nurse working the unexperienced significant scheduled doses of	ant pain after missing narcotic medication when no ne to the unit to administer		F725 Resident #201, 203, 205, 207 230-258 attending Physician a Representative were notified of not receiving their ordered medications/treatments for the the evening of 2/7/22 into the morning of 2/8/22. No new or received. Current residents in the cente potential to be affected. Licensed will be educated by Director of Clinical Services/d the center □s policy on adminit documentation of medications provided to the resident. The	and Resident of residents e 12 hrs., early rders r have the the Regional esignee on istration and is/treatments	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDI	NG _		Ь Б	-C
		495105	B. WING				10/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
LVNOUBL	DO HEALTH & DELIA	DU ITATIONI CENTED		56	615 SEMINOLE AVENUE		
LYNCHBU	RG HEALIH & REHA	BILITATION CENTER		Ľ	YNCHBURG, VA 24502		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 725	Continued From pa	age 113	F	725			
	The findings includ	le:			will include ensuring residents receive		
					their scheduled medications and		
		s admitted to the facility on			treatments as per MD orders. In additi	on,	
		oses that included morbid			the DON/Nursing		
		ion, chronic pain syndrome,			Leadership/Administrator will be educa	ted	
		order, depression, spinal			by the Regional Director of Clinical		
	· ·	ebral disc disorder, lumbago			Services/designee on the emergency		
	and gastroesophageal reflux disease. The MDS dated 12/20/21 assessed Resident #207 as				preparedness policies to ensure adequestaffing in the center. The DON	ate	
cognitively intact.		sessed Resident #207 as			/designee will contact the Regional		
	cognitively intact.				Director of Clinical Services when the		
	 Resident #207's cli	inical record documented			emergency preparedness policies have	٠	
		orders that included the			been activated to ensure there is	·	
		ons and treatments.			adequate staffing in the center.		
	3				The DON/designee will interview 5 aler	t	
	Doxepin 150 mg at	t bedtime for depression			and oriented residents weekly to ensur		
	Gabapentin 900 m	g three times per day for			the residents are receiving their		
	neuropathy				medications as per MD orders. The		
		every 8 hours for pain			EMAR/ETAR will be reviewed 5x week	- 1	
	-	0 mg four times per day for			to ensure medications have been giver	1	
	pain				and documented as given on the		
		ash cream 15% to bilateral			EMAR/ETAR. In addition, The		
		lly each day and evening shift			DON/Administrator/Nursing		
	for chaffing				Leadership/designee will review staffin		
	Pesident #207's M	AR documented these			daily to ensure there is adequate staffir in the center. The DON/Nursing	ig	
		not administered on the			Leadership will be notified when there	are	
		and the early morning of 2/8/22.			call offs to determine if the emergency	A1 C	
	The gabapentin wa				preparedness policies need to be		
		7/22 at 9:00 p.m., methadone,			implemented.		
		nd doxepin were scheduled for			The results of the review will be discus-	sed	
		n. and an additional dose of			at the monthly QAPI meeting. Once th	e	
	morphine sulfate w	as scheduled for 2/8/22 at			QAPI committee determines the proble	m	
	6:00 a.m.				no longer exists, the reviews will be		
					conducted on a random basis.		
		o.m., the licensed practical			The Administrator/Director of Nursing a		
	nurse (LPN) #1 wo			responsible for implementation of the p	lan		
	` <i>'</i>	erviewed. LPN #1 stated she			of correction.		
	worked on 2/7/22 f	rom 7:00 a.m. until 7:00 p.m.			Date of compliance-3/23/2022	ļ	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMP	SURVEY LETED			
		495105	B. WING			R-C 02/10/2022	
	ROVIDER OR SUPPLIER	L		5	TREET ADDRESS, CITY, STATE, ZIP CODE 615 SEMINOLE AVENUE YNCHBURG, VA 24502	1 027	10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	unit when she left on she gave a verbal rep East unit prior to leav stated there was no n she arrived this morn LPN #1 stated she discheduled to work the West unit. LPN #1 st unit manager for the VON (DON) was interviewed administered to reside evening of 2/7/22 and The DON stated nurs and sign off a medical (MAR) or treatment a The DON had no exp did not receive medical 2/7/22 and stated she The DON stated, "We last night." The DON LPN #4 worked the estated that LPN #2 wand "house supervisors shift. On 2/8/22 at 3:35 p.m and corporate consulting met with the survey to physician ordered medical with the survey to residents on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 medications on the Wesp.m. until 2/8/22 at 7: consultant stated LPN unit manager (LPN #2 me	was no nurse on the West 2/7/22 around 7:30 p.m. and port to the unit manager on ing the building. LPN #1 nurse on the West unit when ing (2/8/22) at 7:00 a.m. d not know who was a evening and night shifts on ated there was currently no West unit. In, the director of nursing and about medications not ents on the West unit on the dearly morning of 2/8/22. The shad 24 hours to clarify tion administration record diministration record diministration why the residents ations on the evening of a would research and clarify. The did have agency nurses stated LPN #2, LPN #3 and vening shift. The DON as the East unit manager or on the 2/7/22 evening In, the administration staff #3) and vening shift. The DON as the East unit manager or on the 2/7/22 evening In, the administration staff #3) and vening shift. The DON at the East unit manager or the 2/7/22 evening In, the administration staff #3) and vening shift. The DON at the East unit manager or the 2/7/22 evening In, the administration staff #3) and vening shift. The DON at the East unit manager of the East unit manager or the 2/7/22 evening In, the administration staff #3) and vening shift. The DON at the East unit manager of the East unit manager or the 2/7/22 evening In, the administration staff #3) and vening shift. The DON at the East unit manager of the East unit manager	F	725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COI	(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			R-C 2/10/2022	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	•	211012022	
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F 725	that evening and onurses working or South and West). not give medications on the polymedications on the DON stated, "The the shift change." #3 and LPN #4 we evening of 2/7/22 stated LPN #2 and p.m. with two nursestarting at 11:00 pare "call out" on 2/7 p.m. to 7:00 a.m.) nurse in the building was contacted and 2/7/22 at 11:00 p.m. was on the East us South unit and the "split" the West unit on 2/8/22 at 3:45 (LPN #2) was interested to 11:00 p.m. shift around 7:30 p.m., her that she was I on West unit had did not go to the Veshift at 11:00 p.m. nothing. I was give East." LPN #2 states were unit on 2/7/2 went home, and sthe evening medicing "Nobody reported"	#2 was the "house supervisor" could have reassigned the in the facility's three units (East, The DON stated LPN #2 did ions on West during the evening l#1 reported that all the ie unit had been given. The ire was a miscommunication at The DON stated LPN #2, LPN ions on the building on the interest of the building on the interest of the building ions. The DON id LPN #4 left on 2/7/22 at 11:00 ions scheduled for the building ions. The DON stated there was i/22 prior to the night shift (11:00 in leaving LPN #3 as the only ing. The DON stated agency ing. The DON stated LPN #3 init, LPN #5 was assigned to ie two nurses were supposed to	F	725			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495105	B. WING			R-C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	, ZIP CODE	02/10/2022	
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI ID TO THE APPROPRIA ICIENCY)	DATE
F 725	left the building on 2 LPN #3 working the a.m. LPN #2 stated in and reported to Sc 11:00 p.m. to work the component of the co	J7/22 at 11:00 p.m. leaving East unit until 2/8/22 at 7:00 an agency nurse was called buth unit on 2/7/22 around ne night shift. m., the administrator, DON litant met again with the ON stated on 2/7/22, that two LPN #5) were the only g from 11:00 p.m. until 2/8/22 DN stated when only two uilding that "they (nurses) est unit. The DON stated esupervisor" on the night	F7	725			
	prescribed medicatic administered on We 7:00 p.m. until 2/8/2 stated again, "There shift change." LPN #3 stated she was unit and helped out op.m. LPN #3 stated went back to the East cover South after the LPN #3 stated she was unit. LPN #3 son West unit on 2/7/stated again she was on 2/7/22 and she was nurse on West unit. Resident #207 called for her methadone pstated, "I didn't know	m., the DON stated that all ons and treatments were not st unit on the 2/7/22 from 2 at 7:00 a.m. The DON was a miscommunication at was assigned to work the East on the South unit after 7:00 on 2/7/22 at 11:00 p.m. she st unit, as LPN #5 came in to e scheduled nurse called out. was not assigned to work the stated there were two nurses 22 until 7:00 p.m. LPN #3 is never assigned to West unit as not aware there was no intil around 11:30 p.m. when it does not the phone and asked ain medication. LPN #3 is there was no nurse back iil then." LPN #3 stated she					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495105	B. WING		,	R-C 2/10/2022
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	1	2/10/2022
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 725	medication because not count the narco change. LPN #3 st giving narcotics on come back on me" LPN #3 stated after LPN #3 stated after LPN #5 were the or with three CNAs. L check on residents was working East. CNA working on We problems. On 2/8/22 at 5:35 p interviewed about a evening of 2/7/22. not get any of her m 7:00 p.m. until 2/8/2 #207 stated that on p.m. dose of gabap missed a dose of m and "a psych med" morphine sulfate so a.m. Resident #207 11:30 p.m., she rep nursing assistant) # get her scheduled p #207 stated CNA #East unit and report luck" as there was a Resident #207 stated phone to the East up ractical nurse) #3 her the pain medical LPN #3 told her "not assigned nurse. Reasked who her assigned states asked who her assigned states asked who her assigned nurse.	that she could not give her the eit was a narcotic and she did tics on that unit at shift ated she was not comfortable that unit because "it might if the counts were wrong. 2/7/22 at 11:00 p.m., she and ally nurses in the building along PN #3 stated she did not on the West unit because she LPN #3 stated she told the est to let her know of any .m., Resident #207 was my missed medications on the Resident #207 stated she did nedications on 2/7/22 after 22 at 11:00 a.m. Resident 2/7/22 she missed a 9:00 entin, on 2/8/22 at 12:00 a.m. ethadone, morphine sulfate and missed another dose of theduled for 2/8/22 at 6:00 of stated that on 2/7/22 around orted to the CNA (certified 55 that she needed a nurse to be a needed and she called on her cell unit and asked LPN (licensed if she would come and give ations. Resident #207 stated when she gned nurse was, LPN #3 told the a nurse this shift. Resident	F 72	25		

OLIVILIY	OT OIL MEDIO, IILE A	WEDIO/ ND CEITVIOLO				CIVID IVC	7. 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
			1 20.25			₽	-C
		495105	B. WING				10/2022
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	10/2022
	10 112 211 011 001 1 21211				615 SEMINOLE AVENUE		
LYNCHBU	RG HEALTH & REHABIL	ITATION CENTER			YNCHBURG, VA 24502		
040.15	CUMMADVCT	ATEMENT OF DEFICIENCIES	- 15				0/5)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE .	DATE
					DEFICIENCY)		
F 725	Continued From page	e 118	F	725			
	#207 stated she then						
	(South). Resident #2						
	•	on South stated the nurse					
		t. Resident #207 stated she					
	· ·	ded her pain, psych meds					
		se to call her when possible.					
		she did not know who					
		but that person told her if the					
		e would and "if not, she					
	(nurse) won't." Resident #207 stated she never got a visit or a call from either nurse. Resident #207 stated there was a CNA working the unit on						
		2/7/22 but she saw no nurse					
		ne day shift reported the next					
	-	sident #207 stated she was					
	in "a lot of pain" due t						
	-	hine. Resident #207 stated					
	-	rms and lower back and					
	rated pain during the	early morning of 2/8/22 as a					
	"9 almost 10" (on sca	le of 0 = no pain, 10 = worst					
	pain). Resident #207	stated she almost called					
	911 to go to the emer	gency room because					
	•	are for her. Resident #207					
		sleep due to the pain, was					
		t" and even emailed the					
		nsultant (administration #3)					
	around 2:00 a.m. abo						
		nt #207 stated she last saw					
		2/7/22 around 7:00 p.m. and					
		urse until 2/8/22 around					
	medications.	day shift nurse brought her					
	medicalions.					[
	On 2/8/22 at 8:30 p.m	n., CNA #1 working on West				[
	-	CNA #1 stated he worked				ſ	
		evening of 2/7/22 until 11:00				ĺ	
		two CNAs from day shift					
	-	ed the unit with him until				ſ	
		ated the nurses on the unit				ĺ	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			R-C 02/10/2022
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	•	02/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725	after 7:30 p.m. there unit and he was the saw no nurses com residents from 7:30 stated most all the r p.m. and he did his When asked if any during his shift, CN, asked to see a nurs Resident #257 asked about an earache. nurse would come a "I didn't want to say stated on the evening answering lights, che "Next thing I know I" On 2/9/22 at 3:00 p again about medical administered with nunit. The DON state only two nurses were nurses had to "split" stated she talked with LPN #3 by telephone 2/7/22. The DON she because she had to cart and LPN #3 was only two nurses for stated she told them that they all had to wo DON stated nobody Resident #207 need residents not getting West. The DON stated nobods the DON stated nobods and the poon stated she told stated residents not getting west. The DON stated nobods the poon stated she told stated residents not getting west. The DON stated nobods the poon stated she told stated residents not getting west. The DON stated nobods the poon stated she told stated residents not getting west. The DON stated nobods the poon stated she told the poon stated she told them that they all had to wo poon stated nobods. The poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they all had to wo poon stated she told them that they	d 7:30 p.m. CNA #1 stated e was no nurse on the entire only CNA. CNA #1 stated he e to the unit and check on p.m. until 11:00 p.m. CNA #1 esidents were in bed by 7:00 best to answer call lights. residents needed a nurse A #1 stated Resident #207 e about her medications and ed to see a nurse "I think" CNA #1 stated he told them a as soon as possible because, there was no nurse." CNA #1 ng of 2/7/22, he was lecking on residents and, I'm the only one here." I.m., the DON was interviewed tions/treatments not on urse working the West ed LPN #3 was aware when re in the building that the I'm the West unit. The DON of the unit manager LPN #2 and the during the evening on tated LPN #2 was upset work the East medication as upset because there were the night shift. The DON on everyone was frustrated and work together as a team. The called or reported to her that ded pain medications or about g medications/treatments on ated she was aware there	F	725		
	stated she told then that they all had to v DON stated nobody Resident #207 need residents not getting West. The DON state were only two nurses	n everyone was frustrated and work together as a team. The called or reported to her that ded pain medications or about g medications/treatments on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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		495105	B. WING _			02/	10/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
LYNCHBU	RG HEALTH & REHABIL	ITATION CENTER		5	5615 SEMINOLE AVENUE			
				L	LYNCHBURG, VA 24502			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX			PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
TAG	REGULATORT OR I	LIGO IDENTIFTING INFORMATION)	TAG		DEFICIENCY)	41C		
					+			
F 725	Continued From page 120		F.	725				
	On 2/10/22 at 2:40 p.m., CNA #2 was		•	0				
		stated she and another						
	CNA worked the day	shift on West on 2/7/22 and						
	stayed on the unit until 7:00 p.m. CNA #2 stated							
	the two nurses on the	e unit left on 2/7/22 at 7:00						
	p.m. CNA #2 stated she and the other CNA had							
	all the residents in the	e bed by 7:00 p.m. except						
		#2 stated she gave report to						
	CNA #1 and left the building at 7:00 p.m. CNA #2							
		nurses on West unit when						
		7:00 p.m. and CNA #1 was						
	the only aide on the u	ınit after 7:00 p.m.						
	The clinical records for	or all residents on the West						
	unit were reviewed by the survey team regarding missed medications and/or treatments on the							
	evening of 2/7/22 and	d early morning of 2/8/22						
		led care and services on the						
		esident #207, fifty-three						
		e unit (#201, #203, #205,						
		nd #230 through #258)						
		edications and/or treatments						
		tube feedings/flushes, blood						
		petic management, tubing						
	changes/site care rela							
		inistration, and care for a						
		dications that were not						
		d a variety of prescriptions medicines for treatment of						
	diagnoses that includ	ed hypertension, oma, muscle spasticity,						
		anagement, congestion,						
		anagement, congestion, atic hyperplasia, depression,						
		in/nutrition deficiencies,						
		, arthritis, dementia, atrial						
		, artınnus, demenua, atnai es. Physician ordered						
	treatments not provid							
		ning of 2/7/22 and early						
		mig of Zilizz and Gally	1		T. Control of the Con		1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
						R-C	
		495105	B. WING _		o:	2/10/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
LYNCHBU	RG HEALTH & REHABIL	ITATION CENTER		5615 SEMINOLE AVENUE			
LINGIIDO	NO HEALING KENADIL	MANOR SERVER		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		SHOULD BE	(X5) COMPLETION DATE	
F 725	Continued From page morning of 2/8/22 inc medications/creams f pain, skin tears/woun prevention/care. Quality of care deficie fifty-four West unit resprovided medications of 2/7/22 and early m related deficiencies w F690, F692, F693, F6	e 121 luded topical for dry/chaffed skin, joint ds and pressure ulcer encies were cited for the sidents that were not /treatments on the evening orning of 2/8/22. Care /ere cited at F684, F686, 695 and F697. reviewed with the r of nursing and corporate			APPROPRIATE		