STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Louisa Health & Rehabilitation Center	210 Elm Street Louisa, VA 23093

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 family/responsible party of a fall with injury for one of eight residents in the survey sample (Resident #5). The findings include: Resident #5 (R5) was admitted to the facility with diagnoses that included diabetes, chronic kidney disease, osteoporosis, hypertension, depression, and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed R5 with severely impaired cognitive skills. R5's clinical record documented a nursing note dated 4/4/25 stating, .Nurse was in the room across the hall performing wound care when Nurse was alerted to Resident being on the floor. Resident was observed on the floor on the right side of the bed in between the bed and the wall .upon assessment there was one skin tear on right elbow. Unit Manager notified, NP [nurse practitioner] notified new orders to cleanse Rt elbow skin tears with wound cleanser apply Xeroform and cover with bordered gauze QD [each day] . The clinical record documented no notification to the resident's responsible party regarding the fall. On 5/27/25 at 2:10 p.m., licensed practical nurse (LPN #4) caring for R5 on 4/4/25 was interviewed. LPN #4 stated R5 rolled out of bed on 4/4/25 and she assessed the resident following the fall with a skin tear on the right elbow. LPN #4 stated she notified the unit manager and the nurse practitioner and obtained orders for care of the skin tear. LPN #4 stated she thought the resident was her own responsible party and did not notify the resident's family member/emergency contact listed on the face sheet. On 5/27/25 at 2:15 p.m., the unit manager (LPN #5) on R5's unit was interviewed. LPN #5 reviewed the clinical record and stated there was no family notification regarding the 4/4/25 fall. LPN #5 stated concerning the notification, That wasn't handled the way it should have been. LPN #5 stated R5's family should have been called and notified immediately regarding the fall/injury. On 5/27/25 at 3:45 p.m., the administrator was interviewed about R5's fall on 4/4/25. The administrator stated LPN #4 did not reach out to the family about the incident and injury of 4/4/25. The administrator stated LPN #4 should have notified the family/responsible party regarding the fall. (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 .Responsible party will be notified of a change in condition . On 5/28/25 at 1:15 p.m., the administrator and regional nurse consultant stated a plan of correction had been implemented in response to the failure to notify R5's family following the fall. The following plan of correction was presented. Problem -Nurse did not notify the responsible party of a fall. Actions taken included: - R5's responsible party was notified of the fall. A meeting was conducted on 4/7/25 with R5's family members and facility administration to discuss family concerns that included the notification failure. -All residents were identified to have the potential to be affected by failure to notify of changes in condition. - LPN #4 was educated and issued corrective action/warning on 4/15/25 regarding failure to notify R5's family of the fall. - In-service education was provided by director of nursing (DON) and/or designee to all nursing staff on 5/1/25 regarding notification to the physician and responsible party following falls and/or changes in condition. Additional training was conducted on 5/12/24 with all nursing staff that included requirements to notify family/responsible party of falls, incidents and changes in condition. - The DON or designee will complete responsible party notification audit during daily clinical meeting for 6 weeks and then randomly during clinical meetings to ensure prompt notifications to the responsible party. - Audit results will be reported to the monthly quality assurance committee for review/discussion until quality assurance committee deems actions taken ensure compliance. - Date of correction was 5/14/25. The survey team verified actions taken. R5's clinical record documented the family meeting was held on 4/7/25 with the notification failure discussed/reviewed with R5's family. Signature sheets documented education and corrective action warning with LPN #4 and all other nurses. Audits sheets were documented and ongoing from the daily clinical meetings regarding notifications. Two current residents that had experienced falls since the correction date of 5/14/25 were added to the survey sample (Residents #7 and #8). Notifications to the residents' family/responsible party were documented in the clinical record following the falls with no deficiency identified since the correction date. The survey team accepted the plan of correction and cited this deficiency as past non-compliance.

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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. Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure a complete and accurate clinical record for one of eight residents in the survey sample (Resident #3, R3). The findings include: Medication Administration Record (MAR) was not documented on multiple times for the month of August 2024. Diagnoses for R3 included: Dementia, peripheral vascular disease, neuropathy, and diabetes. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/7/2025. R3 was assessed as being cognitively intact. Review of R3's medication orders documented an order dated 8/14/24 that read: Gabapentin Capsule 100 MG [milligrams] Give 2 capsules by mouth three times a day for Neuropathy. Review of R3's MAR for the month of August 2024 did not indicate the medication had been signed off as being given on 8/14/24 for the 2:00 p.m. dose and the 9:00 p.m. dose, and also not signed off as being given on 8/15/24 for the 9:00 a.m. dose and the 2:00 p.m. dose. On 5/28/25 at 12:00 p.m. the facility's nurse consultant (administrative staff, AS #2) was interviewed. AS #2 verbalized the nurse that was giving medications on the days in question was no longer employed at the facility. AS #2 was able to provide narcotic sign out sheet indicating that the medication in question was signed off for distribution for R3, however did agree that the medication was not signed off on the MAR indicating that it had been given. A policy titled General Guidelines for Medication Administration read in part: IV. Documentation 1. The individual who administers the medication dose records the administration the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medication reviews the MAR to ensure the necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications. On 5/28/25 at 1:30 p.m. the above information was presented to the administrator. No other information was presented prior to exit conference on 5/28/25.