STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495191	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bland County Nursing & Rehab Center	12185 Grapefield Road Bastian, VA 24314

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on staff interview, clinical record review, and facility document review, the facility staff failed to follow medical provider orders for the administration of Gabapentin for 1 of 3 sampled residents, Resident #3.The findings included: An admission Record revealed the facility admitted Resident #3 on 4/08/26. According to the admission Record, the resident had a medical history that included chronic respiratory failure with hypoxia, quadriplegia, central cord syndrome at C5 level of cervical spinal cord, dependence on ventilator, and chronic pain syndrome. An admission minimum data set (MDS) with an assessment reference date (ARD) of 4/14/26 indicated the resident had a Brief Interview for Mental Status (BIMS) summary score of 0 out of 15 which indicated the resident was severely cognitively impaired.Resident #3's comprehensive person-centered care plan included a focus area dated 4/09/26, that indicated the resident had pain related to pressure injuries, muscle spasms, neuropathy, C5 fracture and contractures with an intervention to administer pain medication as per MD orders. Resident #3's clinical record included a medical provider order dated 4/08/26 for Gabapentin 100 mg via peg-tube three times a day for neuropathy. A review of Resident #3's April 2026 Medication Administration Record (MAR) revealed Gabapentin was not administered on 4/09/26 at 2:00 PM and 10:00 PM. A nursing progress note dated 4/09/26 at 2:18 PM documented Gabapentin was on hold until prescription comes in. A 4/09/26 10:02 PM nursing progress documented Gabapentin was on hold. The facility's onsite medication back-up system, Omnicell, Inventory List indicated Gabapentin 100 mg capsules were available for administration. During an interview on 5/06/26 at 9:58 AM, the Director of Nursing (DON) stated staff should have pulled the Gabapentin from the Omnicell to administer to Resident #3 on 4/09/26. A facility policy titled, Medication Shortage/Unavailable Medications, revised 8/01/24, indicated 3. If a medication is unavailable is discovered after normal Pharmacy hours: 3.1 A facility nurse should obtain the ordered medication from the Emergency Medication Supply.On 5/06/26 at 11:57 AM, the concern of staff failing to administer Gabapentin on two occasions on 4/09/26 was discussed with the Administrator, DON, and Regional Corporate Representative.No further information regarding this concern was presented prior to the exit conference on 5/06/26.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on staff interview and clinical record review, the facility staff failed to ensure that a provider ordered medication was available for administration for 1 of 3 sampled residents, Resident #3.The findings included:For Resident #3, the facility staff failed to ensure the antibiotic Cefepime was available for administration on 5/05/26 and 5/06/26. An admission Record revealed the facility admitted Resident #3 on 4/08/26. According to the admission Record, the resident had a medical history that included chronic respiratory failure with hypoxia, quadriplegia, central cord syndrome at C5 level of cervical spinal cord, dependence on ventilator, and chronic pain syndrome. An admission minimum data set (MDS) with an assessment reference date (ARD) of 4/14/26 indicated the resident had a Brief Interview for Mental Status (BIMS) summary score of 0 out of 15 which indicated the resident was severely cognitively impaired.Resident #3 was seen by the medical provider on 4/30/26 for pneumonia with the final sputum culture positive for CRP (carbapenem-resistant Pseudomonas) with new orders to add Cefepime 1 gram intramuscularly twice a day for seven days. Resident #3's medical provider orders included an order dated 4/30/26 for Cefepime 1 gram intramuscularly two times a day for seven days for pneumonia. Resident #3's comprehensive person-centered care plan included a focus area dated 4/23/26 stating the resident had a pneumonia infection with an intervention for medications as ordered. A review of Resident #3's May 2026 Medication Administration Record (MAR) revealed Cefepime was not administered on 5/05/26 at 5:00 AM and 5:00 PM, and 5/06/26 at 5:00 AM. During an interview with the Director of Nursing on 5/06/26 at 9:33 AM, the DON stated Resident #3 had received nine doses of Cefepime since 4/30/26. She stated the pharmacy sent a partial supply of six doses on 4/30/26 and three doses had been pulled from the Omnicell and there were no more doses available in the Omnicell. The DON stated Resident #3's Medicaid coverage was pending and that often created problems when the pharmacy tried to bill for medication. The DON stated the pharmacy did not send a pre-authorization request to the facility regarding the Cefepime. Resident #3's clinical record included a pharmacy Non-Covered Medication Notification form dated 5/03/26 which indicated Resident #3's Cefepime refill was canceled because the facility instructions for non-covered medications indicate facility authorization is required for this fill therefor pharmacy has initiated an insurance prior authorization. The form included an area to check to indicate if the facility was accepting financial responsibility or responsible party had been notified by the facility and is accepting financial responsibility. The form was not addressed, and all options were left blank and scanned into the resident's medical record. The cost of the medication was listed as $16.64. The form included fax documentation across the top indicating the form was faxed on 5/03/26 at 9:55 AM. On 5/06/26 at 11:57 AM during a meeting with the Administrator, DON, and Regional Corporate Representative, the concern of Resident #3 failing to receive Cefepime as ordered was discussed including the unaddressed pre-authorization present in the resident's clinical record. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/06/26.

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on staff interview and clinical record review, the facility staff failed to provide laboratory services to meet the needs of 1 of 3 residents in the survey sample, Resident #3.The findings included:For Resident #3, the facility staff failed to obtain a urinalysis as ordered by the medical provider on 4/22/26.An admission Record revealed the facility admitted Resident #3 on 4/08/26. According to the admission Record, the resident had a medical history that included chronic respiratory failure with hypoxia, quadriplegia, central cord syndrome at C5 level of cervical spinal cord, dependence on ventilator, and chronic pain syndrome. An admission minimum data set (MDS) with an assessment reference date (ARD) of 4/14/26 indicated the resident had a Brief Interview for Mental Status (BIMS) summary score of 0 out of 15 which indicated the resident was severely cognitively impaired.A nursing progress note dated 4/22/26 at 10:11 AM indicated the medical provider was notified of Resident #3's elevated temperature of 103.0 and hypotension. New orders were provided, which included urinalysis with reflex. An order dated 4/22/26 for a urinalysis with reflex was present in the resident's clinical record. Resident #3's clinical record failed to include results or evidence of the urinalysis being obtained as ordered. During an interview with the Director of Nursing (DON) on 5/06/26 at 9:19 AM, the DON stated the urinalysis was not obtained and she did not know the reason, but Resident #3 was being treated for pneumonia. On 5/06/26 at 11:57 AM, the Administrator, DON, and the Regional Corporate Representative were informed facility staff failed to obtain a urinalysis as ordered for Resident #3. No further information regarding this concern was presented prior to the exit conference on 5/06/26.

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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. Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record by failing to document medical provider notification of an x-ray that could not be obtained as ordered for 1 of 3 sampled residents, Resident #3. The findings included:An admission Record revealed the facility admitted Resident #3 on 4/08/26. According to the admission Record, the resident had a medical history that included chronic respiratory failure with hypoxia, quadriplegia, central cord syndrome at C5 level of cervical spinal cord, dependence on ventilator, and chronic pain syndrome. An admission minimum data set (MDS) with an assessment reference date (ARD) of 4/14/26 indicated the resident had a Brief Interview for Mental Status (BIMS) summary score of 0 out of 15 which indicated the resident was severely cognitively impaired. Resident #3 was seen by the medical provider on 4/10/26 due to an elevated inflammatory panel indicating concern for osteomyelitis secondary to Stage IV wounds with bone exposure to the sacrum, iliac crests, and bilateral scapula. Orders included an x-ray of bilateral scapula. Resident #3's clinical record included a medical provider order dated 4/10/26 to obtain an x-ray of bilateral scapula; however, there were no results in the resident's clinical record. During an interview with the Director of Nursing (DON) on 5/06/26 at 9:19 AM, the DON stated the x-ray company would not obtain the bilateral scapula x-ray due to limitations caused by Resident #3's anatomy. The DON stated she notified the medical provider but failed to document the notification in Resident #3's clinical record. On 5/06/26 at 11:57 AM, the Administrator, DON, and the Regional Corporate Representative were informed of the concern regarding the lack of documentation of medical provider notification in the clinical record. No further information regarding this concern was presented prior to the exit conference on 5/06/26.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to maintain an infection prevention and control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections by failing to follow transmission-based precautions for 1 of 3 sampled residents, Resident #3.The findings included:An admission Record revealed the facility admitted Resident #3 on 4/08/26. According to the admission Record, the resident had a medical history that included chronic respiratory failure with hypoxia, quadriplegia, central cord syndrome at C5 level of cervical spinal cord, dependence on ventilator, and chronic pain syndrome. An admission minimum data set (MDS) with an assessment reference date (ARD) of 4/14/26 indicated the resident had a Brief Interview for Mental Status (BIMS) summary score of 0 out of 15 which indicated the resident was severely cognitively impaired. On 5/05/26 at 1:50 PM, Registered Nurse (RN) #1 donned gloves only and entered Resident #3's room and proceeded to pull up the resident's gown to expose their enteral feeding tube site. RN #1 stated Resident #3 was on enhanced barrier precautions, and she was not working with the tubes and no gown was needed. Resident #3's clinical record included a lower respiratory culture report dated 4/29/26 which indicated the resident tested positive for carbapenem-resistant Pseudomonas aeruginosa (CRPA). According to the CDC, Pseudomonas aeruginosa bacteria are a common cause of infections in healthcare settings. They can cause pneumonia, bloodstream infections, urinary tract infections, and surgical site infections, and they are particularly dangerous for patients with chronic lung diseases. Carbapenems are last-line antibiotics used to treat serious multi-drug-resistant infections. CRPA infections are not susceptible to the effects of these antibiotics. Resident #3's current medical provider orders included an order dated 4/30/26 for contact isolation.Resident #3's comprehensive person-centered care plan included a focus area dated 4/30/26 stating the resident requires isolation related to CRP (carbapenem-resistant Pseudomonas) in the sputum with an intervention to maintain isolation precautions per infection control policy. The facility's Infection Preventionist (IP) was interviewed on 5/06/26 at 10:14 AM outside of Resident #3's room. The IP stated a gown, and gloves were required to enter Resident #3's room since they were on contact precautions. The IP stated there were currently two residents positive for CRPA. A contact isolation sign was posted by the resident's door indicating staff must put on a gown before room entry. A facility policy titled, Transmission-Based (Isolation) Precautions, revised 4/02/25, indicated Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. On 5/06/26 at 11:57 AM the Administrator, Director of Nursing, and the Regional Corporate Representative were notified of the concern regarding staff failing to follow contact precautions.No further information was provided prior to the exit conference on 5/06/26.