STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Ridge Health & Rehab	189 Monica Blvd 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 0585 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49456 Based on observation, staff interviews, resident interviews, and facility documentation, the facility staff failed to update the grievance officer's information so residents would know with whom to file a grievance on two of two units. The findings included: The facility staff failed to update the postings in the common area on each of the nursing units with the grievance officer's correct information, so the residents would know to whom to file their grievance. On 6/3/24 at 3:00 p.m., a resident council group meeting was conducted, with seven residents in attendance. Residents # 1, 5, 12, 20, 21, 31, and 56 were in attendance and verbalized that they were not aware of who to file a grievance with, if they needed to do file a grievance. On 6/3/24 at 3:45 p.m., an observation was made of two postings with the grievance officer's information. The two postings were located at the nurse's station on each unit. On each of the grievance postings, the grievance official's name, phone number, and address was noted, which identified other staff #8 as the grievance officer. On 6/3/24 at 4:00 p.m., an interview was conducted with staff members. When questioned about other staff #8 being the grievance officer as posted, the director of nursing (DON), licensed practical nurse (LPN#4), and the unit manager (LPN#5) verbalized that they did not know that person and that other staff #8 no longer worked at the facility. On 6/4/24 at 3:45 p.m., an end of day meeting was conducted. The administrator was at the meeting and verbalized that he was presently the grievance officer and had been the grievance officer for over four years. The regional nurse consultant verbalized that it had been a long time since the grievance officer on the posting was employed there at the facility. (continued on next page)

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
	495411	A. Building B. Wing	06/05/2024

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Many	On 6/5/24, a facility documentation review was conducted. The policy titled, Resident Grievances and Concerns Policy, read in part, The facility will make available to all residents via a posting in a prominent location in the facility, information of the right to file grievances orally or in writing; the right to file grievances anonymously; contact information for the Grievance Official; a reasonable time frame for completing the review of the grievance. Grievance Official is the person designated by the Administrator to receive all grievances to be investigated by the Grievance Committee. On 6/5/24 at 11:00 a.m., an exit conference was conducted. The administrator, DON, and regional nurse consultant attended the exit conference, and no additional information was provided prior to the exit conference.

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	495411	A. Building B. Wing	06/05/2024

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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 0658 Level of Harm - 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** 49371 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to follow professional standards of practice during medication administration, that resulted in harm for 1 of 21 residents in the survey sample. (Resident # 33 - R 33). The findings include: Facility staff administered medications to R33 that had been ordered for another resident, R15, who was her roommate. The nurse that prepared the medications gave the medication to another nurse to administer, which resulted in R33 receiving medications not intended or ordered for her, requiring hospitalization , which is harm. On 6/4/24 and 6/5/24, a clinical record review was conducted of R33's chart. This review revealed that on 1/12/24 R33 was transferred to the ER (emergency room) for treatment after receiving medications that had been ordered for R15. Per the 1/12/24 ER records, R 33 was administered atropine by emergency medical services, while in route to the ER, and was admitted with diagnoses that included: 1. Acute metabolic encephalopathy (due to accidental ingestion of several medications that were not prescribed for her) 2. Medication administered in error (resident was accidentally given amlodipine 10 mg, digoxin 125 mcg 1 1/2 tabs, Lasix 40 mg, iron 325 mg, potassium chloride 10 meq, Seroquel 75 mg, enalapril 20 mg, Klonopin 0. 25 mg, docusate, Eliquis 5 mg) 3. Supratherapeutic INR (abnormal coagulation profile . supratherapeutic INR after receiving Coumadin and Eliquis, presented with an INR 4.93. Goal INR 2-3 in the setting of chronic A-fib.) 4. Accidental clonazepam poisoning (poisoning by benzodiazepines, accidental) 5. Accidental digoxin overdose (Digoxin level 0.8) While at the ER, R33 received a CT scan of her brain/head, chest x-ray, cardiac monitoring via telemetry, labs and was given intravenous fluids. Following treatment and stabilization, R33 was discharged to return to the facility on [DATE]. On 6/4/24, a review of the facility event summary report revealed that on 1/12/24 a licensed nurse (Licensed practical nurse-LPN #7) was overseeing another licensed nurse (registered nurse - RN#3) in orientation. This event summary revealed that RN #3 prepared R15's medications and then handed the cup of medications to the other nurse (LPN #7), who administered the medications to the wrong resident, R33. According to the summary, the incident was discovered immediately, and reported to the NP, who assessed R33 and subsequently sent R33 to the ED for treatment. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Also, according to the facility documentation, both LPN #7 and RN #3 were immediately suspended, pending investigation, residents who had already received medications from LPN #7 and RN #3 that shift had assessments completed to ensure there was no change in condition, and residents who were able to be interviewed were asked if they had any issues with their medication administration that day. No concerns were identified. On 6/4/24 at 10:30 AM, RN #3 was interviewed regarding the incident. RN #3 stated that she was being orientated to the med cart.by LPN # 7. RN #3 stated she pulled meds for R15 and handed them to LPN #7, who then left the med cart and entered the resident's room. RN #3 stated that when she entered the resident's room, she realized that LPN #7 had given the medications to the wrong resident. RN #3 stated the unit manager and nurse practitioner (NP) were notified and that R33 was sent to ER for treatment. RN#3 stated she was immediately educated on the 5 rights of medication administration and suspended pending investigation. Upon returning to work, RN #3 stated that she received additional education on medication administration. When asked how this could have been avoided, RN #3 stated, You pull what you give and give what you pull, basically nursing 101. On 6/5/24 at 10:24 AM, LPN #3 who was the unit manager was interviewed. LPN #3 stated that the situation was handled by the DON and that since the situation occurred there have been med pass audits, inservices, and med cart audits. LPN #3 stated that the error occurred due to one nurse pulling the medications and another nurse giving the medication. LPN #3 stated that since the incident occurred staff had been instructed that .if you pull it [a medication], you give it. On 6/5/24 at 10:29 AM, LPN #7 was interviewed via phone regarding the incident. LPN #7 stated that she was late arriving to work and that RN #3 was already on the med cart. LPN #7 stated that RN #3 had popped the meds as they were talking about R33. She stated that she took the meds from RN #3 and gave them to R33. LPN #7 stated the error was immediately realized and the NP was notified. LPN #7 stated that as R33 was being monitored, there was a drastic change with her blood pressure and was sent to the ER for treatment. LPN #7 stated she was immediately suspended for 3 days. Since returning to work LPN #7 stated she had been reeducated and observed during med pass administrations. LPN #7 then stated, I know I should not have done it, but we were late, and I was trying to help her (RN3#) out. RN #3 was orientating to supervisor role and was getting used to the med cart. R33 was not interviewed due to severe cognitive impairment. A review was conducted of the facility policy titled General Dose Preparation and Medication Administration. Per the facility policy, prior to administration of medication facility staff should .verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident. Fundamentals of Nursing, by [NAME] directs that The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients. Guidance is given from [NAME] Solutions, Safe Medication Administration Practices, General 10/02/2015. Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. Building B. Wing	06/05/2024

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Additional Guidance from [NAME]'s Nursing Center.com (www.nursingcenter.com) Rights of Medication Administration were noted as: 1. Right patient, 2. Right medication, 3. Right dose, 4. Right route, 5. Right time, 6. Right documentation, 7. Right reason, 8. Right response Reference: Nursing 2012 Drug Handbook. (2012). [NAME] & [NAME]: Philadelphia, Pennsylvania. The facility self-identified the deficient practice, initiated, and implemented a plan of correction, which included: RN #3 and LPN #7 were immediately suspended after reporting the medication error. Nursing staff education provided on 1/12/24 through 1/15/24 that stated, 5 rights of medication administration must be completed for every resident, every medication and that if two nurses are on a med cart for any reason, orienting or sharing responsibility the nurse that prepared and signed the medication off was responsible for ensuring the 5 rights of medication administration was met. This was also added to new hire orientation. The DON/designee was to complete random med pass observations 5 times per week for 4 weeks, then monthly for 2 months. The DON/designee was to randomly interview 3 residents a week for 12 weeks. The DON/designee was to assess 3 random non-interviewable residents 3 x week for 12 weeks to ensure they had no indication of med error changes in condition. The results of the audits were submitted to the QAPI committee. The DON stated the date of correction and compliance was achieved on 5/20/24. During the survey, facility staff were observed during medication administration with no deficient practice noted. The facility Quality Assessment and Performance Improvement Plan and Quality Assessment and Assurance Programs were reviewed, with no deficient practice noted. On 6/5/24, facility nursing staff were interviewed about receiving education on medication administration and were able to voice that they had received education on the 5 rights of administration and that the nurse who prepares and signs the medication is responsible for the 5 rights and giving the medication. The facility's medication administration audits and observations were reviewed. Resident interviews conducted by the facility's DON were reviewed. Inservice attendance records for nursing staff were reviewed. No concerns were found. No further information was provided. During the survey, no additional concerns were identified with regards to professional standards of nursing practice not being followed. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Past non-compliance was achieved on 5/20/24.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure two residents (Resident #70- R70) and (Resident #67- R67), were free from unnecessary psychotropic medications, in a survey sample of 21 residents. The findings included: 1. For Resident #70 (R70), the facility staff failed to limit an order to 14 days for the psychotropic medication Ativan, an antianxiety medication, ordered to be given as needed. On 6/3/24 at 11:51 a.m., R70 was observed in their room and appeared comfortable. On 6/3/24 and 6/4/24, a clinical record review was conducted of R70's chart. This review revealed that R70 had an active physician order for Ativan 0.5 mg tablet to be administered every 4 hours as needed (prn) for anxiety or agitation. The order was written 4/15/24, had no stop date, and at the time of survey, it remained an active order. On 6/4/24 at 2:50 p.m., an interview was conducted with CNA #1 (certified nursing assistant). When asked about R70, CNA #1 said that R70 is a very friendly and cooperative with care. CNA #1 said that R70 had no behaviors but did get anxious at times. On 6/4/24 at 02:53 p.m., an interview was conducted with LPN #6. LPN #6 accessed R70's medication administration record and confirmed that the Ativan was an active order and was ordered to be given every 4 hours as needed. LPN #6 also confirmed that the order did not have a stop date and said, It's been 2 months ago that we got the order for it. When asked about the duration of prn (as needed) orders, LPN #6 said, 15 days, if not used we are to discontinue it. On 6/4/24 at approximately 3:15 p.m., the director of nursing (DON) was made aware of the above findings. The DON confirmed that any psychotropic medications that are ordered prn are to be ordered for no more than 14 days and they must be re-evaluated following 14 days. On 6/4/24 at 9:05 a.m., the DON provided the surveyor with a copy of the order and said she had spoken to the doctor, and it was discontinued on 6/4/24, following notification by the surveyor. The DON stated, The doctor ordered it for comfort and didn't think the resident would live as long as he did. The DON was asked to provide the facility policy related to prn orders for psychotropic medications. On 6/4/24 at 10:15 a.m., the DON stated that the facility did not have a policy related to prn orders for psychotropic medications. On 6/4/24 at approximately 11:15 a.m., the facility administrator was made aware of the above findings. (continued on next page)

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	495411	A. Building B. Wing	06/05/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided. 21875 2. Resident #67 had a prn (as needed) order for the antipsychotic medication Seroquel, which was entered without a stop date and was in place beyond the 14-day limit. Resident #67 (R67) was admitted to the facility with diagnoses that included coronary artery disease, dementia with agitation, mood disorder and hypertension. The minimum data set (MDS) dated [DATE] assessed R67 as cognitively intact. R67's clinical record documented a physician's order dated 4/7/24 for Seroquel 25 mg (milligrams) with instructions to give 1/2 tablet every 8 hours as needed (prn) due to dementia/psychosis. The clincal record revealed that the order was entered with no stop date and was in place for 30 days prior to being discontinued on 5/8/24 in response to a pharmacy recommendation. R67's clinical record documented no physician and/or nurse practitioner assessments indicating the need/rationale for the prn Seroquel use beyond a 14-day limit. On 6/4/24 at 10:58 a.m., the director of nursing (DON) was interviewed about R67's prn Seroquel order that had been in place without a stop date. The DON stated the prn Seroquel order was entered when the resident was admitted on [DATE]. The DON stated the order was entered without a stop date and was not discontinued until 5/8/24. The Nursing 2022 Drug Handbook on pages 1250 and 1251 describes Seroquel as an antipsychotic medication used for the treatment of schizophrenia and bipolar disorder/depression. This reference documents on page 1252 that Seroquel has a Black Box Warning stating, The risk of death is increased in elderly patients with dementia-related psychosis. Quetiapine [Seroquel] isn't approved for the treatment of patients with dementia-related psychosis (1) This finding was reviewed with the administrator, DON, and regional consultant during a meeting on 6/4/24 at 4:00 p.m. with no further information presented prior to the end of the survey. (1) Woods, [NAME] Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49371 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure that 1 of 21 residents in the survey sample were free of significant medication errors, which resulted in harm (Resident # 33 - R 33). The findings include: Facility staff administered medications to R33 that had been ordered for another resident, R15, who was the roommate. The nurse that prepared the medications gave the medication to another nurse to administer, which resulted in R33 receiving medications not intended or ordered for her. resulting in hospitalization , which caused harm. According to the clinical record, R33 had diagnoses that included dementia, muscle weakness, hypertension, major depressive disorder, long term use of anticoagulants, and chronic atrial fibrillation. The most recent minimum data set, which was a quarterly assessment, assessed R33 with severe cognitive impairment. On 6/4/24 and 6/5/24, a clinical record review was conducted of R33's chart. This review revealed that on 1/12/24 R33 was transferred to the ER (emergency room) for treatment after receiving medications that had been ordered for R15. Per the ER records, R 33 received atropine by emergency medical services while in route to the ER and was admitted with diagnoses that included: 1. Acute metabolic encephalopathy (due to accidental ingestion of several medications that were not prescribed for her) 2. Medication administered in error (resident was accidentally given amlodipine 10 mg, digoxin 125 mcg 1 1/2 tabs, Lasix 40 mg, iron 325 mg, potassium chloride 10 meq, Seroquel 75 mg, enalapril 20 mg, Klonopin 0. 25 mg, docusate, Eliquis 5 mg) 3. Supratherapeutic INR (abnormal coagulation profile) (supratherapeutic INR after receiving Coumadin and Eliquis, presented with an INR 4.93. Goal INR 2-3 in the setting of chronic A-fib.) 4. Accidental clonazepam poisoning (poisoning by benzodiazepines, accidental) 5. Accidental digoxin overdose (Digoxin level 0.8) While at the ER, R33 received a CT scan of her brain/head, chest x-ray, cardiac monitoring via telemetry, labs and was given intravenous fluids. Following treatment and stabilization, R33 was discharged to return to the facility on [DATE]. (continued on next page)

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	495411	A. Building B. Wing	06/05/2024

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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 0760 Level of Harm - Actual harm Residents Affected - Few	On 6/4/24, a review of the facility event summary report revealed that on 1/12/24 a licensed nurse (Licensed practical nurse-LPN #7) was overseeing another licensed nurse (registered nurse - RN#3) in orientation. This event summary revealed that RN #3 prepared R15's medications and then handed the cup of medications to the other nurse (LPN #7), who administered the medications to the wrong resident, R33. According to the summary, the incident was discovered immediately, and reported to the NP, who assessed R33 and subsequently sent R33 to the ED for treatment. Also, according to the facility documentation, both LPN #7 and RN #3 were immediately suspended, pending investigation, residents who had already received medications from LPN #7 and RN #3 that shift had assessments completed to ensure there was no change in condition, and residents who were able to be interviewed were asked if they had any issues with their medication administration that day. No concerns were identified. On 6/4/24 at 10:30 AM, RN #3 was interviewed regarding the incident. RN #3 stated that she was being orientated to the med cart.by LPN # 7. RN #3 stated she pulled meds for R15 and handed them to LPN #7, who then left the med cart and entered the resident's room. RN #3 stated that when she entered the resident's room, she realized that LPN #7 had given the medications to the wrong resident. RN #3 stated the unit manager and nurse practitioner (NP) were notified and that R33 was sent to ER for treatment. RN#3 stated she was immediately educated on the 5 rights of medication administration and suspended pending investigation. Upon returning to work, RN #3 stated that she received additional education on medication administration. When asked how this could have been avoided, RN #3 stated, You pull what you give and give what you pull, basically nursing 101. On 6/5/24 at 10:24 AM, LPN #3 who was the unit manager was interviewed. LPN #3 stated that the situation was handled by the DON and that since the situation occurred there have been med pass audits, inservices, and med cart audits. LPN #3 stated that the error occurred due to one nurse pulling the medications and another nurse giving the medication. LPN #3 stated that since the incident occurred staff had been instructed that .if you pull it [a medication], you give it. On 6/5/24 at 10:29 AM, LPN #7 was interviewed via phone regarding the incident. LPN #7 stated that she was late arriving to work and that RN #3 was already on the med cart. LPN #7 stated that RN #3 had popped the meds as they were talking about R33. She stated that she took the meds from RN #3 and gave them to R33. LPN #7 stated the error was immediately realized and the NP was notified. LPN #7 stated that as R33 was being monitored, there was a drastic change with her blood pressure and was sent to the ER for treatment. LPN #7 stated she was immediately suspended for 3 days. Since returning to work LPN #7 stated she had been reeducated and observed during med pass administrations. LPN #7 then stated, I know I should not have done it, but we were late, and I was trying to help her (RN3#) out. RN #3 was orientating to supervisor role and was getting used to the med cart. R33 was not interviewed due to severe cognitive impairment. A review was conducted of the facility policy titled General Dose Preparation and Medication Administration Per the facility policy prior to administration of medication facility staff should verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident. Fundamentals of Nursing, by [NAME], stated The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients. (continued on next page)

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	495411	A. Building B. Wing	06/05/2024

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Guidance is given from [NAME] Solutions, Safe Medication Administration Practices, General 10/02/2015. Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions. Additional Guidance from [NAME]'s Nursing Center.com (www.nursingcenter.com) Rights of Medication Administration were noted as: 1. Right patient, 2. Right medication, 3. Right dose, 4. Right route, 5. Right time, 6. Right documentation, 7. Right reason, 8. Right response Reference: Nursing2012 Drug Handbook. (2012). [NAME] & [NAME]: Philadelphia, Pennsylvania. The facility self-identified the deficient practice, initiated, and implemented a plan of correction, which included: RN #3 and LPN #7 were immediately suspended after reporting the medication error. Nursing staff education provided on 1/12/24 through 1/15/24 that stated, 5 rights of medication administration must be completed for every resident, every medication and that if two nurses are on a med cart for any reason, orienting or sharing responsibility the nurse that prepared and signed the medication off was responsible for ensuring the 5 rights of medication administration was met. This was also added to new hire orientation. The DON/designee was to complete random med pass observations 5 times per week for 4 weeks then monthly for 2 months. The DON/designee was to randomly interview 3 residents a week for 12 weeks. The DON/designee was to assess 3 random non-interviewable residents 3 x week for 12 weeks to ensure they had no indication of med error changes in condition. The results of the audits were submitted to the QAPI committee. The DON stated the date of correction and compliance was achieved on 5/20/24. During the survey, facility staff were observed during medication administration with no deficient practice noted. The facility Quality Assessment and Performance Improvement Plan and Quality Assessment and Assurance Programs were reviewed, with no deficient practice noted. On 6/5/24 facility nursing staff were interviewed about receiving education on medication administration and were able to voice that they had received education on the 5 rights of administration and that the nurse who prepares and signs the medication is responsible for the 5 rights and giving the medication. The facility's medication administration audits and observations were reviewed. Resident interviews conducted by the facility's DON were reviewed. Inservice attendance records for nursing staff were reviewed. (continued on next page)

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	495411	A. Building B. Wing	06/05/2024

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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 0760 Level of Harm - Actual harm Residents Affected - Few	No further information was provided. During the survey, no additional concerns were identified with regards to professional standards of nursing practice not being followed. Past non-compliance was achieved on 5/20/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495411	A. Building B. Wing	06/05/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 21875 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to accurately label a medication and discard an expired medication on one of two units (skilled unit). The findings include: 1. The medication metoprolol administered to Resident #132 during a medication pass observation was labeled with an incorrect dosage. A medication pass observation was conducted on 6/4/24 at 7:39 a.m., with licensed practical nurse (LPN #2) administering medications to Resident #132 (R132). Among the medications administered was a half tablet of metoprolol 25 mg (milligrams) for a 12.5 mg dose. R132's pharmacy supply card of metoprolol was labeled with instructions to give 25 mg twice per day. There was nothing documented on the supply card label indicating the half tablet (12.5 mg) dose or of any recent dose change. R132's clinical record documented a physician's order dated 5/30/24 for metoprolol 25 mg with instructions to give 1/2 (one half) tablet twice per day for treatment of hypertension. On 6/4/24 at 8:26 a.m., LPN #2 was interviewed about the metoprolol label not matching the current 12.5 mg dose. LPN #2 stated the resident was previously on 25 mg twice per day and the order was changed on 5/30/24 to 25 mg half tablet (12.5 mg) twice per day. LPN #2 stated the new order was sent to pharmacy, but the half tablets had not been supplied and the label not changed. LPN #2 stated the tablets were scored so she cut the tablet in half to give the proper dose. LPN #2 stated she did not know why the label and/or new half tablet supply were not provided by pharmacy. On 6/4/24 at 9:20 a.m., the pharmacy manager (other staff #4) was interviewed about R132's metoprolol label not matching the ordered dosage. The pharmacy manager stated R132's metoprolol order was changed on 5/30/24 from 25 mg to 12.5 mg twice per day. The pharmacy manager stated when the 12.5 mg order was entered, the insurance company did not approve a new supply of tablets, so the facility was to cut the whole tablets in half to meet the dose requirements and consume the current supply. When asked about the pharmacy label indicating the discontinued dose, the pharmacy manager stated stickers were available to place on supply cards alerting nursing staff of a recent dose or instruction change. On 6/4/24 at 9:57 a.m., the administrator stated that the pharmacy had no written policy regarding use of the dose change alert stickers but that the stickers were available for use. This finding was reviewed with the administrator, director of nursing and regional consultant during a meeting on 6/4/24 at 4:00 p.m. with no further information provided prior to the end of the survey. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49371 2. Failed to ensure expired medications were discarded on 1 of 2 units, the skilled unit. Findings were: During a medication storage review conducted on 6/5/24 at 8:54 AM, the medication cart on the skilled unit was reviewed with licensed practical nurse (LPN # 2). A floor stock bottle of psyllium husk powder was noted to have a manufacturer's expiration date of 3/24. LPN # 2 also reviewed the medication and verbalized that the medication should have been discarded. LPN # 2 then removed the medication from the cart. A facility policy titled Storage and Expiration Dating of Medications, Biologicals read in part 4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. On 6/5/24 at 11:00 AM the above information was presented to the director of nursing and the administrator. No further information was obtained prior to the exit conference on 6/5/24.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41449 Based on observation, resident and staff interviews, and facility documentation review, the facility staff failed to follow the posted menu, affecting residents on 2 of 2 nursing units. The findings included: The facility staff failed to follow the posted menu with regards to the vegetable. On 6/3/24 at 3 p.m., the resident council met with a surveyor. During the meeting, residents verbalized that they do not get what is posted on the menu. On 6/3/24 at approximately 4 p.m., observations were made of the menu posting on each of the resident units. The evening meal was listed as chicken tenders, greens, and macaroni and cheese. On 6/3/24, in the afternoon, the menu was reviewed, and it listed the evening meal as being chicken tenders, seasoned greens, macaroni and cheese, and fresh fruit cup. On 6/3/24 at 04:24 p.m., observations were conducted in the kitchen of the evening meal that was being prepared by the cook/other staff #6 (OS #6). The cook said that she was preparing broccoli because they didn't have greens. When asked what the process is when they do not have what is on the menu to prepare. The cook said, Since it was greens, I try to stick with something green, he [the dietary manager] said he thought he saw greens on shelf. The surveyor asked the cook if they have a substitution log, the cook said, what do you mean by that? The cook was asked if she doesn't have something on the menu to prepare, does she have to have someone approve it, she said, No. On 6/3/24 at approximately 4:30 p.m., the dietary manager/other staff #5 (OS #5) was interviewed and asked about when items are not available on the menu. The dietary manager said, We try to stay as close to the menu as we can. When asked if there is a substitution log, the manager said, There should be one in the back. When the dietary manager was accompanied to the food prep area, a 3-ring binder was observed on a table next to the oven, which was found to contain the substitution logs, but were last filled out on 2/10/2022. On 06/04/24 at 02:10 p.m., an interview was conducted with the registered dietician/RD (other staff #7- OS #7). The RD said that substitutions are to be put in the logbook so that she can review and sign off on them to ensure substitutions are nutritionally equivalent. When asked if that is being done at this facility, she stated, No. A review was conducted of the facility policy titled, Menu Substitution(s) Policy. The policy read in part, All changes to the menu (including date, menu item substitution, and reason for the substitution) will be recorded on the Menu Substitution Form. Posted menus will be updated to reflect menu substitutions as soon as possible to notify residents of changes. Menu changes should be evaluated periodically by the RD/DTR [registered dietician], and an appropriate plan of action made to correct any concerns . (continued on next page)

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	495411	A. Building B. Wing	06/05/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/04/24 at 3:47 p.m., during an end of day meeting the facility Administrator and Director of Nursing (DON) were made aware of the above concerns. No additional information was provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41449 Based on observations, resident and staff interviews, and facility documentation review, the facility failed to provide foods that were at appetizing temperatures on two of two nursing units, affecting multiple residents. Findings include: The facility staff failed to serve foods at an appetizing temperature on the long-term care unit. On 6/3/24 at 3 p.m., a meeting was held with the resident council, of which seven residents were in attendance. During the meeting, the residents verbalized that the food is not hot. On 6/3/24 at 3:15 p.m., an interview was conducted with Resident #51 (R51) who stated, The food is lukewarm, coffee is not hot. I could probably get someone to heat it up or get me another cup, but then you have to wait. On 6/3/24 at 4:24 p.m., observations were conducted in the kitchen. The dietary manager was asked how coffee was prepared and distributed to residents. The dietary manager explained that coffee is brewed in the kitchen, cooled with ice, and then put into coffee dispensers that are sent to the dining room. The dietary manager stated that from the dining room, the nursing staff fill coffee cups and distribute them to residents. On 6/4/24 at 7:45 a.m., the tray line in the kitchen was observed for the breakfast meal. At 8:01 a.m., a test tray was prepared and placed on the last meal cart, which was for the 100 hall, leaving the kitchen immediately after the test tray was prepared. The facility staff were then observed in the dining room, filling cups with coffee from a coffee dispenser, then placing them on the meal trays, uncovered, and then distributing the trays to resident rooms. The dietary manager and surveyor noted that the residents on the 100 hall were the last residents being served. At 8:25 a.m., there were 3 resident trays remaining on the cart to be distributed so the test tray was swapped with a resident tray and the temperature of the foods were taken. The temperatures were noted as follows: milk. 52.5 degrees farenheight, coffee 126.7 degrees farenheight, eggs 107 degrees farenheight, oatmeal 131.7 degrees farenheight, biscuit: 106.5 degrees farenheight. Following the above observation and taking the temperatures of the test tray, the dietary manager was asked what he thought of the temperatures. The dietary manager stated the temperatures were a little low but added, It is breakfast foods, which don't hold heat too well. Review of the related food policies revealed two policies that addressed food temperature being served to the residents. One was the policy titled Food Brought in From Outside the Facility Policy, which addressed reheating of foods and specificed that . goal temp is 130-155 when served The second policy titled, Food Temperatures Policy, read in part, Hot food should be palatable at point of delivery. (continued on next page)

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	495411	A. Building B. Wing	06/05/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Food and Drug Administration's Food Code 2017: 7 Recommendations of the United States Public Health Service Food and Drug Administration, reviewed and current as of 03/2022, read in part, Foodborne illness in the United States is a major cause of personal distress, preventable illness, and death . Epidemiological outbreak data repeatedly identify five major risk factors related to employee behaviors and preparation practices in food service settings as contributing to foodborne illness: Improper holding temperatures, Inadequate cooking, such as undercooking raw shell eggs, Contaminated equipment, Food from unsafe sources, and Poor personal hygiene . The Food Code addresses controls for risk factors and further establishes 5 key public health interventions to protect consumer health. Specifically, these interventions are demonstration of knowledge, employee health controls, controlling contamination, and time and temperature parameters for controlling pathogens. 3-202.11 Temperature. (A) Except as specified in (B) of this section, refrigerated temperature control for food safety will be maintained at a temperature of 5oC (41oF) or below when served/received. (D) Temperature control for food safety of cooked foods that is cooked to a temperature and for a time specified under SS 3-401.11 - 3-401.13 and received hot shall be at a temperature of 57oC (135oF) or above. On 6/4/24 at 3:45 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No further information was provided.

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	495411	A. Building B. Wing	06/05/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, staff interview, and facility documentation review, the facility staff failed to store and prepare food in accordance with food safety standards in the main kitchen having the potential to affect residents on 2 of 2 resident care units. The findings included: 1. The facility staff failed to store foods in a manner to prevent contamination and failed to label and date items in the freezer and refrigerators. On [DATE] at 10:35 a.m., an initial tour of the kitchen was conducted with the dietary manger. This observation revealed that in the dry storage room there was two bags of pasta that were open to air. One bag of pasta had the bag tied but a hole had also been ripped into the bag. Neither bag was dated as to when they were opened. There was also a bag of brown sugar that was open to air and didn't have any date as to when it was opened, or when it was to be used by. When asked how such items were expected to be stored, the dietary manager stated, In a re-usable bag. There were three containers that held dry cereal that had been removed from the original package, two of the containers had no date. When asked about the dating of items, the dietary manager said, I'm not sure dry goods need to be labeled, I will have to check the code. On [DATE] at 11:09 a.m., an additional observation was conducted of the dry food storage area. There was a package of sausage gravy, and a package of brown gravy that had both been placed in storage bags that were not secured and were open to air. Neither of the packages had any dates as to when they were opened or to be used by. There was a package of pink lemonade drink mix that was open to air and without any dates. There was a bag of powdered sugar that had been stored in a zip lock bag but didn't have any dates. There was also a package of flour tortilla shells that were in a zip lock bag that was not closed, leaving the contents open to air, and that had not been labeled with any dates of when the items were opened, or to be used by. On [DATE] at 02:10 p.m., an interview was conducted with the facility's registered dietician (RD). The RD confirmed that the expectation was that all items are to be closed and dated with the date opened. When asked why the dates are important, the RD said, So we know when to use it by. A review was conducted of the facility policy titled, Storage of Dry Food Policy. The policy read in part, . 7. When original packaging is opened food must be stored in containers intended for food that are durable, leak-proof, that can be sealed or covered. 8. Except when holding food that can be unmistakable recognized such as dry pasta, containers will be identified with the common name of the food item and date opened . The CFR [Federal code] read, ,d+[DATE].11 Food Storage .D. A date marking system that meets the criteria . (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded (continued on next page)

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	495411	A. Building B. Wing	06/05/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 2017 Food Code published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section ,d+[DATE].15, page 64 stated: Package Integrity. Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants. On [DATE] at 3:45 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided. 2. The facility staff failed to ensure expired food items were removed and were not available to be served to residents. On [DATE] at 10:35 a.m., observations were conducted of the facility's main kitchen. The dietary manager was present for the walk-through. In the dry storage area there was a container had colored rings of dry cereal, that appeared to be fruit loops. It had a date of [DATE], which was the date opened, and a use by date of [DATE]. Observation of the walk-in cooler revealed skim milk with an expiration date of [DATE], which was the day of the inspection. On [DATE] at 7:45 a.m., the tray line in the kitchen was observed for the breakfast meal. During this observation, facility staff had milk at the side of the tray line, where they were using the supply to put on resident trays. Observations were noted that there were four cartons of milk with an expiration date of [DATE], that were available to be served to residents. The dietary aide stated she had not noticed the milk had expired. During the above observations, the dietary manager removed the expired milk and discarded it in the trash. The dietary manager said he would talk to the milk supplier, because they are supposed to give us 10 days out [referring to the expiration date being 10 days past the date of delivery]. On [DATE] at 02:10 p.m., an interview was conducted with the facility's registered dietician (RD). The RD confirmed that the expectation was for all items to be closed and dated with the date opened. When asked why the dates are important, the RD said, so we know when to use it by. The food storage policies of the facility were reviewed and didn't address the use of expired food items. According to SERV Safe Fourth Edition manual page ,d+[DATE] read, When food is stored improperly and not used in a timely manner, quality and safety suffer Page ,d+[DATE] stated, Discard food that has passed the manufacturer's expiration date. On [DATE] at 3:45 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The facility staff failed to properly dry dishes to prevent the development of microorganism growth. On [DATE] at 10:35 a.m., observations were conducted of the facility staff washing dishes. It was noted that a dietary aide was observed removing dishes from the dish washer and immediately stacking them, while wet. This was with the tulip bowls, which were stacked, and then turned upside down and placed on the shelf above the steam table. The surveyor observed water running from the bowls as they were inverted. The dietary manager and surveyor observed the bowls and confirmed that water was in them. The dietary manager stated that this was wet nesting and could allow the growth of bacteria. Review of the facility policy titled, Manual Ware Washing Policy read in part, . 14. Pan(s), utensils, etc., shall be allowed to air-dry on sanitized drain board/rack/cart. Wet pans, dishes, and other small wares shall not be stacked until they are allowed to air dry . According to the 2017 Food Code published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 4, section ,d+[DATE].11, titled Equipment and Utensils, Air-Drying Required pages , d+[DATE] stated: After cleaning and sanitizing, equipment, and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food; and (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry. On [DATE] at 3:45 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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	495411	A. Building B. Wing	06/05/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview and clinical record review, the facility staff failed to ensure an accurate clinical record for one of twenty-one residents in the survey sample (Resident #68) The findings include: Resident #68 (R68) was admitted to the facility with diagnoses that included anemia, atrial fibrillation, diabetes and arthritis. The minimum data set (MDS) dated [DATE] assessed R68 as cognitively intact. R68's clinical record documented a Durable Do Not Resuscitate Order signed by the physician and resident on 5/19/24. R68's clinical record also documented an Advance Care Planning Tracking Form dated 5/21/24 for Resident #73. Resident #73's Advance Care Planning Tracking Form documented a verified full code status and was dated 5/21/24. On 6/4/24 at 10:54 a.m., the medical records clerk (other staff #1) was interviewed about R73's advance directive checklist found in R68's clinical record. The medical records clerk stated that the social services department was responsible for entering forms regarding resuscitation status into the clinical record. On 6/4/24 at 11:37 a.m., the social services director (other staff #2) was interviewed about R68's record including R73's advance directive checklist. The social services director stated R73's advance directive form, verifying a full code status, was scanned and entered into the wrong clinical record. The social services director stated R73's documents should not have been saved to R68's clinical record. This finding was reviewed with the administrator, director of nursing and regional consultant during a meeting on 6/4/24 at 4:00 p.m. with no further information provided prior to the end of the survey.