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 12/20/2022

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

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 12/19/2022 through 12/20/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey. Complaint VA00057149 with two allegations was substantiated without deficient practice identified. Complaint VA00055927 with one allegation was unsubstantiated without .deficient practice identified. Complaint VA00056481 with one allegation was substantiated with deficient practice identified.. The census in this 180 certified bed facility was 167 at the time of the survey. The survey sample consisted of seven (7) closed record reviews and two (2) current resident reviews.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and complaint investigation, the facility staff failed to follow professional standards of practice for two of nine residents in the survey sample, Residents #3 and #4. These were closed record reviews. The findings include:	F 658	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be	1/13/23

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

Electronically Signed | 01/10/2023

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F 658	Continued From page 1 The nurse assigned to Resident #3 and #4 was unable to locate the DNR (Do Not Resuscitate) status during a medical emergency. 1. Diagnoses for Resident #3 included; Cerebral Palsy, Malnutrition, sepsis, intellectual disabilities, seizures and depression. The most current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 8/23/2022. Resident #3 was assessed as having short and long-term memory problems and severely cognitively impaired. Review of the resident #3's clinical record on 12/19/22 documented a physician's order dated 8/19/22 that read "Code status DNR." A nursing note dated 9/12/22 2:00 AM indicated that a CNA (certified nursing assistant) found Resident #3 on the floor beside his bed and alerted the assigned nurse to assess Resident #3. The nurse (license practical nurse, LPN #2, person writing the nursing note) assessed Resident #3 and was unable to obtain vital signs and documented that Resident #3 had rapid breathing. A call was placed to the nurse practitioner, giving an order to call 911 and send to the emergency department. Another nursing note dated 9/12/22/ at 3:10 AM Documented "EMT [emergency medical technician] arrived at facility observed resident with no response when touched [...] CPR begun by EMT's and was stated 'had a pulse' and EMT's transferred to [name of hospital]." On 12/19/22 at 2:50 PM the complainant (EMT on	F 658	corrected by the date or dates indicated. F 658 1. Resident # 3 and 4 are no longer in the facility. 2. Current residents in the center were assessed for Code status orders (including DNR orders) to ensure there are appropriate orders in the clinical record. 3. Current nursing staff will be educated by the Staff Development Coordinator/designee on Code status (including DNR) process. The education will include where to find Code status (including DNR) orders in the clinical record. 4. The DON/designee will review new admissions/readmissions in daily clinical meeting 5x/weekly to ensure code status orders are in the clinical record. In addition, the DON/designee will interview 5 nurses weekly to ensure they know where the Code status is located in the clinical record. 5. The results of the review/interviews will be discussed in the Monthly QA meeting for review. Once the QA Committee determines the problem no longer exist the reviews/interviews will be conducted on a random basis. 6. 1/13/23	

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F 658	Continued From page 2	F 658		

scene) was interviewed. The complainant verbalized upon arrival to the facility Resident #3 was sitting in a wheelchair and was unresponsive. Complainant stated that Resident was pulled to the floor and CPR was started, adding that during this time a nurse came by and said to stop CPR as Resident #3 was a DNR. The complainant asked the nurse to present documentation regarding a DNR status for Resident #3, but the nurse was unable to present a DNR order. The complainant then said that the nurse opened up Resident #3's chart and typed DNR on Resident #3's face sheet. The complaint responded to the nurse that that was not legal and needed a physician's order. During this time Resident #3 was revived and sent to the hospital.

On 12/19/22 at 3:25 PM LPN #2 was interviewed regarding the concern involving Resident #3's DNR status. LPN #2 verbalized that she could not remember the incident that well, but did say that she was unable to find Resident #3's DNR status and thought it was on the profile sheet. When asked since the incident does she know where a nurse would be able to find the DNR status, LPN #2 verbalized that she thought it was in a book, but didn't know for sure, adding that the book is locked up in the office.

On 12/19/22 starting at 4:05 PM interviews were conducted with three LPN's working on different units. All three LPN's interviewed were able to explain where to find the DNR status of residents in the facility and demonstrated the DNR status on the computer for randomly picked resident's.

On 12/20/22 at 9:15 AM the above information was presented to the director of nursing (DON) and nurse consultant. The DON verbalized that

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F 658	Continued From page 3	F 658		

after taking the position she realized a few things were not being done the way they should be done based on the previous DON, but things have been put into place and education has been a priority.

The DON and nurse consultant were asked if there were any procedures that the nurses should be doing to check for DNR status prior to beginning CPR. The nurse consultant verbalized that it is hard for her to believe that LPN #2 did not know where to look in the chart to retrieve a DNR status and went on to say it is a nursing standard of practice and something that is taught to all nurses that a DNR has to have an physician's order, adding that LPN #2 should have reviewed the orders.

This a complaint deficiency.

No other information was presented prior to exit conference on 12/20/22.

2. The findings include:

Diagnoses for Resident #4 included; Dementia, dysphagia, epilepsy, and chronic kidney disease. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 9/2/2022. Resident #4 was assessed as having short and long-term memory problems and severely cognitively impaired.

Review of the resident #4's clinical record on 12/19/22 documented a physician's order dated 8/30/22 that read "Code status DNR."

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A nursing note dated 9/12/22 5:30 AM documented: "Observed resident laying in bed unresponsive. Vitals unable to obtain. CPR started and 911 was telephone to facility until second gave order that resident was a DNR (SIC), CPR stopped per writer and two nurses. 0545 eMT's arrived cpr started and called the resident deceased... (SIC)"

On 12/19/22 at 2:50 PM the complainant (EMT on scene) was interviewed regarding Resident #4. The complainant verbalized that a call came in reporting a resident was in cardiac arrest and CPR was being performed by nursing staff. Upon arrival to the facility, the resident was found on the floor with no one attending to the resident and was informed that resident #4 was a DNR, but they [the facility] didn't have the paperwork to confirm a DNR status. So CPR was started by EMS medic, until code status was confirmed. The complainant verbalized that another medic was able to reach out to a physician that gave direction to stop CPR, based on wife request for Resident #4 to be a DNR.

On 12/19/22 at 3:25 PM, LPN #2 (nurse that was assigned to Resident #4 at the time of the incident) was interviewed regarding the concern involving Resident #4's DNR status. LPN #2 verbalized that she could not remember the incident that well, but did say that she was unable to find Resident #4's DNR status and thought it was on the profile sheet. When asked since the incident, does she know where a nurse would be able to find the DNR status, LPN #2 verbalized that she thought it was in a book, but didn't know for sure, adding that the book is locked up in the office.

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