STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. Building B. Wing	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynchburg Health & Rehabilitation Center	5615 Seminole Avenue Lynchburg, VA 24502

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29123 Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility failed to ensure one of fifty-eight residents in the survey sample did not have a significant weight loss, and failed to ensure six of fifty eight residents received tube feeding and flushes for hydration as ordered by the physician. Resident #204 lost a total of 57.7 pounds (23.89%) from the time of admission on 08/07/2021 until his hospital admission on 10/24/2021. The significant weight loss was not identified by facility staff and no nutrition interventions were put into place to prevent further loss, resulting in harm. Residents #208, #209, #210, #247, #201 and #222 did not receive tube feedings or flushes for hydration from 7:00 p.m. on 02/07/2022 until 07:00 a.m. on 02/08/2022. Findings were: 1. Resident #204 was admitted to the facility on [DATE] with diagnoses including but not limited to: syphilis, multiple sclerosis, encephalopathy, hypertension, and dementia. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 09/07/2021 assessed Resident #204 as severely impaired with a cognitive summary score of 05. Under section K0200 Height and Weight Resident #204's height was listed as 70 inches, no weight was recorded, and section K0300 Weight Loss was coded as No or unknown. Resident #204's clinical record was reviewed on 02/08/2022 beginning at approximately 2:00 p.m and included the following: An admission assessment dated [DATE] which included, F. Cardiac/Circulation and assessed Resident #204's Pulse as Regular rate and rhythm. Also, under Section F were questions regarding edema: Edema present, Location of Edema, Pitting, none of those questions were marked as present. Resident #204's capillary refill was documented as (symbol meaning less than or equal to) 3 sec (seconds) -Normal. A Rehabilitation Services Screen was completed by the speech language patholigist on 08/09/2021. A speech therapy evaluation was not recommended. The current diet order was Heart Healthy diet Level 7 - Regular texture, Regular Liquids consistency. No fluid restriction was ordered. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The current care plan included, Nutrition Risk r/t (related to) recent hospitalization , medical dxs (diagnoses), therapeutic diet d/t HTN (due to hypertension) and edema, elevated BMI. Focus: Resident will avoid significant weight change through next review. Interventions included: Weights per protocol, Monitor/document/report PRN (as needed) s/sx of dysphagia (difficulty swallowing) . The following weights were recorded: 08/07/2021 242.88 lbs (pounds) 09/01/2021 241.2 lbs 10/04/2021 198.3 lbs The weight from 10/04/2021 had been stricken through and a note from the RD (registered dietitian) was written on 10/07/2021 indicating, Incorrect Documentation. There were no other weights in the clinical record. A Malnutrition Universal Screening Tool was completed for Resident #204 on 08/09/2021, 08/24/2021, and 09/06/2021. All three tools documents were identical using the admission weight from 08/07/2021. Resident #204 was assessed with a BMI (body mass index) score of greater than 20, no unplanned weight loss in the past 3-6 months, and the question Is the patient acutely ill and there has been or is likely to be no nutritional intake for > 5 days? was marked as No. All three documents were completed by the RD. There was no other nutrition assessment or documentation by the RD. The following note was written on 10/07/2021, Culinary Director spoke to resident at bedside about the dining program and reviewed food preferences. Dietary management system updated and IDT (inter-disciplinary team) will honor resident's preferences and requests. Culinary Director if available to follow up with resident to review food preferences as consulted or requested. A note written on 10/21/2021 documented, Ate 50% or less for 2 or more meals in one day. Offered a snack after meal. There were no other notes in the clinical record regarding meal/ fluid intake or weights. At approximately 2:30 p.m. on 02/08/2022, the DON (director of nursing) was interviewed about the weight protocol used by the facility. She stated, We weigh everyone within 24 hours of admission, weekly for four weeks, and everyone is weighed at least monthly unless they refuse .if they refuse we document that in the progress notes. Then we notify the physician and the RP (responsible party) and of course we try again later or the next day. Resident #204 was sent to a local hospital on 10/24/2021 after being observed by the nursing staff as very lethargic, cold to touch with shallow breathing. A progress noted in the clinical record dated 10/25/2021 documented: Resident admitted for AKI (acute kidney injury), hypernatremia, septic shock, dehydration, elevated troponins, chronic encephalopathy. Hospital records were reviewed. The emergency department note written on 10/24/2021 documented that Resident #204 weighed 84 kilograms (185.18 pounds) at the time of arrival to the emergency room . A difference of 57.7 pounds (23.8%) since his admission to the facility on [DATE]. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 02/10/2022 at 10:45 a.m., the RD was interviewed regarding Resident #204. He was asked why he had marked through the weight recorded in the clinical record on 10/04/2021. He stated, I am sure we discussed that as a team. I marked through it because it is very unlikely that someone would lose that much weight in a month .it was likely to be inaccurate. We usually weigh the residents on Monday and then we meet on Thursdays .he should have been reweighed before that meeting. The RD was asked if he had asked for a reweigh on Resident #204. He stated, No, I don't ask for reweights. He was asked if he felt marking through a licensed nurse's documentation and labeling it as inaccurate without discussing it with the nurse was appropriate. He stated, The resident's weight was stable for the first month, it is unlikely that he lost 50 pounds in one month. The RD was informed of Resident #204's weight at the time of admission to the hospital. He stated, I don't know that I would have done anything differently .the policy states the weight will be verified within five days when there is a variance of five pounds .nursing should have reweighed him. The RD was asked how he knew whether or not the weight he struck was a reweight. He stated, That's a good point. The nurse practitioner that cared for Resident #204 was interviewed on 02/10/2022 at 11:45 a.m. She was asked if she had noticed Resident #204 losing weight. She stated, I only saw him acutely when something happened .I saw him in August for behaviors, in September because he broke his glasses and he had a sore on his nose, and again because he had a fall. I did his recert in October and I used the weight from September .I didn't notice that his weight didn't look right .If I see someone for weights it is because it has been brought to my attention by the nursing staff or the RD. I don't remember anyone mentioning that. On 02/10/2022 at 12:10 p.m., during a meeting with the DON, the administrator and two corporate nurse consultants, the above information was discussed. Concerns were voiced that Resident #204 had lost 23.8% of his body weight while at the facility; weights were not obtained per facility protocol; and weights had been marked through in the clinical record by the RD without follow-up. There was no documentation in the clinical record regarding Resident #204 refusing to eat, refusing to be weighed, or any interventions to monitor his weight and/or prevent weight loss. The DON was asked what should have happened. She stated, He should have been weighed per our policy, a reweight should have been obtained. LPN #1 who documented the weight on 10/04/2021 that was marked through by the RD was interviewed on 02/10/2022 at approximately 2:40 p.m. She was asked if she remembered Resident #204. She confirmed that she did. She was asked about the weight obtained on 10/04/2021 and if a reweight had been obtained due to the difference of 44 pounds since the previous weight. She stated, I am sure that was the reweight. She was asked if Resident #204 had been refusing to eat. She stated, He fed himself, I don't remember him refusing to eat. On 02/20/2022, at approximately 2:45 p.m., CNA (certified nursing assistant) #2 was interviewed about Resident #204. She stated, I never took care of him .but I remember him. He drank his drinks, sometimes he refused to eat. She was asked if the nursing staff had been notified that he refused to eat and how often that happened. She stated, I'm not sure how often it happened, I don't know if anyone told the nurses or not. At 3:00 p.m. on 02/10/2022 two additional CNAs were interviewed about Resident #204. CNA #4 stated that she had taken care of Resident #204, He fed himself, he hardly ate . CNA #5 stated, He was mean, he ate a lot of fruit. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The policy Weight Monitoring and Tracking dated 11/01/2019 contained the following: The Director of Nursing is responsible for ensuring patients are weighed in a timely manner .Nursing staff is responsible for recording weight in the patient medical record; All patients will be weighed on admission/readmission and weekly X 4 weeks, or until the interdisciplinary team determines weight is stable, then monthly thereafter if weight is stable; Weights will be verified within five days when a weight variance of 5 # (pounds) from last weight and/or significant weight change is identified. No further information was obtained prior to the exit conference on 02/10/2022. 2. Resident #208 was admitted to the facility on [DATE] with the following diagnoses, including but not limited to: dysphagia, hemiplegia, acute kidney failure, depression, and hypertension. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/20/2021, assessed Resident #208 as having problems with both long and short term memory and severely impaired with daily decision making skills. Resident #208's clinical record included the following physician orders: Enteral Feed Order every 4 hours 220 ml H2O flush via PEG tube Enteral Feed Order every 4 hours Osmolite 1.5 @ 237 ml bolus feed via PEG tube The care plan was reviewed and included, The resident requires tube feeding r/t (related to) dysphagia, swallowing problem. He is at risk for aspiration with lowering HOB (head of bed) . Interventions included: Provide TF (tube feeding) per order; Provide water flushes per MD order. Review of Resident #208's February MAR (medication administration record) documented water flushes were not provided at 8:00 p.m. on 02/07/2022, or at midnight and 4:00 a.m. on 02/08/022, for a total of 660 cc of water not given. Resident #208 also did not receive Osmolite 1.5 bolus feedings at 8:00 p.m. on 02/07/2022, or at midnight and 4:00 a.m. on 02/08/2022, for a total of 711 cc (1066.5 calories) of tube feeding not provided. 3. Resident #209 was admitted to the facility on [DATE] with the following diagnoses, including but not limited to: cerebral infarct, hemiplegia, aphasia, and hypertension. A quarterly MDS with an ARD of 12/23/2021, assessed Resident #209 as having problems with both long and short term memory and severely impaired with daily decision making skills. Resident #209's clinical record included the following physician orders: Enteral Feed Order every 4 hours 200 ml H2O flush via PEG tube Enteral Feed Order every 4 hours Osmolite 1.5 @ 237 ml bolus feed via PEG tube The care plan was reviewed and included, The resident requires tube feeding r/t dysphagia. Interventions included: Provide TF per order; Provide water flushes per MD order. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #209's February MAR documented water flushes were not provided at 8:00 p.m. on 02/07/2022, or at midnight and 4:00 a.m. on 02/08/022, for a total of 600 cc of water not given. Resident #208 also did not receive Osmolite 1.5 bolus feedings at 8:00 p.m. on 02/07/2022, or at midnight and 4:00 a. m. on 02/08/2022, for a total of 711 cc (1066.5 calories) of tube feeding not provided. 4. Resident #210 was admitted to the facility on [DATE] with the following diagnoses, including but not limited to: cerebral infarct, Alzheimer's, adult failure to thrive, and dysphagia. A quarterly MDS with an ARD of 11/29/2021, assessed Resident #210 as having problems with both long and short term memory and severely impaired with daily decision making skills. Resident #210's clinical record included the following physician orders: Enteral Feed Order every 4 hours 300 ml H2O flush via PEG tube Enteral Feed Order 4 times per day for nutrition Jevity 1.5 Cal @ 237 ml bolus via PEG tube The care plan was reviewed and included,The resident requires tube feeding r/t inability to consume adequate po (by mouth) to maintain weight, and adequate nutritional status d/t (due to) feeding problems r/t dx (diagnoses) dementia, multiple CVA (cerebral vascular accidents), slightly elevate BMI. Interventions included: Provide TF per order; Provide water flushes per order. Review of Resident #210's February MAR documented water flushes were not provided at 10:00 p.m. on 02/07/2022, or at 2:00 a.m. and 4:00 a.m. on 02/08/022, for a total of 900 cc of water not given. Resident #210 also did not receive Jevity 1.5 Cal bolus feedings at midnight and 6:00 a.m. on 02/08/2022, for a total of 474 cc (711 calories) of tube feeding not provided. 5. Resident #247 was admitted to the facility on [DATE] with the following diagnoses, including but not limited to: Peripheral vascular disease, hypertension, hypothyroidism, and dysphagia. An annual MDS with an ARD of 11/18/2021 assessed Resident #247 as moderately impaired with a cognitive summary score of 10. Resident #247's clinical record included the following physician orders: Enteral Feed Order every 6 hours 275 ml H2O flush via PEG tube The care plan was reviewed and included,The resident requires tube feeding r/t swallowing problem. Interventions included: Provide water flushes per MD order. Review of Resident #247's February MAR documented water flushes were not provided at midnight or 6:00 a. m. on 02/08/2022, for a total of 550 cc of water not provided. The above information was discussed with the director of nursing, the administrator, and both nurse consultants, during a meeting at approximately 12:15 p.m. on 02/10/2022. No further information was obtained prior to the exit conference on 02/10/2022. 21875 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	6. Resident #201 was admitted to the facility on [DATE] with a readmission on 1/12/21. Diagnoses for Resident #201 included Alzheimer's, pneumonitis, dysphagia, hypertension, mood (affective) disorder, prostatic hyperplasia, atherosclerotic heart disease, anxiety, depression and atrial fibrillation. The MDS dated [DATE] assessed Resident #201 with severely impaired cognitive skills. Resident #201's clinical record documented current physician orders for the following enteral feedings/flushes to meet the resident's nutritional and hydration needs: 7/10/21 - Enteral feed order - Jevity 1.5 @ 474 ml (milliliters) bolus three times per day 7/10/21 - Flush feed tube with 250 ml of water every 4 hours 1/13/21 - Flush feed tube with 20 to 30 ml of water before and after each medication pass Resident #201's medication administration record (MAR) documented the Jevity bolus (474 mls) was not administered on the 2/7/22 at 8:00 p.m. as scheduled. This amount was 1/3 of the resident's daily feeding formula requirement (711 calories). The MAR documented water flushes scheduled every four hours were not administered via the feeding tube on 2/7/22 at 8:00 p.m., 2/8/22 at 12:00 a.m. and 2/8/22 at 4:00 a.m. resulting in 750 ml of the 1500 ml daily water flushes (50%) not provided. Medications scheduled for 2/7/22 at 8:00 p.m., 9:00 and on 2/8/22 at 6:00 a.m. were not administered and therefore no water was provided with medication passes. Resident #201's plan of care (revised 2/1/22) documented the resident was at risk of dehydration, was at nutritional risk due NPO (nothing by mouth) status and requirement for tube feeding due to dysphagia and esophageal dysmotility. Interventions to prevent dehydration, prevent weight loss and avoid tube feeding complications included, .Monitor/document report PRN s/sx (signs/symptoms) of dehydration .the HOB (head of bed) elevated 30-45 degrees at all times .Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than 500 cc aspirate .Monitor/document/report PRN (as needed) s/sx of: Aspiration .Provide TF (tube feeding) as ordered .Provide water flushes per MD order . Provide Tube Feeding and water flushes per order . 7. Resident #222 was admitted to the facility on [DATE] with diagnoses that included persistent vegetative state, traumatic cerebral edema, cerebrovascular accident (stroke) diabetes and joint contractures. The MDS dated [DATE] assessed Resident #222 as comatose with cognitive skills unable to be assessed. Resident #222's clinical record documented current physician orders for the following enteral feedings/flushes to meet the resident's nutritional and hydration needs: 12/2/20 - Enteral feeding of Osmolite 1.0 at 70 ml/hour via PEG (percutaneous endoscopic gastrostomy) 6/18/20 - Water flushes 150 ml every 4 hours via PEG tube (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Resident #222's MAR documented no amount of Osmolite administered on the evening or night shift of 2/7/22. The MAR documented no water flushes were administered on 2/7/22 at 8:00 p.m., 2/8/22 at 12:00 a. m. and on 2/8/22 at 4:00 a.m. as scheduled. This resulted in 450 ml out of the ordered 900 ml daily water (50%) not administered. Resident #222's plan of care (revised 12/2/21) documented the resident was at risk of dehydration due to tube feeding, required tube feeding due to dysphagia, had a history of weight loss and was at risk of nutrition/dehydration due to dependence upon tube feedings. Interventions to prevent dehydration, weight loss and complications from tube feeding included, .Administer medications as ordered . Monitor/document/report PRN any s/sx of dehydration .observe for further episodes of vomiting and observe for signs of aspiration .the HOB elevated 30-45 degrees during and thirty minutes after tube feed .Check tube for placement and gastric contents/residual volume per facility protocol and record .Provide TF and flushes as ordered . On 2/8/22 at 3:35 p.m., the administrator, DON and corporate consultant (administration staff #3) met with the survey team and reported that no physician ordered medications and/or treatments were administered to any of the residents on the [NAME] unit from 2/7/22 at 7:00 p.m. until 2/8/22 at 7:00 a.m. The DON stated LPN #2 was the house supervisor that evening and could have reassigned the nurses working on the facility's three units (East, South and West). The DON stated LPN #2, LPN #3 and LPN #4 worked in the building on the evening of 2/7/22 until 11:00 p.m. The DON stated LPN #2 and LPN #4 left on 2/7/22 at 11:00 p.m. with two nurses scheduled for the building starting at 11:00 p.m. The DON stated LPN #3 was on the East unit, LPN #5 was assigned to South unit and the two nurses were supposed to split the [NAME] unit. On 2/8/22 at 4:45 p.m., the administrator, DON and corporate consultant met again with the survey team. The DON stated last night (2/7/22) that two nurses (LPN #3 and LPN #5) were the only nurses in the building from 11:00 p.m. until 2/8/22 at 7:00 a.m. The DON stated when only two nurses worked the building that they (nurses) knew to split the [NAME] unit. The DON stated there was no house supervisor on the night shift. On 2/8/22 at 5:10 p.m., the DON again stated that all prescribed medications and treatments were not administered on [NAME] unit on the 2/7/22 from 7:00 p.m. until 2/8/22 at 7:00 a.m. The DON stated, There was a miscommunication at shift change. These findings were reviewed with the administrator, director of nursing and corporate consultant during a meeting on 2/9/22 at 3:00 p.m. No further information was provided to the survey team regarding the missed enteral feedings and flushes.