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 04/09/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 4/8/25 through 4/9/25. Four complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Complaint VA00063060 was unsubstantiated. Complaint VA00063388 was unsubstantiated. Complaint VA00063720 was unsubstantiated. Complaint VA00063754 was substantiated with deficiencies cited. The census in this 180 certified bed facility was 159 at the time of the survey. The survey sample consisted of two current resident reviews and two closed record reviews.	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	F 580		5/15/25

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

Electronically Signed | 04/30/2025

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F 580	Continued From page 1 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 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, facility document review and clinical record review, the facility staff failed to notify the responsible party of a change in condition for one of four residents in the survey sample (Resident #3).	F 580	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	

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F 580	Continued From page 2 The findings include: The facility provided no notification to Resident #3's responsible party regarding a change in condition and subsequent transfer to the hospital. Resident #3 (R3) was admitted to the facility following hospitalization with diagnoses that included end-stage liver disease, alcoholic cirrhosis of liver with ascites, pyothorax, sepsis with septic shock, bacteremia, MRSA (methicillin resistant staphylococcus aureus), hepatic encephalopathy, influenza, anemia, acute kidney failure, chronic peripheral venous insufficiency, alcohol-induced dementia, hypotension, history of pneumothorax, diabetes, and mood disorder. The minimum data set (MDS) dated 2/18/25 assessed R3 as cognitively intact. R3's clinical record documented the resident was transported to the hospital on 2/25/25 due to a change in condition. The clinical record documented no notification to the resident's emergency contact/responsible party regarding the change in condition and transport. On 4/8/25 at 3:15 p.m., the director of nursing (DON) was interviewed about notification to R3's responsible party (RP) regarding the resident's change in condition and transfer to the hospital on 2/25/25. The DON stated nursing assessed R3 with low blood pressure and altered mental status around 6:00 a.m. on 2/25/25. The DON stated R3 was sent to the hospital due to change of condition. The DON stated there was no notification to R3's responsible party regarding the resident's change and transfer. The DON stated she talked with the resident's RP later in the day on 2/25/25 and the RP reported that	F 580	allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F 580 1. Resident # 3 is no longer in the facility. 2. Current residents that have been discharged have been audited for change in condition and to assure that Responsible Parties were notified of changes. 3. Nursing staff have been educated by the Staff Development Coordinator on notification of emergency contact for change of condition by 5/9/2025. 4. Residents that are identified as having a change in status will be discussed at least 5 times per week in the clinical meeting and reviewed for documentation that emergency contact has been notified. Any identified noncompliance will be reported to the QAPI committee for tracking and trending and progressive disciplinary action as needed. 5. Date of compliance: 5/15/2025.	

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F 580	Continued From page 3	F 580		

nobody had called informing her of the change/transfer. The DON stated nurses were expected to notify the listed emergency contact regarding changes in condition and the notification should have been documented in the clinical record.

On 4/8/25 at 8:30 a.m., the registered nurse (RN #3) who was unit manager during R3's stay was interviewed. RN #3 stated the resident was sent to the hospital around 6:00 a.m. on 2/25/25. RN #3 stated when she arrived at work, she noted that R3 had been sent to the emergency room. RN #3 stated she was not aware notification had not been made to the RP.

On 4/9/25 at 11:00 a.m., RN #1 that cared for R3 on 2/25/25 at the time of transfer was interviewed. RN #1 stated around 5:50 a.m., R3 was assessed with a low blood pressure and oxygen saturations varying from 83% to 90%. RN #1 stated he attempted to call the on-call provider with no answer and then called the on-call nurse manager who instructed him to send the resident to the emergency room. RN #1 stated emergency services were called, and the resident was transported to the emergency room prior to 6:30 a.m. RN #3 stated he did not call or notify the resident's listed RP of the change in condition/transfer. RN #3 stated he communicated R3's transfer during shift change and thought the day shift nurses would make notification to the RP.

The facility's policy titled Significant Change of Condition (effective 1/29/24) documented, "...A licensed nurse will assess the patient for signs and symptoms of change of condition...Responsible party will be notified of a

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F 580	Continued From page 4 change in condition..." This finding was reviewed with the administrator, assistant administrator and regional nurse consultant during a meeting on 4/9/25 at 2:50 p.m. with no further information presented prior to the end of the survey.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		5/15/25

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F 584	Continued From page 5 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure a clean, homelike room environment for one of four residents in the survey sample (Resident #3). The findings include: Resident #3 (R3) was admitted to the facility following hospitalization with diagnoses that included end-stage liver disease, alcoholic cirrhosis of liver with ascites, pyothorax, sepsis with septic shock, bacteremia, MRSA (methicillin resistant staphylococcus aureus), hepatic encephalopathy, influenza, anemia, acute kidney failure, chronic peripheral venous insufficiency, alcohol-induced dementia, hypotension, history of pneumothorax, diabetes, and mood disorder. The minimum data set (MDS) dated 2/18/25 assessed R3 as cognitively intact. On 4/8/25 at 3:15 p.m., the director of nursing (DON) was interviewed about R3's room cleanliness. The DON stated R3's family member reported on 2/13/25 that the bed had not been made, and the room was not clean. The DON stated she went to R3's room and had the	F 584	F584 1. Resident # 3 is no longer in the facility. 2. The room was cleaned as soon as the complaint was brought to the attention of the staff. The Housekeeping staff member that did not clean the room was counseled and terminated. 3. Housekeeping staff were educated on cleaning a resident room for new admissions by the Housekeeping director by 5/9/2025. 4. Admission Director and Housekeeping Director will review rooms for new admissions and complete the room audit list at least 5 times per week. Any identified noncompliance will be reported to the QAPI committee for tracking and trending and progressive disciplinary action as needed. 5. Date of compliance: 5/15/2025.	

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F 584	Continued From page 6	F 584		

bed made/cleaned.

On 4/8/25 at 4:15 p.m., the housekeeping supervisor (other staff #4) was interviewed about any issues/concerns with the cleanliness of R3's room during February 2025. The housekeeping supervisor stated on 2/13/25, R3's family member reported the resident's room was not clean with trash in the floor, bed not made and sticky floors. The housekeeping supervisor stated he and two housekeepers went to R3's room. The housekeeping supervisor he observed the bed not made, trash in the floor and the floor was "sticky." The housekeeping supervisor stated the housekeeper assigned to this room had reported she cleaned the room but had not. The housekeeping supervisor stated R3's room cleanliness "was not up to standards." The housekeeping supervisor stated that nursing aides were responsible for making beds and providing clean linens. The housekeeping supervisor stated all resident rooms were supposed to the cleaned daily and that cleaning including mopping, emptying trash and cleaning the bathroom. The housekeeping supervisor stated rooms were cleaned as needed if there was an incident. The housekeeping supervisor again stated R3's room on 2/13/25 was "not up to standards."

The facility's policy titled Method of Cleaning (undated) documented, "...general cleaning practices, routine, and systems need to be in place and followed...Restrooms - address the same as a room, paying careful attention to the sink and commode...Check privacy curtain, linens and the overall condition of the room... Remove all debris from floors, counters, and edges...Remove all trash and replace liners as

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F 584	Continued From page 7 needed...mop floors using disinfecting neutral floor cleaner or quaternary disinfectant cleaner..." This finding was reviewed with the administrator, assistant administrator and regional nurse consultant during a meeting on 4/9/25 at 2:50 p.m. with no further information presented prior to the end of the survey.	F 584		
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, facility document review and clinical record review, the facility staff failed to follow professional standards of quality for one of four residents in the survey sample (Resident #3). The findings include: Assessments and interventions implemented regarding a change in condition for Resident #3 were not recorded/documented. Resident #3 (R3) was admitted to the facility following hospitalization with diagnoses that included end-stage liver disease, alcoholic cirrhosis of liver with ascites, pyothorax, sepsis with septic shock, bacteremia, MRSA (methicillin resistant staphylococcus aureus), hepatic encephalopathy, influenza, anemia, acute kidney failure, chronic peripheral venous insufficiency,	F 658	F 658 1. Resident # 3 is no longer in the facility. 2. Current residents that have been transferred out for change in condition since time of survey were audited to assure vital signs, change is in status notes and physician and responsible parties were notified and documented. 3. Nursing staff were educated on Assessment of residents for change of condition and obtaining orders and notification by the SDC by 5/9/2025. Residents that are identified as having a change in status will be discussed at least 5 times per week in the clinical meeting and reviewed for documentation that emergency contact has been notified, assessments complete and orders obtained. 4. Any identified noncompliance will be	5/15/25

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F 658	Continued From page 8 alcohol-induced dementia, hypotension, history of pneumothorax, diabetes, and mood disorder. The minimum data set (MDS) dated 2/18/25 assessed R3 as cognitively intact. R3's clinical record documented the resident was transferred to the hospital on 2/25/25 due to a change in condition. R3's clinical record included no documentation regarding the 2/25/25 change in condition or any assessments, interventions, communications leading to the transfer to the emergency department. A nursing note dated 2/25/25 at 8:57 a.m. documented the resident was sent to the emergency department on the prior shift. On 4/8/25 at 3:15 p.m., the director of nursing (DON) was interviewed about any documentation of R3's change in condition/transfer that occurred on 2/25/25. The DON stated R3 experienced altered mental status and was transferred to the emergency department on 2/25/25 "around 6:00 a.m." The DON stated the nurse caring for R3 at the time of the transfer did not document assessments of the resident, interventions or communications regarding the change in condition and transfer. The DON stated it was an expectation that nurses document in the clinical notes regarding any changes in condition, any assessments conducted and significant events such as hospital transfer. On 4/9/25 at 11:00 a.m., registered nurse (RN) #1 that cared for R3 during the early morning shift on 2/25/25 was interviewed. RN #1 stated he assessed R3 on 2/25/25 around 12:30 a.m. with oxygen saturation at 93% and he applied the resident's oxygen. RN #1 stated he asked R3 about pain and the resident stated he had no	F 658	reported to the QAPI committee for tracking and trending and progressive disciplinary action as needed. 5. Date of compliance: 5/15/2025	

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F 658	Continued From page 9	F 658		

pain. RN #1 stated the other vital signs were "nothing unusual" but he did not remember the vital sign readings other than the oxygen saturation. RN #1 stated he checked on R3 multiple times during the shift. RN #1 stated another set of vitals signs were obtained mid-shift and they were "ok" with improved oxygen saturation. RN #1 stated he did not remember the vital sign readings and he did not record them in the clinical record. RN #1 stated around 5:50 a.m., R3's blood pressure was assessed as low at 100/50, and oxygen saturations were varying between 83% to 90%. RN #1 stated he attempted to call the nurse practitioner but got no answer so informed the on-call nurse manager. RN #1 stated the nurse manager instructed him to send R3 to the emergency room due to the change in condition. RN #1 stated he did not document the vital signs taken during the shift, did not document the attempted communication to the provider or the call to the nurse manager. RN #1 stated he did not document any nursing notes about R3's change in condition or transfer. RN #1 stated after EMS transferred R3 to the hospital, he administered medications before the end of his shift at 7:00 a.m. RN #1 stated he communicated R3's change/transfer to the day shift at shift change. RN #1 stated he left at the end of his shift and stated, "I just didn't document it." When asked if he considered a late entry of the events, RN #1 stated he was an "agency" nurse and had not worked at the facility since 2/25/25.

On 4/9/25 at 1:40 p.m., the regional nurse consultant (administration staff #4) was interviewed about lack of documentation regarding R3's change of condition/transfer. The regional nurse consultant stated nurses were

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F 658	Continued From page 10 supposed to document any assessments and changes in condition in the clinical record at the time of the events. The regional nurse consultant stated standards of practice included timely documentation of changes and events. The facility's policy titled Significant Change of Condition (effective 1/29/24) documented, "...A licensed nurse will assess the patient for signs and symptoms of change of condition...Notify provider and document in Progress Notes..." The Lippincott Manual of Nursing Practice 11th edition on page 15 documents regarding common departures from standards of nursing care, "...A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events..." (1) This finding was reviewed with the administrator, assistant administrator and regional nurse consultant during a meeting on 4/9/25 at 2:50 p.m. with no further information presented prior to the end of the survey. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2019.	F 658		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842		5/15/25

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resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 12 record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide a complete and accurate clinical record for one of four residents in the survey sample (Resident #3). The findings include: Resident #3's clinical record did not include documentation regarding assessments and interventions implemented related to a change in condition with subsequent transfer to the hospital. Resident #3 (R3) was admitted to the facility	F 842	F 842 1. Resident # 3 is no longer in the facility. 2. Current residents that have been assessed for change in condition since survey were audited to assure vital signs, change is in status notes and physician and responsible parties were notified and documented. 3. Nursing staff were educated on Assessment of residents for change of condition and documentation of findings and obtaining orders and notification of MD and Responsible Party by the SDC by 5/9/2025.	

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 04/09/2025

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F 842	Continued From page 13 following hospitalization with diagnoses that included end-stage liver disease, alcoholic cirrhosis of liver with ascites, pyothorax, sepsis with septic shock, bacteremia, MRSA (methicillin resistant staphylococcus aureus), hepatic encephalopathy, influenza, anemia, acute kidney failure, chronic peripheral venous insufficiency, alcohol-induced dementia, hypotension, history of pneumothorax, diabetes, and mood disorder. The minimum data set (MDS) dated 2/18/25 assessed R3 as cognitively intact. R3's clinical record documented the resident was transferred to the hospital on 2/25/25 due to a change in condition. R3's clinical record included no documentation regarding the 2/25/25 change in condition or any assessments, interventions, communications leading to the transfer to the emergency department. A nursing note dated 2/25/25 at 8:57 a.m. documented the resident was sent to the emergency department on the prior shift. On 4/8/25 at 3:15 p.m., the director of nursing (DON) was interviewed about any documentation of R3's change in condition/transfer. The DON stated R3 experienced altered mental status and was transferred to the emergency department on 2/25/25 "around 6:00 a.m." The DON stated the nurse caring for R3 at the time of the transfer did not document assessments of the resident, interventions and/or communications regarding the change in condition and transfer. The DON stated nurses should document in the clinical notes regarding any changes in condition, any assessments conducted and significant events such as hospital transfer. On 4/9/25 at 11:00 a.m., registered nurse (RN) #1	F 842	4. Any residents that have been sent to ED for treatment or evaluation will be audited by the nursing administration team in the daily clinical meeting at least 5 times per week to assure accurate documentation is in place. Any identified noncompliance will be reported to the QAPI committee for tracking and trending and progressive disciplinary action as needed. 5. Date of compliance: 5/15/2025	

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F 842	Continued From page 14	F 842		

that cared for R3 during the early morning shift on 2/25/25 was interviewed. RN #1 stated he assessed R3 on 2/25/25 around 12:30 a.m. and his oxygen saturation was at 93% and he reapplied the resident's oxygen. RN #1 stated he asked R3 about pain and the resident stated he had no pain. RN #1 stated the other vital signs were "nothing unusual" but he did not remember the vital sign readings other than the oxygen saturation. RN #1 stated he checked on R3 multiple times during the shift. RN #1 stated around 5:50 a.m., R3's blood pressure was low at 100/50, and oxygen saturations were varying between 83% to 90%. RN #1 stated he attempted to call the nurse practitioner but got no answer so informed the on-call nurse manager. RN #1 stated the nurse manager instructed him to send R3 to the emergency room due to the change in condition. RN #1 stated he did not document the vital signs taken during the shift, did not document the attempted communication to the provider or the call to the nurse manager. RN #1 stated he did not document any nursing notes about R3's change in condition or transfer. RN #1 stated after EMS transferred R3 to the hospital, he administered medications before the end of his shift at 7:00 a.m. RN #1 stated he communicated R3's change/transfer to the day shift at shift change. RN #1 stated, "I just didn't document it." When asked if he considered a late entry of the events, RN #1 stated he was an "agency" nurse and had not worked at the facility since 2/25/25.

On 4/9/25 at 1:40 p.m., the regional nurse consultant (administration staff #4) was interviewed about lack of documentation regarding R3's change of condition/transfer. The regional nurse consultant stated nurses were

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F 842	Continued From page 15 supposed to document any assessments and changes in condition in the clinical record. The facility's policy titled Significant Change of Condition (effective 1/29/24) documented, "...A licensed nurse will assess the patient for signs and symptoms of change of condition...Notify provider and document in Progress Notes..." This finding was reviewed with the administrator, assistant administration and regional nurse consultant during a meeting on 4/9/25 at 2:50 p.m. with no further information presented prior to the end of the survey.	F 842		