

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Seven Hills Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 2081 Langhorne Road Lynchburg, VA 24501	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49371</p> <p>Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure misappropriation of medications did not occur for one of nine residents, resident # 7 (R7).</p> <p>The findings included:</p> <p>On 5/14/24, licensed practical nurse #2 (LPN #2) was observed removed medications belonging to R7 from the facility med cart and gave them to certified nursing assistant #2, (CNA#2) for personal use.</p> <p>A review of the clinical record revealed that R7 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, dementia, cerebral infarction, major depressive disorder, chronic pain, generalized anxiety disorder, and hypertension. The most recent minimum data set (MDS) assessment was a quarterly assessment, dated 3/3/24, which assessed R7 as cognitively intact.</p> <p>On 6/11/24 at 8:38 AM, other staff #1 (OS#1), who was the director of rehabilitation, was interviewed. OS #1 stated that on 5/14/24 she was in the facility gym when she observed 2 facility employees in the parking lot talking. OS#1 stated that LPN #2 was observed running into the facility, so OS#1 stated that she went to .see what was wrong. OS #1 stated that when she reached the med cart where LPN #2 had been, she noticed a medication supply card lying on the med cart. OS #1 stated that she then went to the door, she watched LPN #2 hand CNA #2 .a baggie. OS#1 stated that CNA #2 left the parking lot and LPN #2 returned to the facility. OS #1 then stated that she reported what she had observed to the director of nursing (DON) and to human resources, then provided a written statement of her observations.</p> <p>On 6/11/24 at 8:45 AM, OS #3 (Speech Therapist) was interviewed. OS #3 stated that she had observed CNA # 2 in tears as she walked down the hall, after speaking to LPN #2. OS #3 then stated that she observed LPN #2 .open the med cart drawer, remove a pill pack, and start popping pills, at least six, into a plastic baggie. OS #3 then stated that LPN #2 placed the baggie into her pocket and left the med cart. OS #3 stated that she noted the medication on the label of the pill pack to be Zofran. OS #3 stated that she reported her observations to her manager, who was OS #1, and provided a written statement.</p> <p>On 6/11/24 at 8:57 AM, R7 was interviewed. R7 stated that she was not aware of the incident and that she always received her medications when she asked for them.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/11/24 at 9:00 AM, OS #2, who was the admissions coordinator, was interviewed. OS #2 stated that he was outside talking to CNA #2 .because she was upset and that he .wanted to make sure she was ok. OS #2 stated that while he and CNA #2 were talking, LPN #2 also came outside, then went back inside the facility. He stated that LPN #2 returned to the parking lot, holding a plastic bag, and handed it to CNA #2. OS #2 stated that he did not observe the contents of the bag, that CNA #2 left the parking lot, and that he returned to the facility. OS #2 stated that he also had provided a written statement.</p> <p>On 6/11/24 at 9:06 AM, the administrator was interviewed. The administrator stated that both LPN #2 and CNA #2 were terminated immediately following the reported observations. The administrator also stated that the incident was due to the .actions of 2 employees, and that no one else was re-educated about the abuse policy since they were not involved.</p> <p>On 6/11/24, the facility event summary for the incident was reviewed. The summary included the witness statements from LPN #2 and CNA #2, evidence that both employees had been terminated, and that the event had been reported to all entities.</p> <p>On 6/11/24 at 10:06 AM, the DON was interviewed regarding conflicting written statements in the event summary that had been obtained from LPN #2. The DON stated that LPN #2 had first reported that the medication she gave to CNA #2 was famotidine which she obtained from the floor stock supply, then later reported it as being Zofran from R7's discontinued medication supply. According to R7's clinical record, Zofran was a current medication she received on an as needed basis.</p> <p>On 6/11/24, the facility policy for Abuse, Neglect, and Exploitation was reviewed. Per the policy, It is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy defines misappropriation as .deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. Per the policy, New employees will be educated on abuse, neglect, exploitation, and misappropriation of resident property during new orientation and existing staff will receive annual education through planned in-services and as needed.</p> <p>Review of LPN #2's employee file did not indicate any occurrences or allegations of misappropriation of medication prior to this incident.</p> <p>On 6/11/24 at 11:04 AM, the DON and administrator were made aware of the above concerns. No further information was provided.</p>		