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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynchburg Health & Rehabilitation Center	5615 Seminole Avenue Lynchburg, VA 24502

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). 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 [DATE] 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 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. (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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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 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.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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, alcohol-induced dementia, hypotension, history of pneumothorax, diabetes, and mood disorder. The minimum data set (MDS) dated [DATE] 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. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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) [NAME], [NAME] M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/[NAME] & [NAME], 2019.

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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 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 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 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 [DATE] 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. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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.