PRINTED: 05/13/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			C 11/12	2/2019
	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 PREFI) TAG	((EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)	_	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F	000			
F 580 SS=D	Survey was conduct required for compliant Federal Long Term complaint was invested at the time of the consisted of one cur (Resident #1). Notify of Changes (ICFR(s): 483.10(g)(14) Notify (i) A facility must improve the consistent with his consult with the resiconsistent with his consults in injury and physician intervention (B) A significant charmental, or psychosodeterioration in heal status in either life-tollinical complication (C) A need to alter the aneed to discontinut treatment due to add commence a new form (D) A decision to train resident from the far §483.15(c)(1)(ii). (iii) When making notices and the complication of the complex o	fication of Changes. mediately inform the resident; dent's physician; and notify, or her authority, the resident nen there is- olving the resident which has the potential for requiring on; nge in the resident's physical, ocial status (that is, a th, mental, or psychosocial hreatening conditions or s); reatment significantly (that is, ne an existing form of verse consequences, or to orm of treatment); or nsfer or discharge the	F 5	580		1:	2/6/19
	is available and pro	tion specified in §483.15(c)(2) vided upon request to the		TITLE			e) DATE

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

Electronically Signed 12/02/2019

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			C 11/12/2019
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		11/12/2013
(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 CORR ((EACH CORRECTIVE ACTION SHORT CROSS-REFERENCED TO THE APDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	resident and the resident there is— (A) A change in roo as specified in §483 (B) A change in resident for the state law or regulat (e)(10) of this sectic (iv) The facility musupdate the address phone number of the representative(s). §483.10(g)(15) Admission to a composite §483.5) must disclosite physical configuit locations that compoart, and must spectroom changes betwonder §483.15(c)(9) This REQUIREMENT by: Based on staff interecord review and investigation, the fanotification of a physto the POA (Power resident (Resident for the POA) Findings include: Resident #1 was ac 08/12/19. Diagnose but were not limited (diabetes mellitus),	t also promptly notify the sident representative, if any, m or roommate assignment 8.10(e)(6); or ident rights under Federal or ions as specified in paragraph on. It record and periodically (mailing and email) and e resident posite distinct part. A facility distinct part (as defined in se in its admission agreement ration, including the various rise the composite distinct cify the policies that apply to reen its different locations of the course of a complaint cility staff failed to ensure sician's appointmentwas given of Attorney) for one of one	F5	The statements made in this placorrection are not an admission not constitute agreement with the deficiencies herein. To remain incompliance with all state and for regulations, the center has taken take the actions set forth in this Correction. In addition, the follow constitutes the center is allegatic compliance. All alleged deficient been or will be corrected by the indicated. F580 1. Resident #1 is face sheet we see the second of the second	and do ne alleged federal n or will Plan of wing plan ion of cies have dates	

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			A. BOILDI			، ا	С
		495105	B. WING			1	12/2019
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		12/2010
				50	615 SEMINOLE AVENUE		
LYNCHBU	RG HEALTH & REHABIL	LITATION CENTER		Ľ	YNCHBURG, VA 24502		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX 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 580	Continued From page	e 2	F	580			
	cardiomyopathy, dep	ression and dementia.			corrected immediately to list POA as		
	, , , ,				contact #1. Contact #1 will be notified of	of	
	The most current MD	S (minimum data set) was a			all future physician⊡s appointments an	d	
		sessment dated 08/21/19.			resident #1 will not go to any outside		
		the resident as having a			appointments without accompaniment.		
	cognitive score of 11,	, indicating the resident had			2. The Director of Nursing or designe	е	
		t in daily decision making			will conduct an audit of the current		
	skills. The resident w				residents□ face sheets to ensure that		
requiring limited assistance with or		•			POA, if established, is listed as contact		
	' '	or transfers, ambulation, and			#1. The Director of Nursing or designed	Э	
	toileting. The resident was assessed as requiring extensive assistance with one person physical				will conduct an audit of currently		
					established outside appointments for		
		otion on and off the unit.			current residents for the next four week		
		sessed using a wheelchair.			to ensure that a progress note is entere		
		sessed on this MDS as			that states who will accompany them to)	
	-	onth prior to admission.			the appointment. Name and contact information of transport company and		
		d in the CAAS (care area			accompaniment will be included.		
		y) section of this MDS for,			3. Staff Development Coordinator or		
	· · · · · · · · · · · · · · · · · · ·	gnition, ADL (activities of			designee will educate all nursing staff a		
	daily living) and falls.				scheduling staff on appropriately listing POA, if established, as contact #1 on the		
	On 11/12/19. the resid	dent's clinical record was			face sheet and establishing who will		
		ed that the resident had two			accompany residents to their outside		
	POAs listed (POA #1	and POA #2).			appointments and subsequently entering a progress note to state such plans with	-	
	 Resident #1's progres	ss notes were reviewed from			contact information included.		
	. •	hrough present 11/12/19.			The Director of Nursing or designed.	:e	
		ere found that indicated that			will audit the transportation log for all		
		ed or made aware of a			residents twice weekly for four weeks t	0	
		or Resident #1 on 10/25/19.			ensure transportation and		
					accompaniment information is set up		
	POA #1 was interviev	ved on 11/12/19 at 10:50 AM			progress note has all information listed		
	via phone. POA#1 s	stated that she and her sister			5. Any issues will be brought to the 0		
	(POA #2) were not m	ade aware of Resident #1's			meeting. Date of compliance 12/06/19		
	appointment and that	the resident was taken to					
		dropped off without anyone					
		he resident was found in the					
	parking lot wandering	around. POA#1 stated					

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	ROVIDER OR SUPPLIER	11.11		5615 SEMINO	RESS, CITY, STATE, ZIP CODE DLE AVENUE G, VA 24502	1 11/	12/2019	
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F 580	been left alone. POA children (including he involved and would he this appointment, but notified of the appoint she complained to the and they told her the had not received any. On 11/12/19 at 12:45 interviewed via phonneither she, nor her sof this appointment. from the facility called office, and no one from the facility called the above in the facility of the facility of the facility of the above in the facility of the facility	dementia and shouldn't have A #1 stated that there are five erself), all of whom are have made arrangements for a they were not informed or atment. POA #1 stated that he facility after this happened by would investigate, but she are response from the facility. 5 PM, POA # 2 was he. POA #2 stated that he sister (POA #1) were notified POA #2 stated that he not one had not one from the doctor's form transportation called hatment. POA #2 stated that he entia and should have had he had have he had had had he had had he had he had had he had had he had had he had had had had had had had he had	F	580				

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LYNCHBU	RG HEALTH & REHABIL	ITATION CENTER		5615 SEMINOLE AVENUE		
				LYNCHBURG, VA 24502		
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F 580	Continued From page	· 4	F 580			
	needs to be addressed was being addressed	d. The ADON stated that it , but did not provide any requested at this time on				
	Transportation and Apnurse will ensure tran related appointments coordinating those ac as appropriatenursi appointment as soon recommendation is rewill ensure transporta appropriate responsible to contact the designator completion of appipatient to use van ser services will be notified the appointment time (van or ambulance). available or canceled notified and the appointment time	Procedures General Care oppointmentsA licensed sportation to medically and will be responsible for commodations for transporting will schedule a physician as a consult occived. A licensed nurse tion as indicated. The ole party may be requested ated transportation company ropriate forms allowing vices. Transportation at at least 24 hours before to schedule their services of transportation is not then all parties will be nument will be reschedule."				
	at 4:00 PM, to eviden and/or family were ma appointment.					
F 600 SS=D	This is a complaint de Free from Abuse and CFR(s): 483.12(a)(1)		F 600		12/6/19	
	Exploitation	m Abuse, Neglect, and right to be free from abuse,				

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TAPAWIE OF TH	TO VIDER OR OUT FIER			, , ,		
LYNCHBU	RG HEALTH & REHABIL	ITATION CENTER		5615 SEMINOLE AVENUE		
				LYNCHBURG, VA 24502		
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F 600	Continued From page	÷ 5	F 600	ס		
F 600	neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chemitreat the resident's mediated the resident the resident the resident the resident the responsible party and without a procedure was checked in at the appointment was schecked.	ation of resident property, befined in this subpart. This sited to freedom from involuntary seclusion and ical restraint not required to bedical symptoms. By must- By verbal, mental, sexual, or oral punishment, or its not met as evidenced siew, family interview, hical record review, facility in the course of a complaint lity neglected to provide sight for of one of one By Maria	F 600	1. Resident #1□s face sheet was corrected immediately to list POA as contact #1. Contact #1 will be notified all future physician□s appointments ar resident #1 will not go to any outside appointments without accompaniment. 2. The Director of Nursing or designe will conduct an audit of the current residents□ face sheets to ensure that POA, if established, is listed as contact #1. The Director of Nursing or designe will conduct an audit of currently established outside appointments for current residents for the next four weet to ensure that a progress note is enter that states who will accompany them to	t ee ks ed	
	but were not limited to	for Resident #1 included, b: atrial fibrillation, DM ncephalopathy, history of		the appointment. Name and contact information of transport company and accompaniment will be included. 3. Staff Development Coordinator or designee will educate all nursing staff scheduling staff on appropriately listing		
	cardiomyopathy, depr	ression and dementia. S (minimum data set) was a		POA, if established, as contact #1 on t face sheet and establishing who will accompany residents to their outside		

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	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		1111212010	
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F 600	This MDS assessed to cognitive score of 11, moderate impairment skills. The resident was requiring limited assist physical assistance for toileting. The resident extensive assistance assistance for locomoderate	the resident as having a indicating the resident had in daily decision making was also assessed as stance with one person or transfers, ambulation, and it was assessed as requiring with one person physical otion on and off the unit. Hessed using a wheelchair. Hessed on this MDS as onth prior to admission. It was assessed as requiring with one person physical otion on and off the unit. Hessed using a wheelchair. Hessed using a wheelchair. Hessed on this MDS as onth prior to admission. It was assessed as requiring with one person physical otion on and off the unit. Hessed using a wheelchair. Hessed using a wheelchair. Hessed on this MDS as onth prior to admission. It was assessed as requiring with one person on the resident's as a much as possible in the person of the person	F 6	appointments and subseque a progress note to state succontact information included 4. The Director of Nursing will audit the transportation I residents twice weekly for formation progress note has all inform 5. Any issues will be broug meeting. Date of compliance	th plans with I. I or designee log for all our weeks to I is set up ation listed. ght to the QAPI		

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F 600	10:50 AM. POA #1 s (POA #2) were not mappointment and that the appointment and the parking lot wand the parking lot wand that Resident #1 has have been left alone are five children (incare involved and wor for this appointment, or notified of the app that she complained happened and they trinvestigate, but she from the facility. PO concerned that Residuith dementia are be is ensuring their care. The clinical record rear a consult report from on 10/25/19, along was resident was transport an outsourced transportdate of service: 1 and permanent atrial coagulation therapy, due to dementia and mild residual right sidual right sidual right sidual residual right sidual right sidual residual right sidual	wed by phone on 11/12/19 at stated that she and her sister nade aware of Resident #1's t Resident #1 was taken to dropped off without anyone Resident #1 was found in ering around. POA #1 stated dementia and shouldn't. POA #1 stated that there luding herself), all of whom all have made arrangements but they were not informed ointment. POA #1 stated to the facility after this old her they would had not got any response A #1 stated that she is dent #1 and other residents eing dropped off and no one except that the cardiology appointment with documentation that the orted to the appointment via	F 6				

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F 600	interviewed and ask Resident #1 on 10/2 representative stated appointment was ma #1 by the facility and resident was to have appointment. The si was asked what exa special service repre- means the resident of appointment, not indoservice representative way to verify if the re-	the transport company was ed about transport for 5/19. The special service If that the transport ade and set up for Resident If that it was entered that the	F 60	00		
	11/12/19 at 11:50 AN interviewed regardin Resident #1 and her The office manager any information regain the parking lot or I manager stated, "Ware just left and drop what happened in the frequently." On 11/12/19 at 12:49 interviewed via phorneither she, nor her of this appointment. from the facility calle office, and no one for regarding this appoin Resident #1 has der someone with her.	ician's office was called on M. The office manager was g any information about appointment on 10/2/5/19. It is stated that she did not have arding Resident #1 being out being left alone. The office is run into it often that patients uped off, not sure if that is is case, but it does happen is case, but it does happen be POA #2 stated that sister (POA #1) were notified POA #2 stated that no one d, no one from the doctor's form transportation called intment. POA #2 stated that nentia and should have had POA #2 stated that it just so the property in the open who saw Resident #1				

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F 600	Continued From page	ge 9	F	600			
		andering around was a nce and knew that something					
	(director of nursing) nursing) and corpor of the above concer notified of Resident resident not having being left alone at the	PM, the administrator, DON, ADON (assistant director of ate nurse were made aware as about the POA not being #1's appointment, the an escort to the appointment, and building and into the parking					
	the above informatic staff were asked if a were notified. The land further stated the DON was made aw documentation in R that evidenced either appointment. The A #1's appointment when and the daughter (Fabout this on Sunda stated that she complete if there is needs to be address was being addressed asked how was it be stated that after hap daughter stated that out to any appointment and the ADON being daughter/POA being daughter/POA being addressed asked how was it be stated that after hap daughter/POA being daughter/POA being	g notified and approving. The					
	above staff were as	ked what is the expectation ementia to be transported to					

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TVAINE OF T	TOVIDER OR GOLT EIER			5615 SEMINOLE AVENUE	-		
LYNCHBU	RG HEALTH & REHABIL	ITATION CENTER		LYNCHBURG, VA 24502			
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F 600	Continued From page	e 10	F 6	500			
	member can go with they will meet them a	re not notified of the					
	been done regarding stated that they compound that she company and it was redropped Resident #1 picked her back up at the building. The corresidents have family with residents, if not a see if they want to go appointment, and furt facility staff were over and so many resident corporate nurse and at that the incident was agency, that it had be not a reportable incidestated, "We didn't repactually prove that it had ministrator and stated how can they know it investigation wasn't condition wasn't condition to comment. The administrator and correct hen asked whe daughter/POA inform the daughter/POA gaif they followed up with the company and it that they followed up with the company and it that they followed up with the company and it was not stated. They followed up with the company and it was not stated that they followed up with the company and it was not stated that they followed up with the company and they company and they followed up with the company and they follow	eported that the driver off in the lobby and then iter the appointment inside porate nurse stated that if they will go to appointments administration will call staff to with a resident to an her stated that at that time rwhelmed with appointments its were going out. The administrator both stated not reported to the state sen discussed but felt it was ent. The administrator ort it because we couldn't nappened." The ff present were then asked, didn't happen if a thorough ompleted. The facility staff e DON, ADON, porate nurse (facility staff)					

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F 600	to attempt contact withen stated a name (correct) of the witness did not write the inforwitness and did not have an escort to stated that the school appointments. The functional transport was set up to have an escort to stated that the school appointments. The functional transport was set up to have an escort to stated that the school appointments. The functional transport was had interview regarding to the school and get transport was asked about have asked ab	e witness had an 7. The DON did not follow up th the witness. The DON which was similar, but not s. The DON stated that she mation down regarding the have any information at all part of the investigation. then stated, "It is a courtesy hts, but we aren't mandated staff were made aware that hy was called and that for Resident #1 by the facility the appointment. The DON fuller makes the facility staff were made aware been contacted for an he above incident. PM, the scheduler was heduler stated that she will tation set up. The scheduler wing an escort. The she will usually request high that the driver takes a fointment and then brings heduler stated that orthopedic have an escort, but stated she to that in for Resident #1 and did not have evidence or any what type of transport she have the contract and/or ransport company to show he responsible for, as far as	F 6				

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F 600	Procedures General appointmentsA lictransportation to me and will be respons accommodations for appropriatenursing appointment as soor recommendation is will ensure transportate responsito contact the design for completion of appatient to use van services will be noted the appointment time (van or ambulance) available or canceled notified and the appointment of the appointment that (van or ambulance) available or canceled notified and the appointment that approximately 2: stated that they did agreement or contravasn't sure, but wo	nted: "Nursing Policies and all Care Transportation and censed nurse will ensure edically related appointments lible for coordinating those or transport as g will schedule a physician	F6			
	verbalize what the of the transport companies stated that he information. At 3:15 PM, the corphone number and on the duties and retransportation comptwice and message was ever returned;	porate nurse could not duties and responsibilities of any were. The corporate e would call and try to get that porate nurse presented a name to call for information esponsibilities of the bany. The number was called s left to return the call. No call no further information was the transport duties and				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		495105	B. WING _			2/2019	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP (2/2010	
				5615 SEMINOLE AVENUE			
LYNCHBU	RG HEALTH & REHA	BILITATION CENTER		LYNCHBURG, 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		THE APPROPRIATE	COMPLETION DATE	
F 600	Continued From paresponsibilities.	age 13	F	600			
	On 11/13/19 at 9:3 interviewed via phywitness stated, " had an appointmeremember the time with me. We went in, I recognized (Not the waiting area in went over and said how are you and sher if she remember my sister's name). Witness) and she (meant to say." The asked the resident she saw that the resident replied, "I to her, "(Name of resident replied, "I to her, "(Name of resident resident to witness stated that that Resident #1 do then stated that she registered and were resident #1 where witness then stated that she thought Resident #1 where witness stated that the resident stated that the resident stated that the resident #1 where witness stated that the resident #1 where she thought Resident #1 where the stated that the resident #1 rolled Resident #1 where that it looked like she that it looked like she witness stated that the resident #1 where that it looked like she that it looked like she that it looked like she witness stated that electronic doors of Resident #1 where that it looked like she witness stated that electronic doors of Resident #1 where that it looked like she witness stated that electronic doors of Resident #1 where that it looked like she witness stated that electronic doors of Resident #1 where that it looked like she witness stated that the resident #1 where that it looked like she witness stated that electronic doors of Resident #1 where that it looked like she witness stated that the resident #1 where the resident #1 wher	one regarding the incident. The It was on the 25th [October], I and at the same office, I can't e, but I had my two daughters into the office and on our way ame of Resident #1) sitting in a big wheelchair by herself. I d hey, (called resident by name) the said she was fine. I asked ered me and she (called me by I said no, I'm (name of resident) said oh, that's what I e witness then stated she how she got there, because esident was alone. The drove." The witness then said tesident) I know you didn't drive get here?" The witness stated old her, "Me and my Lord." The ta she was surprised and knew idn't drive herself. The witness he went up to get herself in back to sit down and saw ling away, down a hall. The dathat she asked her daughter if ent #1 may need to use the thess stated that her daughter and a sked the resident and I no and just kept wheeling and he was coming back. The ta they saw her approach the they saw her approach they saw her approach they saw her app					

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			1 20.25	_			С
		495105	B. WING			l	12/2019
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			STREET ADDRESS, CITY, STATE, ZIP CODE	. 11/	. <i>L.</i> L. U. I. U
					615 SEMINOLE AVENUE		
LYNCHBU	RG HEALTH & REHABIL	ITATION CENTER			YNCHBURG, VA 24502		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	l	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
			-				
F 600	Continued From page	<u>.</u> 14	F	600			
		ng the resident) come inside,		000			
		The witness then told the					
		as going to see where she					
	was going. The witne						
		e door and looked and					
	_	d herself to the end of the					
	parking lot and had s						
		attempting to get into an					
	unoccupied car. The witness stated it must have						
	been locked because						
	and sat down in the chair and she was afraid she						
	was going to fall, stat	ing that the chair whipped					
		nt #1 sat down. The witness					
		aughter went down to check					
		he (the witness) went back					
	-	that someone needed to					
		, then she came back					
		ady came out. The witness					
	-	n worked there, but did not o't sure about the other					
	_	stated that she told the					
	· •	name and that something					
		elt like "her [resident] mind is					
		en stated that the two ladies					
	were getting Residen	t #1 back to go in and the					
		ent #1 what she did with her					
	papers, and that her	shirt and pants were kind of					
	bunched up and Resi	dent #1 had put her					
	paperwork into her pa	ants and covered it with her					
	shirt. The witness sta						
		ed and told the women that					
		me to her children. The					
		e ladies finally got her					
		esident #1 back inside the					
	_	/. The witness stated that					
		questions or anything					
		I. The witness stated that					
		n her appointment she and					
	her daughters were s	hocked and upset about the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495105	B. WING			C / 12/2019
NAME OF PROVIDER OR SUPPLIER LYNCHBURG HEALTH & REHABILITA			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		112/2013
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		_D BE	(X5) COMPLETION DATE
at 4:00 PM, to evidence of free of neglect by the factor of the factor o	to figure out how to get 1's family regarding the ted that finally they were call Resident #1's sister Resident #1's daughters and out about it. ad/or documentation was cit conference on 11/12/19 that Resident #1 was cility staff. iency. lations to allegations of abuse, mistreatment, the facility at all alleged violations, exploitation or injuries of unknown ation of resident property, y, but not later than 2 in is made, if the events involve abuse or result in not later than 24 hours if the allegation do not involve in serious bodily injury, to facility and to other State Survey Agency and where state law provides or care facilities) in the awthrough established		609		12/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		495105	B. WING _			C 11/12/2019		
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		12/2010	
				561	I5 SEMINOLE AVENUE			
LYNCHBU	RG HEALTH & REHABI	LITATION CENTER		LY	NCHBURG, VA 24502			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 609	Continued From pag	e 16	F 6	609				
	designated represent accordance with State Survey Agency, with incident, and if the appropriate corrective This REQUIREMENT by: Based on staff interwitness interview, clithe course of a compailed to report an all one resident (Resident taken to an appoint myithout proper superoffice unassisted and around in the parking Findings include: Resident #1 was add 08/12/19. Diagnose	administrator or his or her tative and to other officials in te law, including to the State in 5 working days of the lleged violation is verified re action must be taken. T is not met as evidenced view, family interview, nical record review, and in plaint investigation, the facility reged violation of neglect for ent #1); the resident was ment set up by the facility rision, the resident exited the drawas found wandering glot. mitted to the facility on se for Resident #1 included, to: atrial fibrillation, DM			1. New allegations that involve lack of supervision will be investigated and reported to the State Agency in a timely manner with thorough documentation of investigation findings. 2. The Administrator or designee will conduct an audit for the previous week 11/24/2019-12/1/2019, will be complete to ensure that any that any allegations lack of supervision have been investigated and reported to the State Survey Agency appropriately. 3. Administrator or designee will educall center staff on reporting and investigating allegations of lack of	y of , ed of		
	(diabetes mellitus), efalls, difficulty walkin cardiomyopathy, department of the most current MI 14 day admission as This MDS assessed cognitive score of 11 moderate impairment skills. The resident's progrefrom admission 08/1 11/12/19. It was doon nursing notes that the	concephalopathy, history of g lumbosacral mass, pression and dementia. OS (minimum data set) was a desessment dated 08/21/19. The resident as having a gradient, indicating the resident had at in daily decision making the making a desert was notes were reviewed 2/19 through present the cumented throughout the gresident was a high fall pted to stand and walk			supervision to include thorough documentation and timely notification to the State Agency. 4. The Administrator will ensure that new allegations of lack of supervision a investigated and reported to the State Survey Agency in a timely manner per policy daily. 5. Any issues will be brought to the Comeeting. Date of compliance 12/06/19.	any are QAPI		

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 _			11/) 12/2019
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	DE	1 11/	12/2010
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ACTION SHOULD BE FO THE APPROPRIATE		(X5) COMPLETION DATE
F 609	A nursing note dated the resident left for ar and then returned at other information in the appointment. Resident #1's Power interviewed via phone POA #1 stated that sh were not made aware appointment and that the appointment and supervising her and F parking lot wandering that Resident #1 has have been left alone. are five children (incluare involved and wou for this appointment, or notified of the appointment, or notified of the appointment of the physicians' of they would investigate had not received any correspondence from administrator. POA # concerned that Resid with dementia are being is ensuring their care. Resident #1's clinical revealed that Resider from the cardiology and along with documents.	d required much redirection. 10/25/19 documented that a appointment at 11:00 AM 1:30 PM. There was no be progress notes regarding of Attorney (POA) #1 was a on 11/12/19 at 10:50 AM. be and her sister (POA #2) a of Resident #1's Resident #1 was taken to dropped off without anyone resident #1 was found in the around. POA #1 stated dementia and shouldn't POA #1 stated that there adding herself), all of whom ald have made arrangements but they were not informed bintment. POA #1 stated to the facility as soon as she dent #1 being in the parking office and that staff told her a, but as of 10/28/19 she response or the facility DON and/or a stated that she is ent #1 and other residents ng dropped off and no one	F6	509			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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	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 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 609	interviewed via phoi Resident #1 has de someone with her. happened that the pin the parking lot wa longtime acquaintar wasn't right and starshe may not have e On 11/12/19 at 1:05 (director of nursing) nursing) and corpor of the above concer Resident #1 not have appointment, being and as a result, Resilobby into the parkir locked car. The above informatic stated that they four daughter/POA and at that time. The ADO appointment was or daughter (POA #1) this on Sunday, Oct that she completed ADON was asked with the ADON stated the complete if there is needs to be addressed asked how was it be was made about with ADON then stated to	5 PM, POA # 2 was ne. POA #2 stated that mentia and should have had POA #2 stated that it was just berson who saw Resident #1 andering around was a nce and knew that something ted if it hadn't been for that, ever known. PM, the administrator, DON ADON (assistant director of ate nurse were made aware ans with the incident regarding ring an escort to the left alone at the appointment sident #1 wandered out of the ag lot attempting to get into a love staff were asked if this	F	509			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		495105 B. WING				C 11/12/2019
	OVIDER OR SUPPLIER G HEALTH & REHABIL	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	DDE	11/12/2019
(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 C ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 610 I SS=D (daughters/POAs being them. The ADON was the fact and had not hactual concerns. The notident was not reported to the DON was asked corporate nurse and a chat the incident was Agency, that it had be was not a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repartually prove that it had be wasn't a reportable in stated, "We didn't repart	iny appointments without the g notified and approved by it is made aware that was after ing really to do with the end DON stated that the ited to the state agency. Why it wasn't reported. The administrator both stated into reported to the State end discussed but they felt it incident. When asked why it cident the administrator or it because we couldn't inappened." In and/or documentation was exit conference on 11/12/19 one that the above incident that Agency regarding it alone at a physician's ingerthat time the resident the building and into the goto access locked cars. In and/or documentation was exit conference on 11/12/19 one that the above incident in the building and into the goto access locked cars. In and/or documentation was exit conference on 11/12/19 one that the above incident in the building and into the goto access locked cars. In and/or documentation was exit conference on 11/12/19 one that the above incident in the building and into the goto access locked cars. In and/or documentation was exit conference on 11/12/19 one that the above incident in the building and into the goto access locked cars. In and/or documentation was exit conference on 11/12/19 one that the above incident in the building and into the goto access locked cars. In and/or documentation was exit conference on 11/12/19 one that the above incident in the province that the above incident in the province in the		609		12/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495105	B. WING		C 11/12/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/12/2019	
				5615 SEMINOLE AVENUE		
LYNCHBU	JRG HEALTH & REHABIL	LITATION CENTER	I	LYNCHBURG, VA 24502		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 610	Continued From page	≥ 20	F 610			
	designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective. This REQUIREMENT by: Based on staff interviceord review, facility course of a complaint failed to ensure a continvestigation was conviolation of neglect for Findings include: Resident #1 was adm 08/12/19. Diagnoses but were not limited to (diabetes mellitus), et falls, difficulty walking cardiomyopathy, depit The most current MD 14 day admission ass This MDS assessed to cognitive score of 11, moderate impairment skills. The resident's progree from admission 08/12 11/12/19. It was documursing notes that the risk, and often attemptions.	administrator or his or her ative and to other officials in e law, including to the State in 5 working days of the eged violation is verified a action must be taken. Tis not met as evidenced iew, family interview, clinical document review and in the trinvestigation, the facility inplete and thorough inpleted for an alleged in Resident #1. Thitted to the facility on infor Resident #1 included, incompanies and dementia. Sometimes (minimum data set) was a sessment dated 08/21/19. The resident as having a indicating the resident making is notes were reviewed.		1. New allegations that involve lack of supervision will be investigated and reported to the State Agency in a timel manner with thorough documentation of investigation findings. 2. The Administrator or designee will conduct an audit for the previous week 11/24/2019-12/1/2019, will be complet to ensure that any that any allegations lack of supervision have been investigated and reported to the State Survey Agency appropriately. 3. Administrator or designee will eduall center staff on reporting and investigating allegations of lack of supervision to include thorough documentation and timely notification to the State Agency. 4. The Administrator will ensure that new allegations of lack of supervision a investigated and reported to the State Survey Agency in a timely manner per policy daily. 5. Any issues will be brought to the Omeeting. date of compliance 12/06/19.	y of A, ed of cate o any are	

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 11/12/2019	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	11/12/2019	
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 PREFI) TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T	ACTION SHOULD BE O THE APPROPRIA	DATE	
F 610	Continued From page	e 21	F 6	510			
F 610	A nursing note dated the resident left for ar and then returned at other information in the appointment. Resident #1's Power interviewed via phone POA #1 stated that she were not made aware appointment and that the appointment and supervising her and Fparking lot wandering that Resident #1 has have been left alone. are five children (incluare involved and wou for this appointment, or notified of the appointment, or notified of the appointment of the physicians' they would investigate had not received any correspondence from administrator. POA # concerned that Resid with dementia are being ensuring their care.	10/25/19 documented that a appointment at 11:00 AM 1:30 PM. There was no me progress notes regarding of Attorney (POA) #1 was a on 11/12/19 at 10:50 AM. The and her sister (POA #2) at of Resident #1's Resident #1 was taken to dropped off without anyone Resident #1 was found in the around. POA #1 stated dementia and shouldn't POA #1 stated that there adding herself), all of whom lid have made arrangements but they were not informed bintment. POA #1 stated to the facility as soon as she dent #1 being in the parking office and that staff told her e, but as of 10/28/19 she response or the facility DON and/or 11 stated that she is ent #1 and other residents ing dropped off and no one in the cardiology.		510			
	documentation that the to the appointment via company.	ne resident was transported a an outsourced transport					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
	495105	B. WING _			C 11/12/2019	
NAME OF PROVIDER OR SUPPLIER LYNCHBURG HEALTH & REHABILITATION CE	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	'		
(X4) ID SUMMARY STATEMENT OF I PREFIX (EACH DEFICIENCY MUST BE PR TAG REGULATORY OR LSC IDENTIFYI	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
question documented, "date of 10/25/19cardiomyopathy and pfibrillationcontinue coagulation therapyischemic workup defendementia and functional status residual right sided weaknesspabnormal gaitShe is quite confido not really believe she knows where" The transport company was called 11:40 AM for an interview. A sperepresentative from the transport interviewed and asked about transport appointment was made and set with appointment was made and set with appointment. The special service was asked what exactly did that special service representative standard thave an appointment, not including the diservice representative was asked way to verify if the resident actual and the special service representative was asked way to verify if the resident actual and the special service representative the service representative was asked way to verify if the resident actual and the special service representative mand the special service representative that the service representative was asked way to verify if the resident actual and the special service representative mand the special service representative that sand the special service representative that sand the special service representative was asked way to verify if the resident actual and the special service representative that sand the special service representative was asked way to verify if the resident actual and the special service representative was asked way to verify if the resident actual and the special service representative was asked way to verify if the resident actual and the special service representative was asked way to verify if the resident actual and the special service representative was asked way to verify if the resident actual and the special service representative was asked way to verify if the resident actual and the special service representative was asked way to verify if the resident actual and the special service representative was asked way to verify if the resident was the resident was the resident was the resident	red due to chronic mild positive for fused today and I why she is red on 11/12/19 at recial service at company was an ansport for pecial service ansport for pecial service ansport for pecial service ansport further the futer of the red that the red that it rescort to the rescort to the river. The special difference was any ally had an escort attative stated, rewas called on the manager was an action about an on 10/2/5/19, the did not have rent #1 being out one. The office often that patients	F6	10			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED		
		495105	B. WING			C 11/12/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		11/12/2013	
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 610	interviewed via pho Resident #1 has de someone with her. happened that the pin the parking lot wa longtime acquaintan wasn't right and stashe may not have ed. On 11/12/19 at 1:05 (director of nursing) nursing) and corpor of the above conce Resident #1 not has appointment, being and as a result, Resilobby into the parking locked car. The abinvestigation had be the above information had be the above information when the daughter/POA information if they finformation. The Didaughter/POA gave	Is PM, POA # 2 was ne. POA #2 stated that mentia and should have had POA #2 stated that it was just person who saw Resident #1 andering around was a nee and knew that something ted if it hadn't been for that, ever known. Is PM, the administrator, DON of ADON (assistant director of rate nurse were made aware rms with the incident regarding wing an escort to the left alone at the appointment sident #1 wandered out of the ng lot attempting to get into a love staff were asked if an even completed. Itated that they were aware of on and concerns. The DON, or and corporate nurse (facility led when the resident's med them of this incident and POA gave them witness ollowed up with that ON stated that the ethem the name of the witness of t	F 6	,			
	witness had an app was asked who tha name of the witness DON stated she did down about the witn	doctor's office and asked if the ointment that day. The DON t was. The DON stated a s (similar, but not exact). The I not write the information ness from the daughter/POA did not attempt to contact the					

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 11/12/2019	
NAME OF PROVIDER OR SUPPLIER LYNCHBURG HEALTH & REHABILITATION 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 PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	CTION SHOULD BE COMPLETION OF THE APPROPRIATE COMPLETION DATE		
F 610	was done. The DOI The investigation did regarding the witness to an appointment a resident was found around alone. The ADON stated the was on Friday, Octooper 27 she completed a see was asked what a see ADON stated that it there is a problem of addressed. The AD addressed. The AD addressed. The fact it being addressed. happened, the resident was not to without being notified. The DON stated that it dropped the resident picked her back up at the building. The act of the point and the picked her back up at the building. The act of the point and point and problem of the poont and that it dropped the resident picked her back up at the building. The act of the poont and point and p	stated that an investigation N presented the investigation. d not have any information as or Resident #1 being taken and being left alone, or that the in the parking lot wandering that the resident's appointment aber 25th and the daughter a concerns about this on th. The ADON stated that rvice concern. The ADON ervice concern is and the is something they complete if ar concern that needs to be iON stated that it was being willity staff were asked how was The ADON stated that after ent's daughter stated that the go out to any appointments d and approved by the POA. It she called the transport was reported that the driver at off in the lobby and then after the appointment inside dministrator stated, "We didn't	F6				
	happened." The ad were then asked, he actually happened it wasn't completed. comment. The corp a courtesy we offer mandated to do it." aware that the trans that transport was s facility to have an estatement of the complete complete.	e couldn't actually prove that it ministrator and staff present ow could they determine if it if a thorough investigation. The facility staff did not porate nurse then stated, "It is to our patients, but we aren't. The facility staff were made uport company was called and et up for Resident #1 by the scort to the appointment. The escheduler makes the					

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 11/12/2019	
NAME OF PROVIDER OR SUPPLIER LYNCHBURG HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502	11/12/2013	
(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 CORRECTIVE ACTION SHOUS CROSS-REFERENCED TO THE APP DEFICIENCY)	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE COMPLETION DATE	
F 610	appointments. On 11/12/19 at 1:45 interviewed. The scall and get it all se asked about having stated that she will meaning that the drappointment and the scheduler stated the have an escort, but put that in for Resideshe did not have ever transport she requestions of stated that she told #1 being in the part returned Resident # witness stated that questions or anythistated that on the wappointment she are shocked and upset trying to figure out I Resident #1's famil witness stated that contact the resident No further information presented prior to that 4:00 PM, to evide and thorough investing regarding Resident	5 PM, the scheduler was cheduler stated that she will to up. The scheduler was an escort. The scheduler usually request hand to hand, river takes a resident in to the en brings them back. The at orthopedic patients always stated she wasn't sure if she lent #1 and also stated that ridence of what type of ested for Resident #1. O AM, the witness was tness stated she observed doctor's office and exiting the parking lot. The witness the office staff about Resident wing lot, and office staff #1 into the building. The no one asked her any ng while there. The witness	F 610			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
	495105	B. WING		1	C 44/40/0040	
NAME OF PROVIDER OR SUPPLIES LYNCHBURG HEALTH & REH	R		STREET ADDRESS, CITY, STATE, ZIP CO 5615 SEMINOLE AVENUE LYNCHBURG, VA 24502		1/12/2019	
PRÉFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR 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 610 Continued From This is a complain		F 610				