

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2025
NAME OF PROVIDER OR SUPPLIER Regency Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 112 N Constitution Dr Yorktown, VA 23692	

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility documentation review and clinical record review, the facility failed to prevent pressure sore formation, for one resident (Resident #3) in a sample of 3 residents. For Resident #3 the facility failed to provide consistent and accurate skin care assessments, provide available prevention techniques, wound care monitoring, and treatment for Resident #3 who suffered an avoidable sacral pressure ulcer. The findings included. Resident #3 was originally admitted to the facility on [DATE]. Diagnoses included acute stroke with craniotomy and paralysis on his (dominant) right side, dysphagia with peg feeding tube insertion, diabetes, chronic kidney disease, cardiomyopathy, bell's palsy, prostatic hypertrophy, foley urinary catheter, and a renal mass. Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9-16-25 was coded as a significant change assessment. The Resident was coded as severe cognitive loss. Resident #3 was coded as being dependent on 1 to 2 staff members for physical assistance with all activities of daily living and two-person assistance with bed mobility, toileting and transfers. Resident #3 was coded as having a catheter for bladder elimination and was frequently incontinent of bowel. The Resident was not coded as having had neurosurgery, in error. The Resident was coded as being at risk for pressure ulcer development and coded only one acquired stage 3 pressure sore. The MDS document coded diabetic ulcers on feet, and there were 3. On 10-21-25 at 2:00 P. M. Resident #3 was observed in bed. The Resident was awake and non- verbal upon questioning. The Resident was lying inclined at a 45-degree angle propped up facing the wall in front of him. The Resident was lying on a mechanical alternating air low air loss mattress which was operating appropriately. On 10-21-25 Resident #3's clinical medical record was reviewed. That review revealed nursing progress notes dated 8-29-25 describing that Resident #3 had orders for treatments. Notes do not indicate who ordered the treatment, nor a description of the wound to be treated. No evaluations, assessments, measurements nor descriptions of the character of the wound accompanied the order for treatment upon identification of the wound until 8 days after identification on 9-5-25. Physician progress notes also document no wound often in the record after identification of the pressure ulcer further indicating no knowledge of the wound by the physician. No skin assessments nor evaluations were completed in the clinical record until 9-5-25 when the Advanced Practice Registered Nurse Practitioner (NP) specializing in wound care saw the Resident and documented such. She documented that the location of the wound was described more appropriately as Sacrum and not left/right lower buttocks. On that day the NP also documented in the first evaluation of the wound for Resident #3 recommendations for an alternating air mechanical low air loss mattress, and other interventions, and described the wound as a stage 3 pressure ulcer to the sacrum. The 4 orders for treatment of the wound follow below in chronological order. 1. 8-28-25 - ordered left lower buttocks, and right lower buttocks DWC (Dakins wound cleanser) Xeroform and border gauze 1 time per day. Discontinued on 9-8-25. 2. 9-8-25 - ordered Sacrum cleanse with wound cleanser, hydrogel gauze and cover with silicone bordered gauze 1 time per day. Discontinued on 9-12-25. 3. 9-17-25- Prostat SF liquid protein supplement for wound healing 30 milliliters via feeding tube 1 time per day. Continued through survey. 4. 9-24-25 - ordered Sacrum cleanse with DWC, apply hydrogel gauze, and apply silicone border gauze one time per day. Discontinued 10-6-25. There was no ordered treatment for the sacral wound from 9-12-25 until 9-24-25 (12 days). Medication and treatment administration records (MAR's/TAR's) were reviewed and documented that the treatments were omitted on the following days. 8-28-25, 8-29-25, 9-1-25, on 9-11-25 the Resident went out to hospital, and returned on 9-12-25. Treatments were not administered 9-12-25 through 9-24-25 (12 days), 9-27-25, 9-28-25, 9-29-25, 10-2-25, and 10-5-25. Treatments to the sacral pressure ulcer were discontinued on 10-6-25 as the wound was healed and remained healed at the time of survey. Braden skin assessments typically completed on admission for risk of wound development were only completed twice for this Resident. Those 2 were completed late, as the first one was completed on 10-14-25, which scored a 10 high risk and the only other one on 10-22-25 a 12 high risk. The Resident's care plan for this period revealed as interventions the following. Assess Resident for risk of skin breakdown. Alternating air mattress. Assist resident to turn and reposition often. Draw sheet for turning and repositioning while in bed. Educate resident and family about pressure ulcer prevention. Enhanced barrier precautions. Keep skin clean and dry as possible. Pressure relieving cushion to the chair. Referral to registered dietician. Skin assessments as indicated. On 10-22-25 at 11:00 a.m. I PN (R) was interviewed stated We keep those skin checks</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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Diagnoses included acute stroke with craniotomy and paralysis on his (dominant) right side, dysphagia with peg feeding tube insertion, diabetes, chronic kidney disease, cardiomyopathy, bell's palsy, prostatic hypertrophy, foley urinary catheter, and a renal mass. Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9-16-25 was coded as a significant change assessment. The Resident was coded as severe cognitive loss. Resident #3 was coded as being dependent on 1 to 2 staff members for physical assistance with all activities of daily living and two-person assistance with bed mobility, toileting and transfers. Resident #3 was coded as having a catheter for bladder elimination and was frequently incontinent of bowel. The Resident was not coded as having had neurosurgery, in error. The Resident was coded as being at risk for pressure ulcer development and coded only one acquired stage 3 pressure sore. 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