STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445279	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynchburg Nursing Center	40 Nursing Home Road Lynchburg, TN 37352

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations and interviews, the facility failed to ensure medical information was not visible for 1 resident (Resident #47) of 60 residents observed.The findings include:Review of the facility's policy titled, Dignity, reviewed on 9/26/2025, revealed .The resident has a right to be treated with respect and dignity .including .Staff should not .document .where others can see a resident's information . Review of the medical record revealed Resident #47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Acute and Chronic Respiratory Failure, Depression, Anxiety, and Dementia.Review of the comprehensive care plan dated 6/18/2025, revealed .Congestive Heart Failure .O2 [oxygen] via nasal cannula @ [at] 2L/M [2 liters per minute] continuously, as tolerated .Review of the comprehensive care plan revised on 6/30/2025, revealed .impaired cognition r/t [related to] dementia .Review of a physician's order dated 8/27/2025, revealed .Oxygen at 2 liters/minute continuously per nasal cannula .Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #47 scored a 7 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Resident #47 received oxygen therapy at the facility. During an observation and interview on 12/1/2025 at 9:48 AM, in Resident #47's room, the resident was seated in a wheelchair beside the bed. There were 2 signs posted above Resident #47's bed. The first sign read, .Please Do Not wrap [Resident #47's] bed control around the bottom of the bed frame . The second sign read .While You're Here, Please check my concentrator/O2 tank . Resident #47 stated, .I don't know why they [the signs] are there .I have wondered .I don't know who would put them there . Both signs were visible to anyone that entered the room. During an observation on 12/1/2025 at 1:29 PM, in Resident #47's room, the resident was seated in a wheelchair beside the bed. There were 2 signs posted above Resident #47's bed. The first sign read, .Please Do Not wrap [Resident #47's] bed control around the bottom of the bed frame . The second sign read .While You're Here, Please check my concentrator/O2 tank . Both signs were visible to anyone that entered the room.Attempted telephone interview on 12/01/2025 at 1:14 PM with Resident #47's responsible party. During an observation on 12/2/2025 at 8:43 AM, in Resident #47's room, the resident was seated in a wheelchair beside the bed. There were 2 signs posted above Resident #47's bed. The first sign read, .Please Do Not wrap [Resident #47's] bed control around the bottom of the bed frame . The second sign read .While You're Here, Please check my concentrator/O2 tank . Both signs were visible to anyone that entered the room.Attempted telephone interview on 12/3/2025 at 10:31 AM with Resident #47's responsible party. Review of Resident #47's medical record revealed no documentation that Resident #47 or Resident #47's representative had requested that signage be posted in the resident's room.During an observation and interview on 12/3/2025 at 10:36 AM, with the Director of Nursing (DON), in Resident #47's room, there were 2 signs posted above Resident #47's bed. The first sign read, .Please Do Not wrap [Resident #47's] bed control around the bottom of the bed frame . The second sign read .While You're Here, Please check my concentrator/O2 tank . The DON confirmed the signage above the resident's bed was visible to anyone that entered the room. The DON was unaware who or why the signage was (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	posted. The DON confirmed the care plan was used to communicate specific resident care needs to staff and signage was not to be posted in resident's rooms and visible to others unless requested by the resident or family. If signs were requested by the resident or their family, it was to be documented in the resident's medical record. During an interview on 12/3/2025 at 2:59 PM, the DON confirmed there was no documentation in Resident #47's medical record to indicate that family requested the signage be posted.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, observations and interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments related to medications for 2 residents (Residents #47 and #44) and related to hearing impairment for 1 resident (Resident #5) of 15 residents reviewed.The findings include: Review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2025, revealed .High-Risk Drug Classes: Use and Indication .Review the resident's medical record for documentation that any of these medications were received by the resident and for the indication of their use during the 7-day look-back period .Anticoagulant .Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period .Antiplatelet: Check if any antiplatelet medication (e.g. [example] .clopidogrel .) was taken by the resident at any time during the 7-day observation period .Do not code antiplatelet medications such as as .clopidogrel as .Anticoagulant .Antipsychotic Medication Review .Review the resident's medication administration records to determine if the resident received an antipsychotic medication since admission/entry .If the resident received an antipsychotic medication, review the medical record to determine if a gradual dose reduction [GDR] has been attempted .If a gradual dose reduction was not attempted, review the medical record to determine if there is physician documentation that the GDR is clinically contraindicated .Enter the date of the last attempted Gradual Dose Reduction .Do not include gradual dose reductions that occurred prior to admission to the facility . Further review revealed, hearing .code .minimal difficulty .has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations .moderate difficulty .Speaker has to increase volume and speak distinctly .Although hearing-deficient, the resident compensates when the speaker adjusts tonal quality and speaks distinctly; or the resident can hear only when the speaker's face is clearly visible . Review of the medical record revealed Resident #47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Acute and Chronic Respiratory Failure, Atherosclerotic Heart Disease (heart disease caused by plaque buildup in arterial walls), Aortic Valve Stenosis (a condition restricting blood flow from the heart to the body), Hypertensive Heart and Chronic Kidney Disease with Heart Failure, and Paroxysmal Atrial Fibrillation. Review of Resident #47's comprehensive care plan revised on 6/25/2025, revealed .The resident is on antiplatelet therapy . Review of a physician's order for Resident #47 dated 8/27/2025, revealed .Clopidogrel Bisulfate [antiplatelet medication used to decrease risk of heart disease and stroke] Oral Tablet 75 MG [milligrams] .by mouth one time a day for anticoagulant . Review of Resident #47's Medication Administration Record (MAR) dated 9/1/2025 – 9/30/2025, revealed the resident received .Clopidogrel Bisulfate Oral Tablet 75 MG .for anticoagulant . daily. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #47 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. It was noted Resident #47 received anticoagulant medication during the 7-day look back period. Continued review revealed Resident #47 did not receive antiplatelet (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication during the 7-day look back period. Review of Resident #47's MAR dated 11/1/2025 – 11/30/2025, revealed the resident received .Clopidogrel Bisulfate Oral Tablet 75 MG .for anticoagulant . daily. Review of the quarterly MDS assessment dated [DATE], revealed Resident #47 scored a 7 on the BIMS assessment which indicated the resident had severe cognitive impairment. It was noted Resident #47 received anticoagulant medication during the 7-day look back period. Continued review revealed Resident #47 did not receive antiplatelet medication during the 7-day look back period. During an interview on 12/2/2025 at 4:30 PM, the MDS Coordinator stated Resident #47's quarterly MDS assessment dated [DATE] states the resident received anticoagulant medications during the 7-day look back period. The MDS Coordinator confirmed Resident #47 was receiving Clopidogrel which is an antiplatelet medication, not an anticoagulant medication. The MDS Coordinator confirmed the quarterly MDS assessment was not coded accurately and should have been coded as receiving antiplatelet and not anticoagulant medications. The MDS Coordinator confirmed Resident #47's quarterly MDS assessment dated [DATE] was also coded inaccurately related to anticoagulant and antiplatelet medications. The MDS Coordinator confirmed Resident #47 did not receive any anticoagulant medications during the look back period for the quarterly assessments dated 9/24/2025 and 11/13/2025. The MDS Coordinator stated the RAI manual was used as a guide for MDS assessments. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including Fracture of Lower End of Left Femur, Dementia, Major Depressive Disorder, and Alzheimer's Disease. Review of a physician's order for Resident #44 dated 5/21/2025, revealed an order for Rexulti [an antipsychotic used to treat agitation that may happen with dementia] 2 mg by mouth daily for Dementia. Review of Resident #44's comprehensive care plan dated 5/21/2025, revealed .resident uses antipsychotic medications .dementia with agitation . Review of Resident #44's comprehensive care plan revised on 6/2/2025, revealed .impaired cognition with intermittent delirium r/t [related to] dementia, Alzheimer's disease .Administer medications as ordered . Review of the quarterly MDS assessment dated [DATE], revealed Resident #44 scored a 3 on the BIMS assessment which indicated the resident had severe cognitive impairment. Resident #44 received antipsychotic medications during the 7-day look back period. Continued review revealed .Antipsychotics were received on a routine basis only .GDR has been documented as clinically contraindicated .Date physician documented GDR as clinically contraindicated .05-05-2025 [5-5-2025 - 15 days prior to Resident #44's admission to the facility] . During an interview on 12/3/2025 at 2:25 PM, the Licensed Practical Nurse (LPN) MDS nurse stated Resident #44 was admitted to the facility on [DATE]. Resident #44 had an order dated for 5/21/2025 for Rexulti (antipsychotic medication) daily. The LPN MDS nurse stated Resident #44's quarterly MDS assessment dated [DATE] revealed the resident received antipsychotic medications on a routine basis and the physician documented that a GDR was clinically contraindicated dated 5/5/2025. The (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN MDS nurse confirmed the MDS assessment was coded in error because the GDR date listed was prior to Resident #44's admission to the facility on 5/20/2025. The LPN MDS nurse stated the RAI manual was used to code MDS assessments. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Heart Failure, Diabetes, and Peripheral Vascular Disease. Review of an Audiology visit dated 12/9/2024, revealed Resident #5 was referred by the facility for decreased hearing. A hearing test was performed, which revealed moderate to severe hearing loss in the right ear, moderate to profound hearing loss in the left ear, word recognition was good in the right ear and poor in the left ear. Further review revealed hearing aids were recommended. Review of the medical record for Resident #5 revealed a diagnosis of Bilateral Hearing Loss was added on 2/12/2025. Review of a quarterly MDS assessment dated [DATE], revealed Resident #5 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact and had adequate hearing. Review of the comprehensive care plan for Resident #5 dated 10/23/2025, revealed interventions including .allow extra time for resident to respond .communicate with resident/family/caregivers regarding resident's capabilities and needs .face the resident .make eye contact .reduce distractions .simple direct sentences .provide necessary cues . During an observation and interview on 12/02/2025 at 9:58 AM, Resident #5 stated, .I can't hear, you'll have to get closer .I have trouble hearing the church singing . The resident complained of hearing difficulty, stated she had an ear test about a year ago, and was told she needed hearing aids. During interview, the resident had difficulty hearing the speaker despite being close to the resident and using an elevated tone of voice. The resident missed and/or misinterpreted words during the conversation. During an observation on 12/2/2025 at 3:30 PM, Resident #5 was observed in the Resident Council Meeting having difficulty hearing the conversation. The resident required frequent repeating and rewording for her to comprehend what was said. During an interview on 12/3/2025 at 4:50 PM, the MDS Coordinator confirmed Resident #5's MDS dated [DATE] was coded incorrectly as adequate hearing and should have been coded for hearing loss.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations and interviews, the facility failed to provide assistance or utilize available resources related to hearing loss for 1 resident (Resident #5) of 15 residents reviewed.The findings include:Review of the facility policy titled, Hearing Impaired Resident Care, dated 9/18/2025, revealed .the facility will provide Hearing Impaired Resident Care in accordance with professional standards of practice .the right .to receive services in the facility with reasonable accommodation of resident needs . Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Heart Failure, Diabetes, and Peripheral Vascular Disease. Review of an Audiology visit dated 12/9/2024, revealed Resident #5 was referred by the facility for decreased hearing. A hearing test was performed, which revealed moderate to severe hearing loss in the right ear, moderate to profound hearing loss in the left ear, word recognition was good in the right ear and poor in the left ear. Further review revealed hearing aids were recommended. Review of the medical record for Resident #5 revealed a diagnosis of Bilateral Hearing Loss was added on 2/12/2025. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #5 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed the MDS reflected Resident #5 had adequate hearing (which was an inaccurate assessment). Review of the comprehensive care plan for Resident #5 dated 10/23/2025, revealed interventions including .allow extra time for resident to respond .communicate with resident/family/caregivers regarding resident's capabilities and needs .face the resident .make eye contact .reduce distractions .simple direct sentences .provide necessary cues . During an interview and observation on 12/02/2025 at 9:58 AM, Resident #5 stated, .I can't hear, you'll have to get closer .I have trouble hearing the church singing . The resident complained of hearing difficulty, stated she had an ear test about a year ago, was told she needed hearing aids, but hadn't heard anything further about it. During interview, the resident had difficulty hearing the speaker despite being close to the resident and using an elevated tone of voice. The resident missed and/or misinterpreted words during the conversation. During an observation and interview on 12/2/2025 at 3:30 PM, Resident #5 was observed in the Resident Council Meeting having difficulty hearing the conversation. The resident required frequent repeating and rewording for her to comprehend what was said. During an interview on 12/2/2025 at 3:45 PM, the Activities Director (AD) acknowledged Resident #5 was very hard of hearing, but she did continue to attend activities of her preference and served as the Resident Council President. During an interview on 12/3/2025 at 4:15 PM, the Licensed Practical Nurse/Unit Care Coordinator (LPN/UCC) stated she thought the family had told the facility they were unable to purchase hearing aids due to the high cost. During a telephone interview on 12/3/2025 at 4:32 PM, Resident #5's daughter stated she had been contacted a year ago about hearing aids but could not afford them. The daughter stated she was not offered assistance in locating any alternatives or utilizing other available resources to help the resident's hearing. During an interview on 12/3/2025 at 4:38 PM, accompanied by the Social Service Director (SSD), Resident #5 confirmed she did not have any type of aid for hearing and she had not been provided with any information, other resources, or items that might be available to assist in hearing loss. During an interview on 12/3/2025 at 4:45 PM, the SSD confirmed Resident #5 had no documentation of follow-up since the audiology testing. The SSD stated the facility had hearing amplifiers available for residents who had hearing loss and were unable to get hearing aids and the hearing amplifier had not been provided to Resident #5.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, observations and interviews, the facility failed to ensure medical records were complete and accurately documented 1 resident (Resident #2) of 26 records reviewed. The findings include: Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Heart Failure, Muscle Wasting, Atrophy, and Encephalopathy. Further review revealed the resident was hospitalized from [DATE] to 6/12/2025. Review of the medical record for Resident #2 from 6/12/2025 to 12/4/2025 revealed no documentation pressure-ulcer prevention interventions had been implemented according to the resident's care plan, which currently included an air mattress and multi-podus boots (heel protective devices with removal of the heel area) to both feet. Continued review revealed no documentation the interventions had been verified for placement daily and no documentation of the resident's behaviors related to the removal of heel protectors and/or multi-podus boots. During an observation on 11/1/2025 at 10:15 AM and 1:45 PM, Resident #5 was lying in the bed on his back, with an air mattress in place and multi-podus boots on both feet. Further observation at 1:45 PM revealed the resident was lying in the bed on his left side, with an air mattress in place and multi-podus boots on both feet. During an observation on 11/2/2025 at 8:15 AM, Resident #5 was lying in the bed on his back, with an air mattress in place and multi-podus boots on both feet. Further observation at 11:30 AM revealed the resident was lying in the bed on his right side, with an air mattress in place and multi-podus boots on both feet. During an observation on 11/3/2025 at 9:45 AM, Resident #5 was lying in the bed on his back, with an air mattress in place and multi-podus boots on both feet. Further observation at 1:30 PM revealed the resident was lying in the bed on his left side, with an air mattress in place and multi-podus boots on both feet, and at 3:55 PM the resident was lying in bed on his back with an air mattress in place and multi-podus boots on both feet. During an interview on 11/3/2025 at 2:45 PM, Certified Nursing Assistant (CNA) A stated, .we used to use heel booties [thick cloth heel protectors] on [Resident #2's] feet .they changed to the heel boots [multi-podus boots] .when [Resident #2 gets up we put the non-skid socks on him instead of shoes because of his heel .we turn and reposition [Resident #2] every two hours .we check the air mattress and make sure it's working every day . During an interview on 11/3/2025 at 2:50 PM, CNA B stated, .we used to float [Resident #2's] heels on a pillow, but he would kick his feet off [of the pillow] .[Resident #2] had the heel booties, but they've been changed to the bigger heel boots [the date was unable to be determined due to lack of documentation] .[Resident #2] is repositioned every two hours .every day, we check and make sure the air mattress is working . During an interview on 11/3/2025 at 2:55 PM, CNA B stated, .we used to float his heels on a pillow, but he fidgets in bed and would kick his feet off sometimes .[Resident #2] had the heel booties, but they've been changed to the bigger heel boots .[Resident #2] is repositioned every two hours . we check and make sure the air mattress is working when we do our rounds . During an interview on 12/3/2025 at 4:15 PM, the Licensed Practical Nurse/Unit Care Coordinator (LPN/UCC) stated the staff monitored residents regularly with pressure ulcers and those who are at high-risk for pressure ulcers the staff made sure the residents' protective equipment was in place. During an interview on 12/3/2025 at 5:20 PM, the Director of Nursing (DON) confirmed Resident #2's behavior of kicking off heel protection was not recorded in the medical record, and confirmed resident behaviors should be documented. The DON confirmed that despite observations and staff interviews confirming the pressure-ulcer prevention activities were performed, the interventions were not documented in the resident's medical record. During an interview on 11/4/2025 at 7:30 AM, the Medical Director stated Resident #2 had received appropriate treatment and preventative measures at the facility, evidenced by the resolution of prior ulcers the resident was admitted with, and the improvement documented for the current ulcer the resident had. Continued interview revealed (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 had clinically unavoidable pressure ulcers due to multiple co-morbidities. During an interview on 12/4/2025 at 11:30 AM, the Executive Director confirmed the resident's medical record should contain accurate and complete documentation of the care provided for Resident #2.