STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appomattox Health & Rehabilitation Center	235 Evergreen Ave Appomattox, VA 24522

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to follow abuse prevention policies for three of six residents in the survey sample (Residents #1, #3 and #4).The findings include:1. For Resident #1, facility staff failed to follow abuse prevention policies for submitting investigation findings within five days to the state agency and failed to report an allegation of abuse involving a certified nurse's aide to the department of health professions per facility policy.Resident #1 (R1) was admitted to the facility with diagnoses that included metabolic encephalopathy, dysphagia, anemia, protein-calorie malnutrition, asthma, cognitive communication deficit, hypothyroidism, myocardial infarction and hypertension. The minimum data set (MDS) dated [DATE] assessed R1 with severely impaired cognitive skills.A facility reported incident form was sent to the state agency on 4/27/25 documenting an allegation of sexual misconduct between R1 and certified nurse's aide (CNA) #1. The initial report was sent to the state agency on 4/27/25. The state agency received no final report of the facility's investigation/findings regarding this allegation. The initial report to the state agency documented no report of the allegation to the department of health professions.Review of the facility's investigation on 8/12/25 revealed a final investigation report dated 4/30/25 summarizing the facility's investigation and findings that did not substantiate sexual assault. The investigation documents included no evidence that the final report was sent to the state agency and no evidence that the allegations regarding CNA #1 were sent to the department of health professions.On 8/12/25 at 3:22 p.m., the administrator was interviewed about the investigation of abuse allegations regarding R1. The administrator stated he thought the former director of nursing (DON) had submitted the findings to the state agency. The administrator reviewed the investigation folder and did not present any evidence that the investigation findings were sent to the state agency. The administrator stated the abuse allegations should have been sent to DHP and he did not know why DHP was not notified.The facility's policy titled Abuse/Neglect Misappropriation/Crime - Reporting Requirements/Investigations (effective 2/5/23) documented, .Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but no later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury . This policy under section 1.b. documented, .Notify within 24 hours the Department of Health Professions (DHP) for incidences involving nurse aides, RNs, LPNs, Physicians, or others licensed or certified by DHP . This policy documented under section 5., .The Administrator must thoroughly investigate and file a complete written report of the investigation of the submitted FRI [facility reported incident] to the State Agency within five (5) working days of the incident . 2. Facility staff failed to thoroughly investigate an injury of unknown for Resident #3 as required in the facility's abuse prevention policies. Statements were not obtained from staff members caring for Resident #3 prior to and/or during the shift when the resident was found with an injury of unknown origin. Resident #3 (R3) was admitted to the facility with diagnoses that included psychotic disorder with delusions, depression, hypertension, anorexia, dementia with behavioral disturbance and dysphagia. The minimum data set (MDS) dated [DATE] assessed R3 with severely impaired cognitive skills.R3's clinical record documented a nursing note dated 4/4/25 listing the resident was observed with an abrasion on the left forehead and an abrasion over the right eyebrow. The note documented that the resident was unable to verbalize the cause or source of the injuries. The director of nursing (DON) documented a note on 4/4/25 at 6:39 p.m. of notification to the family about the assessed abrasion.Notification of R3's injury of unknown origin was sent to the state agency on 4/4/25 with investigation findings sent to the state agency on 4/7/25. On 8/12/25, the facility's investigation of R3's injury of unknown origin was reviewed. The investigation included written statements from a licensed practical nurse and a CNA (certified nurse's aide) that worked on 4/4/25 starting at 7:00 p.m., after the abrasion was identified. One statement was from a CNA that worked 4/3/25 starting at 7:00 p.m. until 4/4/25 at 7:00 a.m. The other statement obtained listed no employee name, job title or when they worked compared to the incident. There were no written statements obtained from staff working the shift when the abrasion was found (4/4/25 from 7:00 a.m. to 7:00 p.m.). On 8/12/25 at 3:30 p.m., the administrator was interviewed about the investigation of R3's abrasion of unknown source. The administrator stated the previous DON obtained statements. The administrator stated, I think she [former DON] interviewed the night shift. When asked about why shift employees working immediately prior to the

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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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to submit investigation findings regarding an abuse allegation to the state agency for one of six residents in the survey sample (Resident #1).The findings include:Resident #1 (R1) was admitted to the facility with diagnoses that included metabolic encephalopathy, dysphagia, anemia, protein-calorie malnutrition, asthma, cognitive communication deficit, hypothyroidism, myocardial infarction and hypertension. The minimum data set (MDS) dated [DATE] assessed R1 with severely impaired cognitive skills.A facility reported incident form was sent to the state agency on 4/27/25 documenting an allegation of sexual misconduct between R1 and certified nurse's aide (CNA) #1. The initial report was sent to the state agency on 4/27/25. The state agency received no final report of the facility's investigation/findings regarding this allegation. Review of the facility's investigation on 8/12/25 revealed a final investigation report dated 4/30/25 summarizing the facility's investigation and findings that did not substantiate sexual assault. The investigation documents included no evidence that the final report was sent to the state agency.On 8/12/25 at 3:22 p.m., the administrator was interviewed about the investigation of abuse allegations regarding R1. The administrator stated he thought the former director of nursing (DON) had sent the findings to the state agency. The administrator reviewed the investigation folder and did not present any evidence that the investigation findings were sent to the state agency. The facility's policy titled Abuse/Neglect Misappropriation/Crime - Reporting Requirements/Investigations (effective 2/5/23) documented under section 5, .The Administrator must thoroughly investigate and file a complete written report of the investigation of the submitted FRI [facility reported incident] to the State Agency within five (5) working days of the incident .This finding was reviewed with the administrator, director of nursing and regional nurse consultant on 8/12/25 at 3:30 p.m. and on 8/13/25 at 12:10 p.m. with no further information presented prior to the end of the survey.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to complete a thorough investigation regarding an injury of unknown origin for one of six residents in the survey sample (Resident #3).The findings include:Resident #3 (R3) was admitted to the facility with diagnoses that included psychotic disorder with delusions, depression, hypertension, anorexia, dementia with behavioral disturbance and dysphagia. The minimum data set (MDS) dated [DATE] assessed R3 with severely impaired cognitive skills. R3's clinical record documented a nursing note dated 4/4/25 listing the resident was observed with an abrasion area on the left forehead and an abrasion over the right eyebrow. The note documented that the resident was unable to verbalize the cause of the injuries. The director of nursing (DON) documented a note on 4/4/25 at 6:39 p.m. of notification to the family about the assessed abrasions.Notification of R3's injury of unknown origin was sent to the state agency on 4/4/25 with investigation findings sent to the state agency on 4/7/25.On 8/12/25, the facility's investigation of R3's injury of unknown origin was reviewed. The investigation included written statements from a licensed practical nurse and a CNA (certified nurse's aide) that worked on 4/4/25 starting at 7:00 p.m., after the abrasion was identified. One statement was from a CNA that worked 4/3/25 starting at 7:00 p.m. until 4/4/25 at 7:00 a.m. The other statement obtained documented no employee name, job title or when they worked compared to the incident. There were no written statements obtained from staff working the shift when the abrasion was found (4/4/25 from 7:00 a.m. to 7:00 p.m.). On 8/12/25 at 3:30 p.m., the administrator was interviewed about the investigation of R3's abrasion of unknown source. The administrator stated the previous DON obtained the statements. The administrator stated, I think she [former DON] interviewed the night shift. When asked about why shift employees working immediately prior to the injury were not interviewed, the administrator stated, Those [statements] were the only ones I saw in the folder.On 8/12/25 at 4:45 p.m., the former DON (RN #1) was interviewed about the lack of employee statements obtained regarding R3's abrasion of unknown source. The former DON stated, I got as many [statements] as I could. The facility's policy titled Abuse/Neglect Misappropriation/Crime - Reporting Requirements/Investigations (effective 2/5/23) documented, .The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations .This finding was reviewed with the administrator, DON and regional nurse consultant on 8/12/25 at 3:30 p.m. with no further information presented prior to the end of the survey.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, the facility staff failed to provide a complete and accurate minimum data set (MDS) for one of six residents in the survey sample (Resident #1).The findings include: Resident #1 (R1) was admitted to the facility with diagnoses that included metabolic encephalopathy, dysphagia, anemia, protein-calorie malnutrition, asthma, cognitive communication deficit, hypothyroidism, myocardial infarction and hypertension. The minimum data set (MDS) dated [DATE] assessed R1 with severely impaired cognitive skills.R1's clinical record documented a MDS assessment dated [DATE]. Section C. of this MDS for assessment of cognitive patterns was not completed. Each category of section C., including the brief interview for mental status (BIMS) and staff assessment of mental status, was marked not assessed.On 8/13/25 at 9:40 a.m., the registered nurse MDS coordinator (RN #2) was interviewed about R1's incomplete assessment. RN #2 reviewed the MDS and stated the cognitive section had not been completed. RN #2 stated the assessment required for section C. of the MDS was not completed during the designated 7-day look back time, so it was marked as not assessed. RN #2 stated the assessment was required to be completed during the designated look back time.The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual on page C-2 documents concerning completion of Section C, Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood . (1) This finding was reviewed with the administrator and regional nurse consultant on 8/13/25 at 12:10 p.m. with no further information presented prior to the end of the survey.(1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1, Centers for Medicare & Medicaid Services, Revised October 2024.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for one of six residents in the survey sample (Resident #1).The findings include:Resident #1's care plan was not revised to include a preference for no male caregivers.Resident #1 (R1) was admitted to the facility with diagnoses that included metabolic encephalopathy, dysphagia, anemia, protein-calorie malnutrition, asthma, cognitive communication deficit, hypothyroidism, myocardial infarction and hypertension. The minimum data set (MDS) dated [DATE] assessed R1 with severely impaired cognitive skills.R1's clinical record documented a nursing note dated 4/29/25 stating, .spoke with [family member] today regarding patient care concerns. resident to not have male caregivers if at all possible .R1's plan of care (revised 7/21/25) documented the resident required total assistance from staff for activities of daily living. The care plan made no mention of a preference for no male caregivers.On 8/13/25 at 8:36 a.m., the registered nurse MDS coordinator (RN #2) responsible for updating care plans, was interviewed. RN #2 reviewed R1's care plan and stated she found nothing added about the preference for no male caregivers. RN #2 stated to her knowledge, the nurses and aides were aware of this preference but that the preference had not been added to the care plan. RN#2 stated the preference for caregivers should have been added to the care plan.This finding was reviewed with the administrator and regional nurse consultant on 8/13/25 at 12:10 p.m. with no further information presented prior to the end of the survey.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide proper medical treatment for abnormal lab values resulting in hospitalization for one of six residents in the survey sample (Resident #4).The findings include:Resident #4 (R4) was admitted to the facility with diagnoses that included chronic kidney disease, bacteremia, endocarditis, congestive heart failure, liver cirrhosis, obesity, diabetes, anemia, atrioventricular block, thrombocytopenia, hypertension, non-alcoholic steatohepatitis (NASH), and diverticulosis. R4's most recent minimum data set (MDS) assessed the resident as cognitively intact.R4's clinical record documented lab test results dated 8/10/23 listing R4 had a low sodium level of 125 mEq/L (reference range of 136 to 145) and normal potassium level of 4.8 mEq/L (reference range of 3.5 tot 5.1). The PA's progress note dated 8/14/23 referenced review of the 8/10/23 lab results and documented under diagnosis/plan that the resident had hypopotassemia (low potassium level) with orders entered for potassium chloride ER, 20 mEq (milliequivalents) daily for the low potassium. The progress note made no mention of a diagnosis or treatment for the low sodium level.R4's medication administration record (MAR) documented the potassium chloride 20 mEq was administered as ordered on 8/15/23 and 8/16/23.R4's nursing notes documented the resident left the faciity on 8/16/23 for an appointment with an infectious disease specialist. A nursing note dated 8/16/23 at 4:16 p.m. documented R4 was assessed at the infectious disease appointment with a critical lab value of potassium at 6.5 with a recheck done with results of 6.6 mEq/L. The note documented the resident was sent as a direct admit to the hospital for treatment of the critically high potassium.R4's hospital Discharge summary dated [DATE] documented the resident was hospitalized from [DATE] until 8/18/23 and treated for hyperkalemia (high potassium level) and acute kidney injury with the medication Lokelma and discontinued use of diuretics. The Discharge summary dated [DATE] documented, .Patient has an enterococcal bacteremia with VRE. She has endocarditis and has been receiving IV daptomycin every 24 hours at a rehab facility. She [R4] went to [infectious disease physician's] office for follow-up appointment today had laboratory findings which showed acute kidney injury as well as hyperkalemia [high potassium level]. Patient direct admitted to [hospital] .In discussions with the patient's [family member] .she states that the director of nursing at the [nursing facility] had called her stating that the patient had been incorrectly prescribed potassium supplementation recently at that facility instead of an apparently intended sodium chloride supplementation for concerns about hyponatremia. This certainly could have led to the patient's hyperkalemia .A facility reported incident form dated 8/17/23 to the state agency documented R4 was hospitalized for a critically high potassium level after the resident was prescribed and administered a potassium supplement by the physician's assistant (PA). The director of nursing (DON) at that time documented on 8/17/23, that she was notified that R4 was admitted to the hospital for hyperkalemia and upon review of the resident's medications, noted that the PA had recently prescribed potassium chloride. The form documented the PA was asked to review the order. The DON's note documented that the PA informed her that she had ordered potassium in error and should have ordered sodium to address the low sodium lab results.A written statement dated 8/17/23 by the PA (other staff #1) documented, I was handed lab results by nurse .I transcribed the abnormal values into my note .paying attention to a sodium of 125 . I did not place orders at this time. After seeing the patient I placed my orders. I had a different pt [patient] that day that I increased their potassium supplementation, it is my belief that when I placed [R4's] orders, my brain was thinking 'potassium' and so I placed an order for 1 tab [tablet] po [oral] daily of Potassium Chloride 20 meq [milliequivalents] instead of sodium .The facility's investigation of this incident dated 8/22/23 documented the PA erroneously ordered potassium for R4 when she meant to order a sodium supplement that resulted in R4's hospitalization for treatment of hyperkalemia. The PA that prescribed the potassium in error was not available for interview as she no longer worked at the facility. The DON at the time of the incident was not available for interview as she no longer worked at the facility.On 8/12/25 at 9:15 a.m., R4 was interviewed about the potassium error and hospitalization. R4 stated the PA gave her potassium when she was supposed to get sodium. R4 stated she had to go to the hospital for treatment of the high potassium. R4 stated, It just knocked me out. The doctor said my potassium was out the roof. R4 stated nothing like that had happened before or since and she got ok after discharge from the hospital. R4 stated regarding the PA, I think she [PA] just made a mistake.On 8/12/25 at 3:22 p.m., the administrator was interviewed about R4's medication error. The administrator stated R4 went out for a

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and clinical record review, the facility staff failed to provide fall mats for injury prevention as required in the plan of care for one of six residents in the survey sample (Resident #3).The findings include:Resident #3 (R3) was admitted to the facility with diagnoses that included psychotic disorder with delusions, depression, hypertension, anorexia, dementia with behavioral disturbance and dysphagia. The minimum data set (MDS) dated [DATE] assessed R3 with severely impaired cognitive skills.On 8/12/25 at 5:05 p.m., R3 was observed in bed. The bed was in low position with no floor mats on either side of the bed. On 8/13/25 at 8:10 a.m., R3 was observed in bed. There were no protective floor mats on either side of the bed.R3's plan of care (revised 8/6/25) documented the resident was at risk of falls/injury due to history of falls, cognitive impairment, muscle weakness, poor vision and use of psychoactive medications. Interventions for fall/injury prevention included, Fall mats bilaterally.On 8/13/25 at 8:12 a.m., the certified nurse's aide (CNA #2) caring for R3, was interviewed about fall mats. CNA #2 stated she was not aware that R3 required floor mats by the bed. CNA #2 stated nurses usually told the aides if fall mats were implemented or required.On 8/13/25 at 8:32 a.m., CNA #2 stated the nurse checked R3's care plan and the fall mats were supposed to be in place when the resident was in bed.On 8/13/25 at 8:36 a.m., registered nurse (RN #3) was interviewed about R3's need for fall mats. RN #3 stated R3's care plan required fall mats in place when the resident was in bed for injury prevention.This finding was reviewed with the administrator and regional nurse consultant on 8/13/25 at 12:10 p.m. with no further information presented prior to the end of the survey.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure one of six residents (Resident #4) was free from a significant medication error resulting in hospitalization for treatment of hyperkalemia.The findings include:Resident #4 (R4) was admitted to the facility with diagnoses that included chronic kidney disease, bacteremia, endocarditis, congestive heart failure, liver cirrhosis, obesity, diabetes, anemia, atrioventricular block, thrombocytopenia, hypertension, non-alcoholic steatohepatitis (NASH), and diverticulosis. R4's most recent minimum data set (MDS) assessed the resident as cognitively intact.R4's clinical record documented lab test results dated 8/10/23 listing R4 had a low sodium level of 125 mEq/L (reference range of 136 to 145) and normal potassium level of 4.8 mEq/L (reference range of 3.5 tot 5.1). The PA's progress note dated 8/14/23 referenced review of the 8/10/23 lab results and documented under diagnosis/plan that the resident had hypopotassemia (low potassium level) with orders entered for potassium chloride ER, 20 mEq (milliequivalents) daily for the low potassium. The progress note made no mention of a diagnosis or treatment for the low sodium level.R4's medication administration record (MAR) documented the potassium chloride 20 mEq was administered as ordered on 8/15/23 and 8/16/23.R4's nursing notes documented the resident left the faciity on 8/16/23 for an appointment with an infectious disease specialist. A nursing note dated 8/16/23 at 4:16 p.m. documented R4 was assessed at the infectious disease appointment with a critical lab value of potassium at 6.5 with a recheck done with results of 6.6 mEq/L. The note documented the resident was sent as a direct admit to the hospital for treatment of the critically high potassium.R4's hospital Discharge summary dated [DATE] documented the resident was hospitalized from [DATE] until 8/18/23 and treated for hyperkalemia (high potassium level) and acute kidney injury with the medication Lokelma and discontinued use of diuretics. The Discharge summary dated [DATE] documented, .Patient has an enterococcal bacteremia with VRE. She has endocarditis and has been receiving IV daptomycin every 24 hours at a rehab facility. She [R4] went to [infectious disease physician's] office for follow-up appointment today had laboratory findings which showed acute kidney injury as well as hyperkalemia [high potassium level]. Patient direct admitted to [hospital] .In discussions with the patient's [family member] .she states that the director of nursing at the [nursing facility] had called her stating that the patient had been incorrectly prescribed potassium supplementation recently at that facility instead of an apparently intended sodium chloride supplementation for concerns about hyponatremia. This certainly could have led to the patient's hyperkalemia .A facility reported incident form dated 8/17/23 to the state agency documented R4 was hospitalized for a critically high potassium level after the resident was prescribed and administered potassium supplement by the physician's assistant (PA). The director of nursing (DON) at that time documented on 8/17/23, that she was notified that R4 was admitted to the hospital for hyperkalemia and upon review of the resident's medications, noted that the PA had recently prescribed potassium chloride. The form documented the PA was asked to review the order. The DON's note documented that the PA informed her that she had ordered potassium in error and should have ordered sodium to address the low sodium lab results.A written statement dated 8/17/23 by the PA (other staff #1) documented, I was handed lab results by nurse .I transcribed the abnormal values into my note .paying attention to a sodium of 125 . I did not place orders at this time. After seeing the patient I placed my orders. I had a different pt [patient] that day that I increased their potassium supplementation, it is my belief that when I placed [R4's] orders, my brain was thinking 'potassium' and so I placed an order for 1 tab [tablet] po [oral] daily of Potassium Chloride 20 meq [milliequivalents] instead of sodium .The facility's investigation of this incident dated 8/22/23 documented the PA erroneously ordered potassium for R4 when she meant to order a sodium supplement that resulted in R4's hospitalization for treatment of hyperkalemia.The PA that prescribed the potassium in error was not available for interview as she no longer worked at the facility. The DON at the time of the incident was not available for interview as she no longer worked at the facility.On 8/12/25 at 9:15 a.m., R4 was interviewed about the potassium error and hospitalization. R4 stated the PA gave her potassium when she was supposed to get sodium. R4 stated she had to go to the hospital for treatment of the high potassium. R4 stated, It just knocked me out. The doctor said my potassium was out the roof. R4 stated nothing like that had happened before or since and she got ok after discharge from the hospital. R4 stated regarding the PA, I think she [PA] just made a mistake.On 8/12/25 at 3:22 p.m., the administrator was interviewed about R4's medication error. The administrator stated R4 went out for a physician's appointment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appomattox Health & Rehabilitation Center	235 Evergreen Ave Appomattox, VA 24522

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 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** Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of six residents in the survey sample (Resident #1).The findings include:There was no documentation in Resident #1's clinical record regarding a physical assessment and actions taken in response to allegations of rough handling/sexual abuse.Resident #1 (R1) was admitted to the facility with diagnoses that included metabolic encephalopathy, dysphagia, anemia, protein-calorie malnutrition, asthma, cognitive communication deficit, hypothyroidism, myocardial infarction and hypertension. The minimum data set (MDS) dated [DATE] assessed R1 with severely impaired cognitive skills.A facility reported incident form to the state agency dated 4/27/25 documented investigation of an allegation of sexual misconduct between R1 and a staff member.R1's clinical record documented a skin assessment dated [DATE] following the allegations but included no mention of any actions taken in response to the allegations.On 8/12/25 at 11:00 a.m., the registered nurse (RN#2) that received the allegations from R1's family member was interviewed. RN #2 stated on 4/27/25 that R1's family member reported that R1 had been changed during the night against her wishes and that the aide was rough providing care. RN #2 stated R1's roommate reported that she heard the resident yell out in the night and reported that it sounded like she was getting raped. RN #2 stated with the family member's permission, and accompanied by the floor nurse, she performed a thorough assessment of the resident, including the genital area, that revealed no evidence of redness, bruising or trauma. RN #2 stated the allegations were immediately reported to the director of nursing (DON) who came to the facility along with notification to the administrator, physician and the police. RN #2 stated she wrote a statement about the incident and entered notes into the clinical record. RN #2 stated she reviewed the clinical record and did not see anything documented about the incident. RN #2 stated she thought she entered the notes and thought the DON at the time had entered notes about the incident.On 8/12/25 at 3:22 p.m., the administrator was interviewed about lack of documentation regarding the care concerns/allegations in R1's clinical record. The administrator stated the DON at that time indicated that she was entering notes into the clinical record. The administrator stated the actions taken should have been included in the clinical record and that he did not know why the incident was not documented. On 8/12/25 at 4:45 p.m., the former DON at the time of the incident (RN #1) was interviewed about the lack of documentation in the clinical record regarding the abuse allegations. The former DON stated that RN #2 should have documented her assessment and actions taken in the nursing notes. The former DON stated the notes were not in the record because RN #2 did not enter them into the electronic health record. The DON stated her notes were documented in the investigation.This finding was reviewed with the administrator, DON and regional nurse consultant on 8/12/25 at 3:30 p.m. with no further information presented prior to the end of the survey.