STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495131	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Bristol	245 North Street Bristol, VA 24201

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interview, record review and facility document review, the facility staff failed to report an allegation of verbal abuse for one of 16 residents in the survey sample, resident # 1. For resident # 1 (R1), the facility staff failed to report an allegation of staff to resident verbal abuse.R1's diagnoses included but were not limited to dementia with behavior disturbance, psychotic disturbance, mood disturbance, anxiety, and adult failure to thrive. The minimum data set assessment (MDS) with an assessment reference date of 7/7/25 assigned the resident a brief interview for mental status score of 3 out of 15 indicating severe cognitive impairment. Attempts to interview R1 were unsuccessful.On 8/19/25 this surveyor asked the facility Administrator for any Facility Reported Incidents or investigations involving R1 from May of 2024. A file was provided that included a Virginia Department of Health Professions complaint form dated 6/6/24. The complaint alleged that a certified nursing assistant (CNA) had verbally abused R1 on 5/27/24. The complaint read in part, The resident had messed herself and had been digging in her brief. The CNA asked her, Have you been digging? Resident said, no, I haven't been digging the CNA said, You are fucking digging, the fuck you ain't been digging! CNA then lifted her covers and said, What's this then bitch? The document went on to say that the complainant had met with the Administrator and the Director of Nursing (DON) and that the Administrator told me I didn't care about these residents because I didn't physically stop (name omitted). He then asked me if I thought what happened was verbal abuse and I said without a shadow of a doubt. He then told me I might need to rethink my answer. I said Well, what would you qualify that as then, and he said I think (name omitted) was just having a bad day.There was a typed response to the complaint from the Administrator included in the file. On page 5 of the document, under the heading, Timeline of investigation the document read in part, 2:48 PM CNA (name omitted) returns text message asking if she still needed to return call . DON interviewed CNA (name omitted) who rereported: on 5/28/24 at approximately 7:00 PM, during walking rounds, CNA (name omitted) and herself arrived at resident's room and smelled an odor. CNA (name omitted) jerked the covers back and asked resident, Have you been digging again? Resident responded, I don't know, but not digging. CNA responded, what the fuck do you think this is? Resident responded, I don't know, and you can kiss my ass. CNA responded, Well what does this look like bitch? The CNA then made a kissing sound with her mouth and said, You can kiss my ass too. The CNA being interviewed stated that the voices were raised and yelling loud enough to be heard outside the room in the hallway. The Administrator documented a thorough investigation that included interviews of all staff working at the time of the alleged incident and none of them could corroborate the allegation. The CNA who allegedly verbally abused R1 denied the allegation and the Administrators report indicated the CNA was open and transparent throughout the course of the investigation while the accusing CNA's story was not consistent. On 8/20/25 at 10:40 AM this surveyor interviewed the Administrator and DON. The Administrator denied stating to the accusing CNA that the other CNA was just having a bad day. This surveyor asked the Administrator for a copy of the Facility Reported Incident (FRI) or evidence the abuse allegation was reported to the State Agency, and they stated, We didn't do a FRI. When it was reported to us, we immediately started an investigation and there were so many inconsistencies, we concluded they had a confrontation between the two of them, not in front of the patient and that the accusation was made in retaliation, so we thought it wasn't credible, so in my mind, it wasn't reportable.On 8/20/25 at 1:25 PM this surveyor met with the Administrator and the Director of Social Work (DSW) who was also involved in the investigation. The DSW stated that they had spoken with the resident representative (RR)during the course of the investigation to inform them of the allegation and the RR stated, I'm surprised (the resident) didn't say worse. They indicated the RR was not upset and stated, I don't recall if I told her exactly what was supposedly said or not, I may have just said it was inappropriate or unprofessional. Knowing the patient and knowing her use of foul language and there was no negative outcome we didn't think it rose to the level of being reportable. The Administrator added, We don't feel it was reportable secondary to there was no negative outcome and language is somewhat cultural. Some people use foul language on a regular basis, it's just how they talk. It was minor and goes back to how the resident responds, was it abuse to her? She can't tell us, and I don't think so. This surveyor explained the Reasonable Person Concept and stated, As a reasonable person, how would the CNA speaking to you like that make you feel? The Administrator provided a copy of the policy entitled, Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation with a revised date of 2/1/23. The document defined verbal

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on staff interview, clinical record review, and facility document review, the facility staff failed to follow medical provider orders for medication administration for 6 of 16 sampled residents (Resident #10, #11, #12, #13, #14, and #15). The findings included:1. For Resident #10, the facility staff administered Levothyroxine at 9:00 PM instead of 6:00 AM as ordered by the medical provider. Levothyroxine is a medication used to treat hypothyroidism. Resident #10's diagnosis list indicated diagnoses, which included, but not limited to Dementia and Hypothyroidism. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 8/12/25 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating the resident was moderately cognitively impaired. On 8/19/25 at 3:35 PM, surveyor spoke with Registered Nurse (RN) #1 who stated a night shift nurse administered 6:00 AM medications with residents' bedtime medications. The Director of Nursing (DON) identified Resident #10 as having received medication at the incorrect time and provided an Event Report dated 6/06/25 indicating Licensed Practical Nurse (LPN) #5 administered Levothyroxine on 6/05/25 at 9:00 PM instead of waiting until 6/06/25 at 6:00 AM as ordered. Resident #10's clinical record included an active order for Levothyroxine 25 mcg administer 1.5 tablets once a day at 6:00 AM. On 8/20/25 at 2:00 PM, surveyor spoke with the DON who stated LPN #5 reported administering Levothyroxine at bedtime because the resident did not want to be awakened at 6:00 AM and the LPN thought the medication could be given on an empty stomach, so they went ahead and gave it. The DON stated LPN #5 should have waited until the ordered administration time and they were educated that should a resident want to change their medication administration time; they should reach out to the provider for a time change. No further information regarding this concern was presented to the survey team prior to the exit conference on 8/20/25. 2. For Resident #11, the facility staff administered Levothyroxine and Omeprazole at 9:00 PM instead of 6:00 AM as ordered by the medical provider. Levothyroxine is a medication used to treat hypothyroidism and Omeprazole is used to treat excess stomach acid. Resident #11's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Gastro-esophageal Reflux Disease, and Hypothyroidism. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/02/25 assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 indicating the resident was severely cognitively impaired. On 8/19/25 at 3:35 PM, surveyor spoke with Registered Nurse (RN) #1 who stated a night shift nurse administered 6:00 AM medications with residents' bedtime medications. The Director of Nursing (DON) identified Resident #11 as having received medication at the incorrect time and provided an Event Report dated 6/06/25 indicating Licensed Practical Nurse (LPN) #5 administered Levothyroxine and Omeprazole on 6/05/25 at 9:00 PM instead of waiting until 6/06/25 at 6:00 AM as ordered. Resident #11's clinical record included an active order for Levothyroxine 75 mcg once a day at 6:00 AM and Omeprazole 40 mg twice a day at 6:00 AM and 5:00 PM. On 8/20/25 at 2:00 PM, surveyor spoke with the DON who stated LPN #5 reported administering Levothyroxine and Omeprazole at bedtime because the resident did not want to be awakened at 6:00 AM and the LPN thought the medications could be given on an empty stomach, so they went ahead and gave them. The DON stated LPN #5 should have waited until the ordered administration time and they were educated that should a resident want to change their medication administration time; they should reach out to the provider for a time change. No further information regarding this concern was presented to the survey team prior to the exit conference on 8/20/25. 3. For Resident #12, the facility staff administered Levothyroxine at 10:00 PM instead of 6:00 AM as ordered by the medical provider. Levothyroxine is a medication used to treat hypothyroidism. Resident #12's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Essential Hypertension, and Wernicke's Encephalopathy.The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/14/25 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. On 8/19/25 at 3:35 PM, surveyor spoke with Registered Nurse (RN) #1 who stated a night shift nurse administered 6:00 AM medications with residents' bedtime medications. The Director of Nursing (DON) identified Resident #12 as having received medication at the incorrect time and provided an Event Report dated 6/06/25 indicating Licensed Practical Nurse (LPN) #5 administered Levothyroxine on 6/05/25 at 10:00 PM instead of waiting until 6/06/25 at 6:00 AM as ordered. Resident #12's clinical record included an active order for Levothyroxine 75 mcg once a day at 6:00 AM. On 8/20/25 at 2:00 PM, surveyor spoke with the DON who stated LPN #5 reported administering Levothyroxine at bedtime because the resident did not want

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure the resident environment remains as free of accident hazards as is possible as evidenced by failure to lock the shower chair breaks prior to transfer resulting in a fall with a subsequent fracture for 1 of 16 sampled residents (Resident #7).The findings included:For Resident #7, the facility staff failed to lock the shower chair breaks prior to transfer causing the resident to fall and suffer a fracture at the base of the left thumb and skin tears to the forearms. Resident #7's diagnosis list indicated diagnoses, which included, but not limited to Chronic Obstructive Pulmonary Disease, Chronic Congestive Heart Failure, Osteoporosis, and History of Falling. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 8/04/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #7's current comprehensive person-centered care plan included a problem area dated 7/28/23 stating the resident was a fall risk related to impaired mobility, difficulty in walking and had a history of falling with an intervention dated 8/21/23 to assist patient in safe transfer technique as needed. A review of Resident #7's clinical record revealed a nursing progress note dated 7/19/25 9:42 AM which documented in part Nurse called to resident room by CNA [certified nursing assistant] to alert of fall in bathroom. Upon entering the room resident was observed on back in the bathroom floor. Bleeding skin tears on left and right forearms.Skin tear to left hand radial side. Notable discoloration and quick swelling to left wrist radial side resident complain of pain to that area. Palm size knot to back of head midline, resident also complaining of pain to head.Resident did request for ER [emergency room] transfer.Resident #7 was assessed and treated at the emergency department (ED). ED Provider Notes dated 7/19/25 documented in part .Patient presents to the ED for evaluation after a fall. Patient reports that her shower chair flipped over causing her to fall landing on her head. She reports head injury.Patient with skin tears to forearms.small subgaleal scalp hematoma.Left hand and wrist x-rays revealing minimally displaced oblique intra-articular fracture at the base of the thumb.Patient placed in thumb spica.On exam areas significant swelling with ecchymosis of the left hand.On 8/20/25 at 10:25 AM, surveyor spoke with Resident #7 regarding the fall. Resident #7 stated the shower chair was not locked and when she stood up to transfer to the wheelchair, she placed her arms on the sides of the chair and it flew out from under her. Resident #7 stated she broke her thumb and caused areas to her forearms and received a knot to the back of her head by falling backward. On 8/20/25 at 10:31 AM surveyor spoke with Certified Nursing Assistant (CNA) #4 who stated she was present in the bathroom with Resident #7 at the time of the fall. CNA #4 stated after giving the resident a shower, she unlocked the shower chair breaks to roll the shower chair down the incline from the shower area to the sink area of the bathroom and forgot to lock the breaks prior to assisting the resident to transfer to the wheelchair. CNA #4 stated she was re-educated following the incident. On 8/20/25 at 10:44 AM, surveyor spoke with Licensed Practical Nurse (LPN) #6 who stated she heard the resident fall but did not witness it. LPN #6 stated Resident #7 had horrible skin tears and her left hand and thumb were swelling fast, and the resident was sent out to the ER. Surveyor requested the facility policy regarding safe transfers and the Director of Nursing (DON) provided a document titled [facility name omitted] -Patient Transfer Guidance which read in part .Assisted Transfer Basics.Ensure the bed and wheelchair (or other surface) are close together, ideally at a 45-degree angle, and the brakes are locked.lock brakes (if applicable), and make sure path is clear.On 8/20/25 at 3:49 PM, surveyor spoke with the DON who stated initially it was reported that Resident #7's fall occurred because her weight shifted during the transfer but after several days it was discovered the shower chair breaks were not locked during the transfer. DON stated CNA #4 and nursing staff were re-educated following the fall and stated the re-education included the locking of breaks prior to a resident transfer. The DON provided a copy of CNA #4's annual competency checklist dated 3/03/25 indicating the CNA demonstrated understanding of falls prevention. The DON stated falls prevention included locking breaks prior to transfer. On 8/20/25 at 4:09 PM, surveyor met with the Administrator and DON and discussed the concern of CNA #4 failing to lock the shower chair breaks prior to transferring Resident #7 which resulted in a fall with a fracture. No further information regarding this concern was presented to the survey team prior to the exit conference on 8/20/25.