STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. BUILDING _____ B. WING _____	C 11/12/2019

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

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abbreviated Survey was conducted 11/12/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 180 certified bed facility was 162 at the time of the survey. The survey sample consisted of one current resident review (Resident #1).	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		12/6/19

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

Electronically Signed | 12/02/2019

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F 580	Continued From page 1 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, clinical record review and in the course of a complaint investigation, the facility staff failed to ensure notification of a physician's appointmentwas given to the POA (Power of Attorney) for one of one resident (Resident #1) . Findings include: Resident #1 was admitted to the facility on 08/12/19. Diagnoses for Resident #1 included, but were not limited to: atrial fibrillation, DM (diabetes mellitus), encephalopathy, history of falls, difficulty walking lumbosacral mass,	F 580	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain incompliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. F580 1. Resident #1□s face sheet was	

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F 580	Continued From page 2 cardiomyopathy, depression and dementia. The most current MDS (minimum data set) was a 14 day admission assessment dated 08/21/19. This MDS assessed the resident as having a cognitive score of 11, indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring limited assistance with one person physical assistance for transfers, ambulation, and toileting. The resident was assessed as requiring extensive assistance with one person physical assistance for locomotion on and off the unit. The resident was assessed using a wheelchair. The resident was assessed on this MDS as having a fall in the month prior to admission. The resident triggered in the CAAS (care area assessment summary) section of this MDS for, but not limited to: cognition, ADL (activities of daily living) and falls. On 11/12/19, the resident's clinical record was reviewed and revealed that the resident had two POAs listed (POA #1 and POA #2). Resident #1's progress notes were reviewed from admission 08/12/19 through present 11/12/19. No progress notes were found that indicated that either POA was notified or made aware of a doctor appointment for Resident #1 on 10/25/19. POA #1 was interviewed on 11/12/19 at 10:50 AM via phone. POA #1 stated that she and her sister (POA #2) were not made aware of Resident #1's appointment and that the resident was taken to the appointment and dropped off without anyone supervising her and the resident was found in the parking lot wandering around. POA #1 stated	F 580	corrected immediately to list POA as contact #1. Contact #1 will be notified of all future physician□s appointments and resident #1 will not go to any outside appointments without accompaniment. 2. The Director of Nursing or designee 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 designee will conduct an audit of currently established outside appointments for current residents for the next four weeks to ensure that a progress note is entered that states who will accompany them to 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 and scheduling staff on appropriately listing a POA, if established, as contact #1 on the face sheet and establishing who will accompany residents to their outside appointments and subsequently entering a progress note to state such plans with contact information included. 4. The Director of Nursing or designee will audit the transportation log for all residents twice weekly for four weeks to ensure transportation and accompaniment information is set up progress note has all information listed. 5. Any issues will be brought to the QAPI meeting. Date of compliance 12/06/19	

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F 580	Continued From page 3	F 580		

that her mother has dementia and shouldn't have been left alone. POA #1 stated that there are five children (including herself), all of whom are involved and would have made arrangements for this appointment, but they were not informed or notified of the appointment. POA #1 stated that she complained to the facility after this happened and they told her they would investigate, but she had not received any response from the facility.

On 11/12/19 at 12:45 PM, POA # 2 was interviewed via phone. POA #2 stated that neither she, nor her sister (POA #1) were notified of this appointment. POA #2 stated that no one from the facility called, no one from the doctor's office, and no one from transportation called regarding this appointment. POA #2 stated that her mother has dementia and should have had someone with her.

On 11/12/19 at 1:05 PM, the administrator, DON (director of nursing), ADON (assistant director of nursing) were made aware of the above. The administrator stated that the the facility was aware of the above information The facility staff were asked if either of the resident's POAs were notified. The DON stated that they were and further stated that a message was left. The DON was made aware that there was no documentation in the resident's clinical record that evidenced either POA was notified of Resident #1's appointment. The ADON stated that the resident's appointment was on Friday, October 25th and POA #1 called with concerns about this on Sunday, October 27th. The ADON stated that she filled out a service concern. The ADON was asked what a service concern is and the ADON stated that it is something staff complete if there is a problem or concern that

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F 580	Continued From page 4 needs to be addressed. The ADON stated that it was being addressed, but did not provide any details. A policy was requested at this time on transportation/appointments/notification. A policy was presented and documented, "Nursing Policies and Procedures General Care Transportation and Appointments...A licensed nurse will ensure transportation to medically related appointments and will be responsible for coordinating those accommodations for transport as appropriate...nursing will schedule a physician appointment as soon as a consult recommendation is received. A licensed nurse will ensure transportation as indicated. The appropriate responsible party may be requested to contact the designated transportation company for completion of appropriate forms allowing patient to use van services. Transportation services will be notified at least 24 hours before the appointment time to schedule their services (van or ambulance). If transportation is not available or canceled, then all parties will be notified and the appointment will be reschedule." No further information and/or documentation was presented prior to the exit conference on 11/12/19 at 4:00 PM, to evidence Resident #1's POA(s) and/or family were made aware of this appointment. This is a complaint deficiency.	F 580		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F 600		12/6/19

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F 600	Continued From page 5 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, witness interview, clinical record review, facility document review and in the course of a complaint investigation, the facility neglected to provide supervision and oversight for of one of one resident (Resident #1). Resident #1, a cognitively impaired resident, was sent to an outside appointment without an escort, without notifying the responsible party (family) of the appointment, and without a procedure to ensure the resident was checked in at the facility where the appointment was scheduled. Resident #1 was found outside the appointment facility, wandering in the parking lot. Findings include: Resident #1 was admitted to the facility on 08/12/19. Diagnoses for Resident #1 included, but were not limited to: atrial fibrillation, DM (diabetes mellitus), encephalopathy, history of falls, difficulty walking lumbosacral mass, cardiomyopathy, depression and dementia. The most current MDS (minimum data set) was a	F 600	1. Resident #1□s face sheet was corrected immediately to list POA as contact #1. Contact #1 will be notified of all future physician□s appointments and resident #1 will not go to any outside appointments without accompaniment. 2. The Director of Nursing or designee 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 designee will conduct an audit of currently established outside appointments for current residents for the next four weeks to ensure that a progress note is entered that states who will accompany them to 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 and scheduling staff on appropriately listing a POA, if established, as contact #1 on the face sheet and establishing who will accompany residents to their outside	

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F 600	Continued From page 6 14 day admission assessment dated 08/21/19. This MDS assessed the resident as having a cognitive score of 11, indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring limited assistance with one person physical assistance for transfers, ambulation, and toileting. The resident was assessed as requiring extensive assistance with one person physical assistance for locomotion on and off the unit. The resident was assessed using a wheelchair. The resident was assessed on this MDS as having a fall in the month prior to admission. The resident's CCP (comprehensive care plan) documented, "...has impaired cognitive function/dementia or impaired thought processess related to dementia...ask yes/no questions in order to determine the resident's needs...use preferred name...reduce any distractions, turn off TV, radio, close door, etc...keep resident's routine consistent...provide consistent care givers as much as possible in order to decrease confusion...monitor/document/report...any changes in cognitive function, specifically changes in: decision making ability, memory, recall, general awareness...anticipate the resident's needs, assistive devices...1:1 redirection...diversional activities..." Resident #1's progress notes were reviewed from admission 08/12/19 through present 11/12/19. A nursing note dated 10/25/19 documented that the resident left for a doctor appointment at 11:00 AM and then returned at 1:30 PM. Resident #1's clinical record revealed that the resident had two POAs listed (POA #1 and POA #2).	F 600	appointments and subsequently entering a progress note to state such plans with contact information included. 4. The Director of Nursing or designee will audit the transportation log for all residents twice weekly for four weeks to ensure transportation and accompaniment information is set up progress note has all information listed. 5. Any issues will be brought to the QAPI meeting. Date of compliance 12/06/19.	

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POA #1 was interviewed by phone on 11/12/19 at 10:50 AM. POA #1 stated that she and her sister (POA #2) were not made aware of Resident #1's appointment and that Resident #1 was taken to the appointment and dropped off without anyone supervising her, and Resident #1 was found in the parking lot wandering around. POA #1 stated that Resident #1 has dementia and shouldn't have been left alone. POA #1 stated that there are five children (including herself), all of whom are involved and would have made arrangements for this appointment, but they were not informed or notified of the appointment. POA #1 stated that she complained to the facility after this happened and they told her they would investigate, but she had not got any response from the facility. POA #1 stated that she is concerned that Resident #1 and other residents with dementia are being dropped off and no one is ensuring their care.

The clinical record revealed that the resident had a consult report from the cardiology appointment on 10/25/19, along with documentation that the resident was transported to the appointment via an outsourced transport company.

The cardiology consult report documented, "...date of service: 10/25/19...cardiomyopathy and permanent atrial fibrillation...continue coagulation therapy...ischemic workup deferred due to dementia and functional status...chronic mild residual right sided weakness...positive for abnormal gait...She is quite confused today and I do not really believe she knows why she is here..."

The transport company was called on 11/12/19 at 11:40 AM for an interview. A special service

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representative from the transport company was interviewed and asked about transport for Resident #1 on 10/25/19. The special service representative stated that the transport appointment was made and set up for Resident #1 by the facility and that it was entered that the resident was to have an escort to the appointment. The special service representative was asked what exactly did that mean and the special service representative stated that it means the resident will have an escort to the appointment, not including the driver. The special service representative was asked if there was any way to verify if the resident actually had an escort and the special service representative stated, "No."

The cardiology physician's office was called on 11/12/19 at 11:50 AM. The office manager was interviewed regarding any information about Resident #1 and her appointment on 10/2/5/19. The office manager stated that she did not have any information regarding Resident #1 being out in the parking lot or being left alone. The office manager stated, "We run into it often that patients are just left and dropped off, not sure if that is what happened in this case, but it does happen frequently."

On 11/12/19 at 12:45 PM, POA # 2 was interviewed via phone. POA #2 stated that neither she, nor her sister (POA #1) were notified of this appointment. POA #2 stated that no one from the facility called, no one from the doctor's office, and no one from transportation called regarding this appointment. POA #2 stated that Resident #1 has dementia and should have had someone with her. POA #2 stated that it just so happened that the person who saw Resident #1

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in the parking lot wandering around was a longtime acquaintance and knew that something wasn't right.

On 11/12/19 at 1:05 PM, the administrator, DON (director of nursing), ADON (assistant director of nursing) and corporate nurse were made aware of the above concerns about the POA not being notified of Resident #1's appointment, the resident not having an escort to the appointment, being left alone at the appointment, and wandering out of the building and into the parking lot.

The administrator stated that they were aware of the above information and concerns. The facility staff were asked if either of Resident #1's POAs were notified. The DON stated that they were and further stated that a message was left. The DON was made aware that there was no documentation in Resident #1's clinical record that evidenced either POA was notified of the appointment. The ADON stated that Resident #1's appointment was on Friday, October 25th and the daughter (POA #1) called with concerns about this on Sunday, October 27th. The ADON stated that she completed a service concern. The ADON was asked what a service concern is and the ADON stated that it is something they complete if there is a problem or concern that needs to be addressed. The ADON stated that it was being addressed. The facility staff were asked how was it being addressed. The ADON stated that after happened, Resident #1's daughter stated that the resident was not to go out to any appointments without the daughter/POA being notified and approving. The above staff were asked what is the expectation for someone with dementia to be transported to

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an appointment. The DON stated that if a family member can go with them that is what is done or they will meet them at the appointment. The DON was made aware that it is difficult for family to arrange to accompany or transport their resident, when they are not notified of the appointment. The DON agreed.

The DON was then asked if an investigation had been done regarding the incident. The DON stated that they completed an investigation. The DON stated that she called the transport company and it was reported that the driver dropped Resident #1 off in the lobby and then picked her back up after the appointment inside the building. The corporate nurse stated that if residents have family they will go to appointments with residents, if not administration will call staff to see if they want to go with a resident to an appointment, and further stated that at that time facility staff were overwhelmed with appointments and so many resident's were going out. The corporate nurse and administrator both stated that the incident was not reported to the state agency, that it had been discussed but felt it was not a reportable incident. The administrator stated, "We didn't report it because we couldn't actually prove that it happened." The administrator and staff present were then asked, how can they know it didn't happen if a thorough investigation wasn't completed. The facility staff did not comment. The DON, ADON, administrator and corporate nurse (facility staff) were then asked when the resident's daughter/POA informed them of this incident and the daughter/POA gave them witness information, if they followed up with that information. The DON stated that the daughter/POA gave them the name of the witness and she called the doctor's

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office and asked if the witness had an appointment that day. The DON did not follow up to attempt contact with the witness. The DON then stated a name (which was similar, but not correct) of the witness. The DON stated that she did not write the information down regarding the witness and did not have any information at all regarding this in any part of the investigation. The corporate nurse then stated, "It is a courtesy we offer to our patients, but we aren't mandated to do it." The facility staff were made aware that the transport company was called and that transport was set up for Resident #1 by the facility to have an escort to the appointment. The DON stated that the scheduler makes the appointments. The facility staff were made aware that the witness had been contacted for an interview regarding the above incident.

On 11/12/19 at 1:45 PM, the scheduler was interviewed. The scheduler stated that she will call and get transportation set up. The scheduler was asked about having an escort. The scheduler stated that she will usually request hand to hand, meaning that the driver takes a resident in to the appointment and then brings them back. The scheduler stated that orthopedic patients always have an escort, but stated she wasn't sure if she put that in for Resident #1 and also stated that she did not have evidence or any type of tracking as to what type of transport she requested for Resident #1.

The administrator, DON and corporate nurse were asked for the policy on transport and appointments, as well as, the contract and/or agreement with the transport company to show exactly what they are responsible for, as far as patient transport and responsibility.

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The policy documented: "Nursing Policies and Procedures General Care Transportation and appointments...A licensed nurse will ensure transportation to medically related appointments and will be responsible for coordinating those accommodations for transport as appropriate...nursing will schedule a physician appointment as soon as a consult recommendation is received. A licensed nurse will ensure transportation as indicated. The appropriate responsible party may be requested to contact the designated transportation company for completion of appropriate forms allowing patient to use van services. Transportation services will be notified at least 24 hours before the appointment time to schedule their services (van or ambulance). If transportation is not available or canceled, then all parties will be notified and the appointment will be reschedule."

At approximately 2:45 PM, the corporate nurse stated that they did not have anything as far as an agreement or contract regarding transport and he wasn't sure, but would find out. The corporate nurse was asked what the transport company's duties are. The corporate nurse could not verbalize what the duties and responsibilities of the transport company were. The corporate nurse stated that he would call and try to get that information.

At 3:15 PM, the corporate nurse presented a phone number and name to call for information on the duties and responsibilities of the transportation company. The number was called twice and messages left to return the call. No call was ever returned; no further information was obtained regarding the transport duties and

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responsibilities.

On 11/13/19 at 9:30 AM, the witness was interviewed via phone regarding the incident. The witness stated, "...It was on the 25th [October], I had an appointment at the same office, I can't remember the time, but I had my two daughters with me. We went into the office and on our way in, I recognized (Name of Resident #1) sitting in the waiting area in a big wheelchair by herself. I went over and said hey, (called resident by name) how are you and she said she was fine. I asked her if she remembered me and she (called me by my sister's name). I said no, I'm (name of witness) and she (resident) said oh, that's what I meant to say." The witness then stated she asked the resident how she got there, because she saw that the resident was alone. The resident replied, "I drove." The witness then said to her, "(Name of resident) I know you didn't drive here, how did you get here?" The witness stated that the resident told her, "Me and my Lord." The witness stated that she was surprised and knew that Resident #1 didn't drive herself. The witness then stated that she went up to get herself registered and went back to sit down and saw Resident #1 wheeling away, down a hall. The witness then stated that she asked her daughter if she thought Resident #1 may need to use the bathroom. The witness stated that her daughter went to Resident #1 and asked the resident and the resident stated no and just kept wheeling and then turned like she was coming back. The witness stated that they saw her approach the electronic doors of the building and when Resident #1 rolled up to it, it opened up and Resident #1 wheeled on out. The witness stated that it looked like someone was helping her some. The witness then saw that person (who

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appeared to be helping the resident) come inside, but not Resident #1. The witness then told the daughters that she was going to see where she was going. The witness, along with her daughters, went to the door and looked and Resident #1 had rolled herself to the end of the parking lot and had stood up out of her wheelchair and was attempting to get into an unoccupied car. The witness stated it must have been locked because Resident #1 then turned and sat down in the chair and she was afraid she was going to fall, stating that the chair whipped around when Resident #1 sat down. The witness then stated that her daughter went down to check on Resident #1 and she (the witness) went back inside and told a lady that someone needed to check on Resident #1, then she came back outside and another lady came out. The witness stated that one person worked there, but did not get a name and wasn't sure about the other person. The witness stated that she told the ladies Resident #1's name and that something was wrong and she felt like "her [resident] mind is bad." The witness then stated that the two ladies were getting Resident #1 back to go in and the witness asked Resident #1 what she did with her papers, and that her shirt and pants were kind of bunched up and Resident #1 had put her paperwork into her pants and covered it with her shirt. The witness stated that Resident #1 became kind of agitated and told the women that she needed to get home to her children. The witness stated that the ladies finally got her paperwork and got Resident #1 back inside the building into the lobby. The witness stated that no one asked her any questions or anything about what happened. The witness stated that on the way home from her appointment she and her daughters were shocked and upset about the

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F 600	Continued From page 15 situation and were trying to figure out how to get in touch with Resident #1's family regarding the matter. The witness stated that finally they were able to find a number to call Resident #1's sister and then she contacted Resident #1's daughters and that is how they found out about it. No further information and/or documentation was presented prior to the exit conference on 11/12/19 at 4:00 PM, to evidence that Resident #1 was free of neglect by the facility staff. This is a complaint deficiency.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		12/6/19

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F 609	Continued From page 16 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, witness interview, clinical record review, and in the course of a complaint investigation, the facility failed to report an alleged violation of neglect for one resident (Resident #1); the resident was taken to an appointment set up by the facility without proper supervision, the resident exited the office unassisted and was found wandering around in the parking lot. Findings include: Resident #1 was admitted to the facility on 08/12/19. Diagnoses for Resident #1 included, but were not limited to: atrial fibrillation, DM (diabetes mellitus), encephalopathy, history of falls, difficulty walking lumbosacral mass, cardiomyopathy, depression and dementia. The most current MDS (minimum data set) was a 14 day admission assessment dated 08/21/19. This MDS assessed the resident as having a cognitive score of 11, indicating the resident had moderate impairment in daily decision making skills. The resident's progress notes were reviewed from admission 08/12/19 through present 11/12/19. It was documented throughout the nursing notes that the resident was a high fall risk, and often attempted to stand and walk	F 609	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 completed to ensure that any that any allegations of lack of supervision have been investigated and reported to the State Survey Agency appropriately. 3. Administrator or designee will educate all 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 any new allegations of lack of supervision are investigated and reported to the State Survey Agency in a timely manner per policy daily. 5. Any issues will be brought to the QAPI meeting. Date of compliance 12/06/19.	

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without assistance and required much redirection. A nursing note dated 10/25/19 documented that the resident left for an appointment at 11:00 AM and then returned at 1:30 PM. There was no other information in the progress notes regarding the appointment.

Resident #1's Power of Attorney (POA) #1 was interviewed via phone on 11/12/19 at 10:50 AM. POA #1 stated that she and her sister (POA #2) were not made aware of Resident #1's appointment and that Resident #1 was taken to the appointment and dropped off without anyone supervising her and Resident #1 was found in the parking lot wandering around. POA #1 stated that Resident #1 has dementia and shouldn't have been left alone. POA #1 stated that there are five children (including herself), all of whom are involved and would have made arrangements for this appointment, but they were not informed or notified of the appointment. POA #1 stated that she complained to the facility as soon as she found out about Resident #1 being in the parking lot of the physicians' office and that staff told her they would investigate, but as of 10/28/19 she had not received any response or correspondence from the facility DON and/or administrator. POA #1 stated that she is concerned that Resident #1 and other residents with dementia are being dropped off and no one is ensuring their care.

Resident #1's clinical record was reviewed and revealed that Resident #1 had a consult report from the cardiology appointment on 10/25/19, along with documentation that the resident was transported to the appointment via an outsourced transport company.

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On 11/12/19 at 12:45 PM, POA # 2 was interviewed via phone. POA #2 stated that Resident #1 has dementia and should have had someone with her. POA #2 stated that it was just happened that the person who saw Resident #1 in the parking lot wandering around was a longtime acquaintance and knew that something wasn't right and stated if it hadn't been for that, she may not have ever known.

On 11/12/19 at 1:05 PM, the administrator, DON (director of nursing), ADON (assistant director of nursing) and corporate nurse were made aware of the above concerns with the incident regarding Resident #1 not having an escort to the appointment, being left alone at the appointment and as a result, Resident #1 wandered out of the lobby into the parking lot attempting to get into a locked car. The above staff were asked if this had been reported to the State Agency.

The administrator stated that they were aware of the above information and concerns. The DON stated that they found out from Resident #1's daughter/POA and an investigation was started at that time. The ADON stated that Resident #1's appointment was on Friday, October 25th and the daughter (POA #1) called with concerns about this on Sunday, October 27th. The ADON stated that she completed a service concern. The ADON was asked what a service concern is and the ADON stated that it is something they complete if there is a problem or concern that needs to be addressed. The ADON stated that it was being addressed. The facility staff were asked how was it being addressed. No comment was made about what was being done. The ADON then stated that after it happened, Resident #1's daughter stated that Resident #1

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F 609	Continued From page 19 was not to go out to any appointments without the daughters/POAs being notified and approved by them. The ADON was made aware that was after the fact and had nothing really to do with the actual concerns. The DON stated that the incident was not reported to the state agency. The DON was asked why it wasn't reported. The corporate nurse and administrator both stated that the incident was not reported to the State Agency, that it had been discussed but they felt it was not a reportable incident. When asked why it wasn't a reportable incident the administrator stated, "We didn't report it because we couldn't actually prove that it happened." No further information and/or documentation was presented prior to the exit conference on 11/12/19 at 4:00 PM, to evidence that the above incident was reported to the State Agency regarding Resident #1 being left alone at a physician's appointment and during that time the resident wandered outside of the building and into the parking lot, attempting to access locked cars. This is a complaint deficiency.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		12/6/19

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F 610	Continued From page 20 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, clinical record review, facility document review and in the course of a complaint investigation, the facility failed to ensure a complete and thorough investigation was completed for an alleged violation of neglect for Resident #1. Findings include: Resident #1 was admitted to the facility on 08/12/19. Diagnoses for Resident #1 included, but were not limited to: atrial fibrillation, DM (diabetes mellitus), encephalopathy, history of falls, difficulty walking lumbosacral mass, cardiomyopathy, depression and dementia. The most current MDS (minimum data set) was a 14 day admission assessment dated 08/21/19. This MDS assessed the resident as having a cognitive score of 11, indicating the resident had moderate impairment in daily decision making skills. The resident's progress notes were reviewed from admission 08/12/19 through present 11/12/19. It was documented throughout the nursing notes that the resident was a high fall risk, and often attempted to stand and walk without assistance and required much redirection.	F 610	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 completed to ensure that any that any allegations of lack of supervision have been investigated and reported to the State Survey Agency appropriately. 3. Administrator or designee will educate all 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 any new allegations of lack of supervision are investigated and reported to the State Survey Agency in a timely manner per policy daily. 5. Any issues will be brought to the QAPI meeting. date of compliance 12/06/19.	

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A nursing note dated 10/25/19 documented that the resident left for an appointment at 11:00 AM and then returned at 1:30 PM. There was no other information in the progress notes regarding the appointment.

Resident #1's Power of Attorney (POA) #1 was interviewed via phone on 11/12/19 at 10:50 AM. POA #1 stated that she and her sister (POA #2) were not made aware of Resident #1's appointment and that Resident #1 was taken to the appointment and dropped off without anyone supervising her and Resident #1 was found in the parking lot wandering around. POA #1 stated that Resident #1 has dementia and shouldn't have been left alone. POA #1 stated that there are five children (including herself), all of whom are involved and would have made arrangements for this appointment, but they were not informed or notified of the appointment. POA #1 stated that she complained to the facility as soon as she found out about Resident #1 being in the parking lot of the physicians' office and that staff told her they would investigate, but as of 10/28/19 she had not received any response or correspondence from the facility DON and/or administrator. POA #1 stated that she is concerned that Resident #1 and other residents with dementia are being dropped off and no one is ensuring their care.

The resident's clinical record revealed that the resident had a consult report from the cardiology appointment on 10/25/19, along with documentation that the resident was transported to the appointment via an outsourced transport company.

The cardiology consult report from the day in

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question documented, "...date of service: 10/25/19...cardiomyopathy and permanent atrial fibrillation...continue coagulation therapy...ischemic workup deferred due to dementia and functional status...chronic mild residual right sided weakness...positive for abnormal gait...She is quite confused today and I do not really believe she knows why she is here..."

The transport company was called on 11/12/19 at 11:40 AM for an interview. A special service representative from the transport company was interviewed and asked about transport for Resident #1 on 10/25/19. The special service representative stated that the transport appointment was made and set up for Resident #1 by the facility and that it was entered that the resident was to have an escort to the appointment. The special service representative was asked what exactly did that mean and the special service representative stated that it means the resident will have an escort to the appointment, not including the driver. The special service representative was asked if there was any way to verify if the resident actually had an escort and the special service representative stated, "No."

The cardiology physician's office was called on 11/12/19 at 11:50 AM. The office manager was interviewed regarding any information about Resident #1 and her appointment on 10/2/5/19. The office manager stated that she did not have any information regarding Resident #1 being out in the parking lot or being left alone. The office manager stated, "We run into it often that patients are just left and dropped off, not sure if that is what happened in this case, but it does happen

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frequently."

On 11/12/19 at 12:45 PM, POA # 2 was interviewed via phone. POA #2 stated that Resident #1 has dementia and should have had someone with her. POA #2 stated that it was just happened that the person who saw Resident #1 in the parking lot wandering around was a longtime acquaintance and knew that something wasn't right and stated if it hadn't been for that, she may not have ever known.

On 11/12/19 at 1:05 PM, the administrator, DON (director of nursing), ADON (assistant director of nursing) and corporate nurse were made aware of the above concerns with the incident regarding Resident #1 not having an escort to the appointment, being left alone at the appointment and as a result, Resident #1 wandered out of the lobby into the parking lot attempting to get into a locked car. The above staff were asked if an investigation had been completed.

The administrator stated that they were aware of the above information and concerns. The DON, ADON, administrator and corporate nurse (facility staff) were then asked when the resident's daughter/POA informed them of this incident and when the daughter/POA gave them witness information if they followed up with that information. The DON stated that the daughter/POA gave them the name of the witness and she called the doctor's office and asked if the witness had an appointment that day. The DON was asked who that was. The DON stated a name of the witness (similar, but not exact). The DON stated she did not write the information down about the witness from the daughter/POA and stated that she did not attempt to contact the

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witness. The DON stated that an investigation was done. The DON presented the investigation. The investigation did not have any information regarding the witness or Resident #1 being taken to an appointment and being left alone, or that the resident was found in the parking lot wandering around alone.

The ADON stated that the resident's appointment was on Friday, October 25th and the daughter (POA #1) called with concerns about this on Sunday, October 27th. The ADON stated that she completed a service concern. The ADON was asked what a service concern is and the ADON stated that it is something they complete if there is a problem or concern that needs to be addressed. The ADON stated that it was being addressed. The facility staff were asked how was it being addressed. The ADON stated that after happened, the resident's daughter stated that the resident was not to go out to any appointments without being notified and approved by the POA. The DON stated that she called the transport company and that it was reported that the driver dropped the resident off in the lobby and then picked her back up after the appointment inside the building. The administrator stated, "We didn't report it because we couldn't actually prove that it happened." The administrator and staff present were then asked, how could they determine if it actually happened if a thorough investigation wasn't completed. The facility staff did not comment. The corporate nurse then stated, "It is a courtesy we offer to our patients, but we aren't mandated to do it." The facility staff were made aware that the transport company was called and that transport was set up for Resident #1 by the facility to have an escort to the appointment. The DON stated that the scheduler makes the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. BUILDING _____ B. WING _____	C 11/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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appointments.

On 11/12/19 at 1:45 PM, the scheduler was interviewed. The scheduler stated that she will call and get it all set up. The scheduler was asked about having an escort. The scheduler stated that she will usually request hand to hand, meaning that the driver takes a resident in to the appointment and then brings them back. The scheduler stated that orthopedic patients always have an escort, but stated she wasn't sure if she put that in for Resident #1 and also stated that she did not have evidence of what type of transport she requested for Resident #1.

On 11/13/19 at 9:30 AM, the witness was interviewed. The witness stated she observed Resident #1 at the doctor's office and exiting the doctor's office out to the parking lot. The witness stated that she told the office staff about Resident #1 being in the parking lot, and office staff returned Resident #1 into the building. The witness stated that no one asked her any questions or anything while there. The witness stated that on the way home from her appointment she and her daughters were shocked and upset about the situation and were trying to figure out how to get in touch with Resident #1's family regarding the matter. The witness stated that finally they were able to contact the resident's daughters/POAs.

No further information and/or documentation was presented prior to the exit conference on 11/12/19 at 4:00 PM, to evidence that a complete, accurate and thorough investigation was completed regarding Resident #1 being found in the parking lot of the physician's office wandering around without assistance on 10/25/19.

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F 610	Continued From page 26 This is a complaint deficiency.	F 610		