Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynn Care Center	1000 Shenandoah Avenue Front Royal, VA 22630

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. 27660 Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for two of four residents in the survey sample, Resident #2 and #3. The findings include: 1. For Resident #2 (R2), the facility staff failed to review and revise the comprehensive care plan for when the resident was moved to a secured dementia unit. The nurse's note dated 6/11/24 at 5:14 p.m. documented, Resident moved from room (XXX-x) to room (XXX-x) in the Shenandoah Gardens (secured dementia unit) MD (medical doctor) and RP (responsible party) made aware. Tolerating well. Will continue to monitor. The comprehensive care plan dated, 8/24/22, documented in part, Focus: (R2) is an elopement risk/wanderer r/t (related to) impaired safety awareness. The Interventions documented, Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Frequent rounding while up in wheelchair. Q (every) 15-minute checks times 1 week. Signage placed on door for visitors not to allow residents out of the facility without permission. Wander guard as ordered. Check per facility protocol. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 7/15/24 at 4:00 p.m. When asked if a resident is on a secured dementia unit, would you expect that to be on the care plan, ASM #2 stated, I would think so. An interview was conducted with LPN (licensed practical nurse) #2, the unit manager of the secured dementia unit, on 7/16/24 at 1:10 p.m. When asked who updates the care plans, LPN #2 stated all nurses do. When asked if a resident is on a secured dementia unit, should that be on the care plan, LPN #2 stated, yes. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Care Planning - Comprehensive Person-Centered documented in part, 16. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a.When requested by the resident/resident representative. b. When there is a significant change in the resident's condition. c. When the desired outcome is not met. d. When goals, needs and preferences change. e. When the resident has been readmitted to the facility from a hospital stay. f. At least quarterly and after each OBRA MDS assessment. ASM #1, the administrator, ASM #2 and ASM #3, regional director of clinical operations, were made aware of the above findings on 7/16/24 at approximately 1:45 p.m. No further information was provided prior to exit. 2. For Resident #3 (R3), the facility staff failed to review and revise the comprehensive care plan to address the resident residing on a secured dementia unit. The comprehensive care plan dated, 3/11/22 and revised on 1/4/24, documented in part, Focus: (R3) has hx of episodes of wandering and can be resistive to care. (R3) can become agitated/anxious with over stimulation, usually easily redirected. (R3) is often resistive or behavior trigger during showers and toileting. The Interventions documented in part, Anticipate and meet resident's needs. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Encourage resident to express feelings appropriately. Explain all procedures to the resident before starting and allow the resident time to adjust to changes. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved and situations. Document behaviors and potential causes. Staff will attempt to bring resident to a quiet area when she becomes anxious/agitated. The resident's trigger for (agitation and being aggressive with other after care. The resident's behavior is de-escalated by trying to keep her redirected when observed being agitated. The care plan further documented, Focus: (R3) is at risk for falls. She is at risk for further falls r/t history of fall, compulsiveness, poor safety awareness, agitation/anxiety, cognitive deficits, impaired mobility, poly pharmacy, and other chronic health conditions. Resident enjoys sitting in grass when outside. Resident will lay or sit on floor. The Interventions documented, 8/10/23 - Encourage resident to wait until staff are able to go out into the garden with her. 4/22/24 - frequent rounding. 7/31/23 - Monitor frequently when outside. The nurse's note dated, 6/2/24 at 8:20 p.m. documented, Resident was found outside lying on R (right) side w/ (with) head resting in mulch & lower body on concrete walkway. Knees pulled up slightly to wait. Resident moaning low negative tone, 'ow, ouch' repeatedly. Very dark, not well-lit. Resident responds to staff promptly. Vital signs assessed & stable. Initial neuro (neurological) check initiated & normal outside of some drowsiness initially noted. Resident assisted to feet & was able to be led by staff back inside. Wounds on L (left) elbow cleaned & dressed initially. PRN (as needed) Tylenol given. Needs met. Placed in comfortable position in bed. Bed placed in lowest position & floor matt in place. No observable changes in baseline cognitive status. RP (responsible party) and MD (medical doctor) notified. Will continue to monitor. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 7/15/24 at 4:00 p.m. When asked if a resident is on a secured dementia unit, would you expect that to be on the care plan, ASM #2 stated, I would think so. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with LPN (licensed practical nurse) #2, the unit manager of the secured dementia unit, on 7/16/24 at 1:10 p.m. When asked who updates the care plans, LPN #2 stated all nurses do. When asked if a resident is on a secured dementia unit, should that be on the care plan, LPN #2 stated, yes. ASM #1, the administrator, ASM #2 and ASM #3, regional director of clinical operations, were made aware of the above findings on 7/16/24 at approximately 1:45 p.m. No further information was provided prior to exit.

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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. 27660 Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of practice for one of four residents in the survey sample, Resident #1. The findings include: For Resident # (R1), the facility staff failed to clarify a physician's order for the application of compression wraps. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/23/24, the resident scored a 15 out of 15on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. The physician order dated, 7/5/23, documented, Bilateral lower legs - wrap with compression wrap once a week for 6 months one time a every Mon (Monday) for edema for 6 months. The nurse's note dated, 7/5/23 at 11:06 a.m. documented, Resident had appointment (Name) Foot and Ankle Center, came back with a new order for edema. Bilateral lower legs - Wrap with compression wrap once a week for 6 months. Resident and Family (son in law) made aware. An interview was conducted with LPN (licensed practical nurse) #3, the wound nurse, on 7/16/24 at 10:57 a. m. When asked what kind of wraps did, she observe on R1 when she cared for him, LPN #3 stated she took his wraps off a few times and they were kling wrap (a light gauze wrap used to hold dressings in place). LPN #3 was asked to review the physician order above. When asked what a compression wrap consisted of, LPN #3 stated the order wasn't clear, there are different kinds of compression wraps, mostly an ace wrap could be used. An interview was conducted with LPN #4 on 7/16/24 at 12:21 p.m. LPN #4 was asked to review the above order for compression wraps. When asked what wrap she would use to complete the physician order, LPN #4 stated she'd use either Kerlix wrap or ace wraps. LPN #4 was asked if the order needed to be clarified, LPN #4 stated, yes, it doesn't say what kind of wrap to use, it's not complete. LPN #4 stated she would question the order. An interview was conducted with LPN #5, the unit manager, on 7/16/24 at 12:50 p.m. LPN #5 was asked to review the above order for compression wraps. After review LPN #5 stated she would clarify the order. When asked if kling wrap is considered a compression wrap, LPN #5 stated, no, I'd do Kerlix before kling but probably ace wraps. The facility policy, Medication and Treatment Orders, documented in part, 12. Orders not specifying the number of doses, or duration of medication, will be clarified by the prescribing practitioner. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations, were made aware of the above concern on 7/16/24 at approximately 1:45 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide supervision to prevent elopement for three of four residents in the survey sample, Residents #2, #3, and #4. The findings include: 1. For Resident #2 (R2), the facility staff failed to provide supervision to prevent the resident was getting out the doors and falling on the pavement outside the building on 5/27/24. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 6/28/24, the resident scored a three out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired for making daily decisions. In Section J - Health Conditions, the resident was coded as having had one fall with minor injuries since the last assessment. The resident's mode of mobility was coded as using a wheelchair. The MDS assessment, prior to the elopement, a quarterly assessment, with an assessment reference date of 4/9/24, the resident scored a seven out of 15 on the BIMS score, indicating the resident was severely impaired for making daily decisions. In Section J - Health Conditions, the resident was not coded as having had any falls during the lookback period. R2 was coded as using a wheelchair for mobility and could self-propel in the wheelchair for at least 150 feet. The Safety Assessment completed, 2/28/24, documented the resident was not an elopement risk at this time. The nurse's note dated, 5/25/24 at 4:20 p.m. documented in part, Nursing observations, evaluation and recommendations are: Resident was observed on ground outside facility with minor injuries. Vitals and Neuro (neurological) checks are WNL (within normal limits). All appropriate notifications have been made. The Incident Report, dated 5/25/24 at 4:21 p.m. documented in part, Resident was observed on the ground outside in the parking lot of the second-floor entrance near the dumpsters. The visitor said that he had fallen and was helped back into his chair. Resident was brought back inside by staff and assessed by RN (registered nurse). He reported pain to his right shoulder, an approximately 2 in (inch) diameter open area was found to the right shoulder, area was cleaned with wound cleaner and covered with dressing, ROM (range of motion) is WNL to all extremities. There is a pin sized opening in the skin of the right knuckles, this was cleaned with alcohol and left OTA (opened to air). Vitals and neuro assessment were all WNL. All appropriate notifications were made. Wander guard was on and functioning .Predisposing Environmental Factors - alarm on and sounding. Uneven floor surfaces .After investigating it was note that another resident witnessed visitors coming in the door and the above-named resident going out the same door. The resident was a builder in the past and likes to go outside. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse practitioner note dated, 5/28/24 documented in part, Assessment/Plan: #2. Elopement Risk: wander guard in place, continue elopement risk monitoring, patient would benefit to be in a secure unit. The Risk Review Note dated 5/29/24 at 4:59 p.m. documented in part, (R2) has had a fall and is at risk for further falls due to cognitive & communication deficits, terminal prognosis, impaired mobility, being resistive to care at times, hx (history) of falls, polypharmacy, multiple chronic health conditions .Administrator to send letter to all families not to let resident out main entrance doors. Family members were educated to not leave resident unattended when outside. The comprehensive care plan dated, 8/24/22, documented in part, Focus: (R2) is an elopement risk/wanderer r/t (related to) impaired safety awareness. The Interventions documented, Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Frequent rounding while up in wheelchair. Q (every) 15-minute checks times 1 week. Signage placed on door for visitors not to allow residents out of the facility without permission. Wander guard as ordered. Check per facility protocol. The nurse's note dated 6/11/24 at 5:14 p.m. documented, Resident moved from room (XXX-x) to room (XXX-x) in the Shenandoah Gardens (secured dementia unit) MD (medical doctor) and RP (responsible party) made aware. Tolerating well. Will continue to monitor. R2 was observed on 7/15/24 at 12:45 p.m. in the dining area of the secured dementia unit, sitting in his wheelchair eating lunch. The staff members that treated R2 on 5/25/24 were not available for interview. An interview was conducted with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations, on 7/16/24 at 10:17 a.m. ASM #3 stated a resident informed a staff member that a visitor had let a man out the doors. The staff were on their way when the alarm was sounding. ASM #2 stated that R2 is very quick in moving in his wheelchair. ASM #1 stated he sent letters to all family members regarding not letting residents out of the building without permission. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Elopement/Unsafe Wandering Risk Evaluations documented in part, Policy: This organization is committed to ensuring that all reasonable measures are in place to ensure that each resident received adequate supervision and assistance devices to prevent accident, including elopement and unsafe wandering .Specific Procedures/Guidance: 1. The Elopement Risk evaluation in PCC (electronic medical record) be completed on admission, re-admission, and quarterly and as needed for a change in resident status. 2. If a resident is determined to be at risk for elopement or unsafe wandering, the staff will notify the resident's attending physician/practitioner and resident' representative of the risk. 3. IF the resident is determined to be at risk for elopement or unsafe wandering, preventive interventions will be implemented. a. Interventions may include but are not limited to: i. 1:1 supervision or frequent visual checks on the resident. ii. Use of an alert system device. iii. Placement [NAME] secured unit/neighborhood. iv. Re-direction and diversional activities. 4. The resident's care plan will, be reflective of identified risk and include person-centered interventions. 5. The medical record will document the resident's behavior including attempts and actual events of elopement or unsafe wandering and preventive interventions being implemented. 6. If it is determined the resident's risks cannot be met at the current facility, the facility will, coordinate discharge planning with the resident and the resident's representative. ASM #1, ASM #2 and ASM #3 were made aware of the above findings on 7/16/24 at approximately 1:45 p. m. No further information was provided prior to exit. 2. For Resident #3 (R3), the facility staff failed to provide supervision to prevent the resident from going out into the gardens, off the secured dementia unit, and falling in the gardens on 6/2/24. On the most recent MDS assessment, a quarterly assessment, with an ARD of 6/20/24, the resident scored a three out of 15 on the BIMS score, indicating the resident was severely impaired for making daily decisions. The resident was coded in Section G - Functional Status as being able to walk at least 150 feet independently. Wandering behaviors were not coded as observed during the lookback period. In Section J - Health Conditions the resident was coded as having had two falls without injury and two falls with minor injuries. The MDS assessment, prior to the resident's fall outside on 6/2/24, coded the resident as scoring a zero out of 15 on the BIMS score, indicating the resident was severely impaired for making daily decisions. R3 was coded in Section G - Functional Status as being able to walk at least 150 feet, independently. Wandering behaviors were coded four to six days during the look back period. In Section J - Health Conditions, the resident was coded as having had one fall without injury. The nurse's note dated, 6/2/24 at 8:20 p.m. documented, Resident was found outside lying on R (right) side w/ (with) head resting in mulch & lower body on concrete walkway. Knees pulled up slightly to wait. Resident moaning low negative tone, 'ow, ouch' repeatedly. Very dark, not well-lit. Resident responds to staff promptly. Vital signs assessed & stable. Initial neuro (neurological) check initiated & normal outside of some drowsiness initially noted. Resident assisted to feet & was able to be led by staff back inside. Wounds on L (left) elbow cleaned & dressed initially. PRN (as needed) Tylenol given. Needs met. Placed in comfortable position in bed. Bed placed in lowest position & floor matt in place. No observable changes in baseline cognitive status. RP (responsible party) and MD (medical doctor) notified. Will continue to monitor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility synopsis of event dated, 6/7/24, documented in part, On Sunday June 2, the resident was observed by staff in the secured courtyard where she had allegedly fallen. Throughout the investigation, it was reported by staff that frequently care for (R3) that she frequently wanders and enjoys the outside atmosphere. When interviewing the resident, she was unable to recall the event. In response to the investigation (R3) was assisted back onto the facility, head to toe assessment completed and it was noted that (R3) sustained a skin tear to the left elbow, treatment implemented; area now resolved. Doors to the courtyard secured, care plan updated, and intervention placed where the resident must be supervised while in the secured courtyard and the facility updated its practice that the doors to the secured courtyard will remain locked at all times. RP and MD notified. Social worker visited (R3) for psychosocial visit and there were no needs noted. The comprehensive care plan dated, 3/11/22 and revised on 1/4/24, documented in part, Focus: (R3) has hx of episodes of wandering and can be resistive to care. (R3) can become agitated/anxious with over stimulation, usually easily redirected. (R3) is often resistive or behavior trigger during showers and toileting. The Interventions documented in part, Anticipate and meet resident's needs. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Encourage resident to express feelings appropriately. Explain all procedures to the resident before starting and allow the resident time to adjust to changes. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved and situations. Document behaviors and potential causes. Staff will attempt to bring resident to a quiet area when she becomes anxious/agitated. The resident's trigger for (agitation and being aggressive with other after care. The resident's behavior is de-escalated by trying to keep her redirected when observed being agitated. The care plan further documented, Focus: (R3) is at risk for falls. She is at risk for further falls r/t history of fall, compulsiveness, poor safety awareness, agitation/anxiety, cognitive deficits, impaired mobility, poly pharmacy, and other chronic health conditions. Resident enjoys sitting in grass when outside. Resident will lay or sit on floor. The Interventions documented, 8/10/23 - Encourage resident to wait until staff are able to go out into the garden with her. 4/22/24 - frequent rounding. 7/31/23 - Monitor frequently when outside. Observation was made of the garden/courtyard off the secured dementia unit on 7/15/24 at 12:40 p.m. The doors to the garden were locked and this writer had to have a staff member open the door with a keypad. The garden area has many gardens, a shed, a waterfall (nonfunctioning), open areas for walking and seating for rest periods. The sidewalk/path is a cement base but is somewhat uneven in places. The area is fenced with an approximately six-foot fence. During this time an interview was conducted with LPN (licensed practical nurse) #1. When asked how the resident can go outside to the secured courtyard, LPN #1 stated the residents are now not allowed outside unless they are supervised. Observation was made of R3 on 7/15/24 at approximately 3:30 p.m. She was walking throughout the unit. R3 then went and sat on one of the recliner chairs in the dining area of the secured unit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with LPN #2, the unit manager, on 7/16/24 at 9:28 a.m. When asked who can use the courtyard/garden off the secured dementia unit, LPN #2 stated, any of the residents can use it as long as they are supervised. LPN #2 was asked if that was the way it was before R3 went outside and was found on the ground, LPN #2 stated that before this, any of the residents could go outside at any time. There are two gentlemen that like to go sit outside in the mornings. When asked if the doors to the courtyard/garden were locked at night/dark, LPN #2 stated the doors are normally locked when it gets dark. Did the doors get locked that evening, 6/2/24, LPN #2 stated she did not know if they had been locked as she was not here. LPN #2 stated that R3 has a history of PTSD (post-traumatic stress disorder) and after she gets a shower or receives incontinence care, she has a tendency to need to walk around after the care is provided. LPN #2 was asked to explain her knowledge of the evening of 6/2/24, LPN #2 stated the CNA (certified nursing assistant) had just changed R3 and went to change another resident. After she finished with the other resident, she went to look for R3. She couldn't find her and then searched out in the courtyard/garden and found her on the ground. An interview was conducted with ASM #1, ASM #2, and ASM #3 on 7/16/24 at 10:17 a.m. ASM #3 stated the doors get disabled when activities take the residents outside in the courtyard/garden. It was not known if the doors were left unlocked at the time R3 got out. There is a keypad to next to the door for a reason. The facility implemented an QAPI (Quality Assurance Performance Improvement) Action Plan dated 6/3/24. The plan was documented as followed: Root Cause Analysis/Related Factors - The doors in Shenandoah gardens will be locked. Residents that enter the courtyard will always enter with supervision. Goals/Objectives/Expected Outcomes: There will be less falls in the courtyard of Shenandoah Gardens. Correction: All doors in Shenandoah Gardens were checked to ensure they are secured. Other Potential: All residents had the potential to be affected. System Changes: Maintenance to check all doors leading to the courtyard and the panel in Shenandoah gardens 3 x week x 3 months to ensure doors are remaining locked. Maintenance to maintain security of alarm panel. Monitoring/Oversight: DON (director of nursing)/designee to review audits weekly, results of the weekly audits will be reported to the QAPI monthly x 3 months. The QAPI committee is responsible for the ongoing monitoring for compliance. Date of compliance: 7/3/24. The credible evidence was reviewed. Interviews were conducted with staff members regarding the locking of the doors. A walk through with ASM #1 and ASM #2 on 7/16/24 at 1:04 p.m. was conducted and all doors were checked for being secured and locked. ASM #1, ASM #2 and ASM #3 were made aware of the above findings on 7/16/24 at approximately 1:45 p.m. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit. PAST NON-COMPLIANCE 3. For Resident #4 (R4), the facility staff failed to provide supervision to prevent the resident from getting out of the building, crossing a parking lot and going a private residence across the parking lot on 6/13/24 at 11:00 p.m. On the most recent MDS, a significant change assessment, with an ARD of 6/25/24, the resident scored an eight out of 15 on the BIMS score, indicating the resident was moderately cognitively impaired for making daily decisions. R4 was coded for having delusions during the look back period. The resident was coded as being able to walk at least 150 feet with supervision. R4 was not coded for wandering. The MDS, prior to the elopement, a quarterly assessment, with an ARD of 3/25/24, the resident scored an 11 out of 15 on the BIMS score, indicating the resident was moderately cognitively impaired for making daily decisions. R4 was not coded for wandering. The nurse's note dated 6/13/24 at 10:58 p.m. documented, Nurse made aware by aides that resident wandered by herself to the homes across the street from the facility. Per the aide, a homeowner from across the street was inquiring if they worked at (name of facility) because they had someone at their home that was lost. Resident began walking toward facility pushing her wheelchair full of personal belongings towards them. DON (director of nursing) and on call nurse made aware. Head to toe assessment completed. All skin intact and resident denies any pain. Resident is at nurses station confused and looking for her son at the moment. Wander guard placed on right wrist. The facility incident report dated 6/13/24, documented the same note as above. The Notes at the bottom documented, Upon investigation it was noted the resident stated, 'I went out of the door because I was looking for people.' Resident was observed outside of the facility and assisted back into the facility. No injury was noted. Elopement assessment completed, wander guard initiated, q (every)15 minutes checks implemented until resident reaches baseline. All parties notified. The Safety Resident assessment dated [DATE] documented under 8. Recommendations: At risk for elopement (implement Care Plan and evaluate need for wander bracelet). 8a. Was a wander bracelet placed on the resident? No. The comprehensive care plan was reviewed. The risk for elopement was not addressed on the care plan until 6/17/24, after she got out of the building. The care plan did address the resident's risk for falls. Observations were made of R4 on 7/15/24 at 12:20 p.m. sitting in her recliner, in her room. A second observation was made of R4 on 7/16/24 at 8:32 a.m. sitting in her wheelchair, in her room. CNA was able to show this writer where the wander guard was located on the resident's left ankle. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Lynn Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Shenandoah Avenue Front Royal, VA 22630	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The witness statement dated 6/14/24 from LPN #6, the nurse on duty when the resident exited the building, documented, The last time I saw (R4) was at 8:04 p.m. when I gave her, her scheduled nighttime medications. The resident was in her room pushing around her wheelchair and bedside table. I asked her if she was ready for bed, but she did not want to get in bed. I was made aware that she was found outside and notified on call nurse (LPN #5) at 11 p.m. I did a head-to-toe assessment which was all normal and had the resident sit near the nurses station after that. LPN #6 was unavailable for interview. An interview was conducted with OSM (other staff member) #1, the director of maintenance, on 7/16/24 at 9:09 a.m. When asked if the door in which R4 got out of is locked, OSM #1 stated that prior to the installation of the badge reader, anyone could come and go out that door. When asked if the doors are locked at night, OSM #1 stated the doors are locked but the handicap button still works. When asked if the handicap button doesn't lock when the doors lock, OSM #1 stated, no, the handicap button works at all times. He further stated now that the badge reader is in place the handicap button doesn't work unless a badge opens it up. That door is now an employee entrance only. An interview was conducted with ASM #1, ASM #2 and ASM #3 on 7/16/24 at 10:17 a.m. ASM #3 stated that the door in which R4 got out was always a door visitors could come and go. There is no supervision by that door as it is between the two units. The door is not visible from either nurse's station. It's on the Terrace Level. ASM #2 stated the resident was not deemed an elopement risk before but did enjoy sitting outside under the portico. ASM #2 stated the resident has had a change in condition as she was started on chemotherapy recently for breast cancer. ASM #2 stated the facility has been in touch with the oncology clinic as there has been a change in her cognitive status that occurred once she started chemotherapy. ASM #3 stated that once she got out, they put a PIP (performance improvement plan) in place to ensure this doesn't happen again. They made that entrance a badge only door, meaning it is locked at all times and only a staff member with a badge can let anyone in or out. All visitors are now coming in and out the lower-level entrance where there is a receptionist. ASM #2 stated the nurse that did the Safety Assessment on 6/8/24 told ASM #2 she coded it incorrectly. The QAPI Plan dated 6/17/24. The plan documented as followed: Issue/Concern: Resident was able to get out of the building with(out) staff knowledge. Root Cause Analysis/Related Factors: Lack of elopement assessments and lack of door security. Goals/Objectives/Expected Outcome: Resident will not be able to access the external part of the facility. Correction: Changed the functionality of the locks to code, updated resident elopement assessment. Other Potential: All residents that are high risk for elopement have the potential to be affected. System Changes: Change door functionality to a code. Educate staff on systematic change. Provide a lock to the panel in Shenandoah Gardens that opens the doors to the courtyard. Maintenance to maintain security. Changed the unsupervised exit door security to always remaining locked. Signage placed at exit door reminding visitors not to allow residents out of the facility. Ordered wander guard tester. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynn Care Center	1000 Shenandoah Avenue Front Royal, VA 22630

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monitoring: Discuss daily with IDT (interdisciplinary) team and report findings to QAPI. Date of compliance: 6/21/24. All credible evidence was reviewed. Interviews were conducted with the staff regarding the exit door on the Terrace Level. Observations were made of the door throughout the survey process. The door functioned with a badge reader. ASM #1, ASM #2 and ASM #3 were made aware of the above findings on 7/16/24 at approximately 1:45 p. m. No further information was provided prior to exit. PAST NON-COMPLIANCE