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	11/13/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff interview and clinical record review, the facility staff failed to develop a care plan for one of two residents in a survey sample.The Findings Include: Resident #1 (R1) did not have a care plan for noncompliance to medications, treatments, hygiene, and incontinence care. R1diagnoses include paraplegia, osteomyelitis, urinary tract infection, indwelling catheter, and MRSA (methicillin-resistant-Staphylococcus aureus. The most recent MDS (minimum data set) was a significant change dated 7/24/25 and indicated R1 was cognitively intact. Review of R1's clinical record including medication administration records, treatment administration record, nursing progress notes, physician progress notes, and activity of daily living (ADL) tool indicated R1 was refusing care and treatments, and medications at times. Interviews conducted on 11/12/25 with license practical nurse (LPN #2, unit manager) and certified Nursing assistant (CNA #2) indicated R1 was noncompliant with hygiene, incontinence, and treatments for wound care and catheter care. LPN #2 verbalized R1 would sign out and leave the building for hours at a time and would refuse treatments or medications that were scheduled during the time away from the facility. On 11/13/25 at 10:00 a.m. the facility physician (other staff, OS #3) was interviewed and verbalized R1 would refuse hygiene after being soiled and would refuse wound treatments. On 11/13/25 at 10:50 a.m. the wound care nurse practitioner (OS #2) was interviewed. OS #2 verbalized R1 was noncompliant with dressing changes to the sacrum. Review of R1's care plan indicated R1 had behaviors with rejecting wound treatments and medications, however the care plan did not address interventions for missing treatments or medications and did not address hygiene or incontinence care. On 11/13/25 at 11:45 a.m. the MDS coordinator (RN #2) was interviewed. RN #2 reviewed R1's care plan and agreed that there should have been more specific interventions put in place for refusal of care. On 11/13/25 at 12:15 p.m. the above information was presented to the director of nursing (DON). No other information was provided prior to exit conference on 11/13/25.

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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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 care regarding skin assessments for one of two residents in the survey sample (Resident #2). The findings include:Resident #2 (R2) was admitted to the facility with diagnoses that included traumatic wounds to neck/chest, pneumothorax, paraplegia, vertebra fractures, neurogenic bladder/bowel, spinal stenosis, and emphysema. The minimum data set (MDS) dated [DATE] assessed R2 as cognitively intact. R2's care plan (revised 11/3/25) documented the resident had traumatic wounds and was at risk of developing additional wounds and skin breakdown due to immobility related to paraplegia. Interventions to prevent further skin breakdown included skin assessments as indicated.R2's clinical record documented weekly skin assessments on 9/17/25, 9/24/25, 9/25/25. There were no documented skin assessments during week ending 10/4/25, 10/11/25 or 10/18/25. Weekly skin assessments resumed on 10/24/25 with the most recent assessment on 11/13/25. The clinical record made no mention of the resident's skin condition during the weeks of 10/4/25, 10/11/25 or 10/18/25 and provided no mention of resident refusal or explanation of why the audits were not performed.On 11/13/25 at 11:05 a.m., the licensed practical nurse unit manager (LPN #1) caring for R2 was interviewed about skin assessments. LPN #1 stated all residents were supposed to have weekly skin audits to identify any new wounds or skin conditions. LPN #1 stated the floor nurses were responsible for weekly skin assessments. LPN #1 stated the skin assessments were triggered in the electronic health record, prompting the nurse when the audits were due. LPN #1 reviewed R2's clinical record and stated she did not find skin assessments for weeks ending 10/4/25, 10/11/25 or 10/18/25. LPN #1 stated if the resident refused, nurses should have documented a note explaining why the audit was not performed. LPN #1 stated she did not know why R2's skin assessments were not completed weekly as required.On 11/13/25 at 11:40 a.m., the director of nursing (DON) was interviewed about R2's missing skin assessments. The DON stated she did not know why R2's skin assessments were not performed. The DON stated facility protocol required weekly skin assessments for all residents and the audits were scheduled in the electronic health record when residents were admitted .The facility's policy titled Skin Assessments (effective 1/29/24) documented, .Skin assessments will be completed for all patients .The Skin Observation Tool will be completed on admission, and at least every 7 days thereafter .This finding was reviewed with the regional nurse consultant and DON on 11/13/25 at 11:50 a.m. with no further information presented regarding R2's missing skin assessments 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview and clinical record review, the facility staff failed to administer medication as ordered by the physician for one of two residents in the survey sample (Resident #2)The findings include:Resident #2 (R2) was admitted to the facility with diagnoses that included traumatic wounds to neck/chest, pneumothorax, paraplegia, vertebra fractures, neurogenic bladder/bowel, spinal stenosis, and emphysema. The minimum data set (MDS) dated [DATE] assessed R2 as cognitively intact.On 11/13/25 at 9:20 a.m., R2 was interviewed about quality of care in the facility. R2 stated that several weeks ago, multiple doses of the medication gabapentin were not administered as ordered. R2 expressed concern that it took several days to get the medication refilled.R2's clinical record documented a physician's order dated 9/16/25 for gabapentin 300 milligrams (mg) with instruction to administer three times per day for pain management. The medication administration record (MAR) documented R2's gabapentin was scheduled each day at 9:00 a.m., 2:00 p.m. and 9:00 p.m.R2's October 2025 MAR documented the resident missed eleven scheduled doses of gabapentin from 10/17/25 through 10/21/25. The MAR documented the gabapentin was not administered on 10/17/25 at 9:00 p.m., 10/18/25 at 2:00 p.m. and 9:00 p.m., 10/19/25 and 10/20/25 at 9:00 a.m., 2:00 p.m. and 9:00 p.m. and on 10/21/25 at 9:00 a.m. and 2:00 p.m. A nurse documented in a note on 10/20/25 that the gabapentin was ordered on hold due to pharmacy delivery. On 11/13/25 at 11:05 a.m., the licensed practical nurse unit manager (LPN #1) caring for R2 was interviewed about the missed doses of gabapentin. LPN #1 stated she thought there had been an issue getting the required script to the pharmacy for prompt delivery of the gabapentin. On 11/13/25 at 11:40 a.m., the director of nursing (DON) was interviewed about R2's missed doses of gabapentin in October 2025. The DON stated there had been a problem with faxes getting to the pharmacy after a new fax/printer installation and that the pharmacy did not get the required script timely. The DON stated gabapentin was kept in the back-up supply (Omnicell) and that nurses should have accessed the back-up supply to prevent missed doses. The facility's protocol titled Omitted Medications (undated) documented, .Medication are to be administered per the provider's order .In the event you do not have a medication you are to do the following .Check Omnicell for medication (check with another nurse or call nurse manager if you cannot access the Omnicell) .If medication is not available in Omnicell, you must contact the provider and ask for an appropriate alternative .Notify the pharmacy of the need for the medication and ask when it should be expected to arrive .This finding was reviewed with the regional nurse consultant and DON on 11/13/25 at 11:50 a.m. with no further information provided prior to the end of the survey.

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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. Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of two residents in a survey sample. The findings include:The treatment administration record (TAR) was not initialed to indicate treatments was or wasn't performed for Resident #1 (R1). R1 diagnoses include paraplegia, osteomyelitis, urinary tract infection, indwelling catheter, and MRSA (methicillin-resistant-Staphylococcus aureus. The most recent MDS (minimum data set) was a significant change dated 7/24/25 and indicated R1 was cognitively intact. Review of R1's TAR for the month of August 2025 evidenced blank spaces (no staff initials) to indicate if treatments had been performed or refused. The treatments in question were a nightly dressing change to the left heel that was not signed off on 8/2/25, 8/3/25, 8/14/25, and 8/17/25, and a nightly dressing change to a sacral wound on 8/2/25, 8/3/25, 8/7/25 and 8/17/25. On 11/12/25 at 2:30 p.m. the DON (director of nursing) and administrator were informed of the concern and was asked to show evidence of the treatments had or had not been performed. The administrator verbalized awareness regarding staff not signing off on treatments and medications. On 11/13/25 at 10:30 a.m. the DON showed evidence that treatment was not performed on 8/7/25 due to R1 refusing. The DON verbalized that staff are being educated on this concern and documentation should be completed on the TAR indicating if the residents had treatments performed or not. No other information was provided prior to exit on 11/13/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control practices during dressing changes for one of two residents in the survey sample (Resident #2).The findings include:Resident #2 (R2) was admitted to the facility with diagnoses that included traumatic wounds to neck/chest, pneumothorax, paraplegia, vertebra fractures, neurogenic bladder/bowel, spinal stenosis, and emphysema. The minimum data set (MDS) dated [DATE] assessed R2 as cognitively intact.R2's clinical record documented a physician's order dated 10/23/25 for Enhanced Barrier Precautions due to the resident's wounds and urinary catheter. R2's clinical record documented a physician's order dated 11/5/25 for cleansing the right heel with normal saline, Xeroform dressing with bordered gauze daily. R2's clinical record documented a physician's order dated 11/10/25 to cleanse the upper back wound with normal saline, apply Betadine and a dry dressing each day shift.On 10/13/25 at 10:30 a.m., accompanied by registered nurse (RN #1) and with R2's permission, dressing changes to the resident's upper back wound and right heel were observed. RN #1 and a certified nurse's aide (CNA #1) washed their hands and put on new gloves prior to interacting with R2 for the dressing change with appropriate privacy provided. RN #1 placed the dressing change supplies (cleanser, Betadine, gauze/dressings) on the over-bed table. RN #1 did not clean/sanitize the bed table or provide any type of barrier prior to placing the supplies. RN #1 washed his hands, put on clean gloves and then removed the previous dressing from the resident's upper back wound. RN #1 discarded the dirty dressing, removed gloves and without hand hygiene, put on new gloves. RN #1 then applied Betadine and a clean dressing to the upper back wound. RN #1 removed gloves and returned to the treatment cart for supplies needed for the right heel wound. RN #1 placed the supplies on the resident's bed linens without a barrier underneath. RN #1 then washed hands, put on clean gloves and removed the old dressing from the right heel. RN #1 removed gloves and without hand hygiene, put on clean gloves, cleansed the heel with saline spray, dried the area with gauze, applied Xeroform dressing and covered the heel with bordered gauze. RN #1 discarded used supplies, removed gloves and washed hands. RN #1 and CNA #1 had no gowns in use during repositioning the resident or during either dressing change.On 11/13/25 at 10:50 a.m., RN #1 was interviewed about personal protective equipment required since the resident was on enhanced barrier precautions. RN #1 stated he thought the resident was on enhanced precautions because of the urinary catheter. When asked about the signage that indicated gowns/gloves were required for direct contact and wound care, RN #1 stated he was not sure about that and again stated he thought the precautions were for catheter care. When asked about hand hygiene between glove changes, RN #1 stated he washed his hands twice and that he thought he washed his hands after the glove changes. When asked about a clean barrier for supplies, RN #1 stated he used a washcloth.On 11/13/25 at 11:05 a.m., the licensed practical nurse unit manager (LPN #1) caring for R2 was interviewed about the dressing change observation. LPN #1 stated enhanced barrier precautions were in place for all residents with wounds and invasive devices and that a gown and gloves were required for direct care. LPN #1 stated the nurse should have provided a clean surface for placement of supplies and that hand hygiene should be performed between glove changes. On 11/13/25 at 11:40 a.m., the director of nursing (DON) was interviewed about R2's wound observation. The DON stated gowns and gloves were required for residents on enhanced barrier precautions, a clean field was required for supplies and that hand hygiene was required between glove changes.The facility's policy titled Enhanced Barrier Precautions (effective 3/26/24) documented, Employees providing high-contact patient care activities will follow Enhanced Barrier Precautions (EBPs) for patients who meet criteria .EBPs require the use of gown and gloves by staff during high-contact patient care activities as defined below . Wound care for chronic wounds .The facility's policy titled Handwashing Requirements (effective 2/6/20) documented, .Employees will wash hands at appropriate times to reduce the risk of transmission and acquisition of infections .Hand hygiene can consist of handwashing with soap and water or use of an alcohol based hand rub .The following is a list of some situations that require hand hygiene .Before and after changing a dressing .After any contact with potentially contaminated materials (used wound/treatment dressings) .This finding was reviewed with the regional nurse consultant and DON on 11/13/25 at 11:50 a.m. with no further information provided prior to the end of the survey.