STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Hills Rehabilitation and Nursing	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 21875 Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive plan of care for one of two residents in the survey sample (Resident #1). The findings include: Resident #1's plan of care was not updated with problems, goals, and interventions regarding a pressure ulcer. R1's clinical record documented the resident was assessed on 12/30/24 with a stage 2 pressure injury on the sacrum. R1's clinical record documented treatment orders dated 12/30/24 for daily dressing changes with wound cleanser, medical grade honey and bordered gauze. R1's clinical record documented current physician orders for pressure ulcer treatment/prevention that included heel protectors, elevation of heels as tolerated when in bed, a pillow between knees at all times in addition to skin barrier cream, and Pro-stat supplement to assist with wound healing. R1's plan of care revised on 12/6/24, documented the resident was at risk of pressure ulcer development. Care plan interventions included protective ointment to buttocks, prompt incontinence care, and skin assessments. R1's care plan had not been updated indicating the resident had a pressure ulcer and included no goals and/or interventions implemented for care/treatment of the ulcer. On 1/8/25 at 10:40 a.m., the registered nurse responsible for care plan updates (RN #1) was interviewed about R1's plan of care. RN #1 stated R1's care plan had not been updated since the pressure ulcer was assessed and treatment initiated. RN #1 stated she was responsible for care plan updates and usually updated plans based upon new treatment orders and wound reports. RN #1 stated R1's plan of care should have been updated to include the pressure ulcer and reflect goals and interventions in place for care of the ulcer. This finding was reviewed with the administrator and director of nursing on 1/8/25 at 12:15 p.m. with no further information presented prior to the end of the survey.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview, and clinical record review, the facility staff failed to implement physician ordered interventions for pressure ulcer prevention for one of two residents in the survey sample (Resident #1). The findings include: Resident #1 (R1) was admitted to the facility with diagnoses that included osteoporosis, vascular dementia, psychotic disturbance, mood disorder, anxiety, atherosclerosis, depression, neuropathy, glaucoma and osteoarthritis. The minimum data set (MDS) dated [DATE] assessed R1 with severely impaired cognitive skills. R1's clinical record documented a physician's order dated 5/18/22, which read, Elevate bilateral heels, as tolerated, when Resident is in bed on pillows to assist w/ [with] skin breakdown prevention. R1's record also documented a physician's order dated 5/19/22 for bilateral heel protectors and a physician's order dated 10/26/22 to keep a pillow between the knees at all times for pressure prevention. On 1/7/25 at 2:15 p.m., accompanied by licensed practical nurse (LPN) #3 and the unit manager (LPN #4), R1 was observed prior to a pressure ulcer dressing change. R1 was in bed with no heel protectors in use. The resident's heels were resting directly on the sheet-covered mattress. There was no pillow between the resident's legs. The heels and legs were observed with no skin breakdown noted. LPN #4 was interviewed at this time about the heel protectors and positioning pillow. LPN #4 stated she was not sure about the heel protectors or pillows. On 1/7/25 at 2:35 p.m., the certified nurses' aide (CNA #1) caring for R1 was interviewed. CNA #1 stated that R1's feet were sometimes elevated on pillows. CNA #1 stated she had not seen the heel protectors today and was not sure where the heel protectors were located. On 1/7/25 at 2:50 p.m., LPN #2 who was caring for R1 was interviewed about the heel protectors and pillows. LPN #2 stated that R1 previously had the pillow placed between the legs, but she had found the pillow soiled and sent it to laundry. LPN #2 stated she had not seen the heel protectors in use today and was not sure why they were not in place. On 1/7/25 at 4:00 p.m., the director of nursing (DON) was interviewed about R1 observed without use of heel protectors or positioning pillows. The DON stated R1 was at high risk of pressure ulcer development and the heel protectors and pillows should have been in use as ordered. The DON stated the pillow between the knees was to prevent skin breakdown as R1 had impaired leg positioning. This finding was reviewed with the administrator and DON on 1/7/25 at 4:15 p.m., with no further information presented prior to the end of the survey.