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	02/20/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview and clinical record review the facility staff failed to develop a comprehensive care plan related to hearing loss for one of 18 current residents in the survey sample, resident # 47. Findings include: Based on observation, resident interview, staff interview and clinical record review the facility staff failed to develop a comprehensive care plan related to hearing loss for one of 18 current residents in the survey sample, Resident # 47.The findings included:Review of the Electronic Medical Record (EMR) revealed that resident #47 (R47) was admitted to the facility on [DATE] with pertinent diagnoses including but not limited to bilateral hearing loss. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed section B (Hearing) documented minimal difficulty- difficulty in some environments (e.g., when person speaks softly or setting is noisy), no hearing devices used and a Brief Interview for Mental Status (BIMS) of 13 which indicated R47 was cognitively intact.During an observation and interview with R47 in their room on 2/18/2026 at 1:50 PM, the resident could not hear throughout most of the visit when spoken to despite speaking very loudly in his left ear (preferred ear). He was able to report having a bath earlier in the morning, and that he is from the area. After some time, R47 became upset and dismissive as he could not understand or hear well enough to answer any other questions and yelled, I can't hear you. R47 did not have any hearing aids or listening devices and was unable to answer questions about assistive devices. R47 did not want to answer questions with written notes. The visit ended due to the resident becoming upset and agitated. During an observation of a medication administration for R47 on 2/19/2026 at 8:34 AM, in order for R47 to understand, Licensed Practical Nurse (LPN) #3 had to lean down towards the resident's left ear and speak very loudly. The interaction was brief and R47 struggled to understand everything LPN #3 was saying, but understood he was to take his medication.During an observation on 2/19/2026 at 1:26 pm of R47 while in his room reading from a printed sheet, he observed this writer from the doorway. After entering the room and standing close to R47, the interaction was brief and R47 reports he is doing well but still cannot hear questions being asked. A review of the Baseline Care Plan on admission on [DATE], revealed a medical status of very hard hearing and needs hearing aids. Review of hearing test by audiologist dated 1/5/2026, revealed R47 is able to answer sentence but not audible words. Hearing loss noted on testing form and signed by audiologist. Review of revised Care Plan dated 1/9/2026, revealed that R47 has behaviors or history of behaviors of: refusing medications, refusing care, yelling at staff, refusing to have bedside table cleaned off. Care Plan did not address hearing loss or difficulty with communication leading to behaviors such as yelling, frustrations, and refusing medications and care. An interview with License Practical Nurse (LPN) #2 on 2/18/2026 at 9:15 am confirmed that R47 is self-sufficient and hard of hearing. It is reported he has become upset with LPN #2 but apologized for his outburst. R47 has anxiety and LPN #2 was unable to confirm if his hearing is why he was upset that day, but they did have communication issues. She thinks he may choose not to wear his hearing aids but is not positive. An interview with LPN #4 on 2/19/2026 at 1:25 pm, revealed that she is able to communicate with R47 if she stands in front of him and speaks loudly on his left side. She reports (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he reads lips well and that he has been able to let her know what his needs are, but he does get agitated and frustrated easily.An interview with Director of Nursing (DON) on 2/19/2026 at 3:40 pm regarding care plan for R47 revealed that the facility does not have a policy regarding care plans but follow the regulations. The DON was familiar with R47 and his hearing issues. The DON returned shortly with an update to the current care plan with new entry dated 2/19/2026, that included a focus of resident has limitations in how they are able to communicate related to, hearing deficit. Updated interventions include anticipating the residents needs as able; ask yes or no questions, when possible; face the resident and speak distinctly and follow up with audiology as needed. On 2/19/2026 at 4:15pm, the administrator and DON were informed of the concern regarding R47's comprehensive care plan failing to address hearing loss and difficulty with communication. No further information was provided prior to the exit conference on 2/20/26.

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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. Based on staff interview and clinical record review, the facility staff failed to review, revise and/or reassess the effectiveness of the interventions of the comprehensive person-centered activity care plan for 3 of 18 current residents, Resident #7, Resident #9 and Resident #35. The findings included:1.For Resident #7, the facility staff failed to review, revise, and/or reassess the effectiveness of the interventions of the comprehensive person-centered activity care plan to meet the resident's needs. Resident #7's diagnosis list indicated diagnoses that included but were not limited to, pain in right hip, chronic kidney disease-stage 3, unsteadiness on feet, and multiple sclerosis. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/29/25, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of the current comprehensive person-centered activity care plan disclosed an initiated date of 2/13/23 with a revision date of 3/6/25 for the focus. The goal associated with the focus had a revision date of 3/17/25. The interventions had only initiation dates of 2/13/23. A review of the clinical record did not disclose any evidence of activity progress notes. Further review of the clinical record disclosed an admission Activity Evaluation dated 3/10/25. A review of the completed MDS schedule revealed the following MDS assessments were completed on the following dates with no evidence of a completed activity assessment, activity care plan review, and/or activity progress note: 3/1/25-annual5/29/25-quarterly8/29/25-quarterly11/29/25-quarterly Requested evidence of activity progress notes, activity assessments, and/or care plan revisions for Resident #7. On 2/19/26 at 2:38 PM, the facility administrator stated quarterly activity progress notes had not been completed. On 2/19/26 at 3:10 PM, the activity director (AD) was interviewed. The AD stated the activity care plan is not changed unless the resident voices a change or if the resident gets a new interest. AD agreed the activity care plan is not reviewed or revised unless there is a significant change. When asked the process to document the effectiveness of activity care plan focus, goals, and/or interventions during MDS reviews, the AD agreed progress is not being documented for the residents as there is not a lot of change with resident activities. This concern was discussed on 2/19/26 at 4:15 PM during the end of day meeting with the administrator, director of nursing, regional director of clinical services, vice president of operations, and regional director of maintenance. Requested a facility policy for activity documentation and/or a facility policy for care plans and was informed by the facility administrator on 2/19/26 at 2:46 PM, that facility staff follow the regulations for care plan documentation and do not have these requested policies. No further information regarding this concern was presented to the survey team prior to the exit on 2/20/26. 2. For Resident #9 the facility staff failed to review, revise, and/or reassess the effectiveness of the interventions of the comprehensive person-centered activity care plan to meet the resident's needs. Resident #9's diagnosis list indicated diagnoses that included but were not limited to, chronic respiratory failure with hypoxia, tracheostomy, gastrostomy, dependence on respirator, peripheral vascular disease, altered mental status, anxiety, intracerebral hemorrhage, anoxic brain damage, and cognitive communication deficit. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/25/25, Section C (Cognitive Patterns) was coded to reflect the resident was rarely/never understood with severe impairment in cognitive skills for daily decision making and never/rarely made decisions. A review of the current comprehensive person-centered activity care plan disclosed an initiated date of 9/25/25 for the focus. The goal associated with the focus had a revision date of 10/8/25. One intervention had an initiated date of 10/16/25 and the other intervention had an initiated date of 9/26/25 with a revision date of 10/16/25. A review of the clinical record did not disclose any evidence of activity progress notes. Further review of the clinical record disclosed an admission Activity Evaluation dated 9/18/25. A review of the completed MDS schedule revealed the following MDS assessments were completed (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the following dates with no evidence of a completed activity assessment, activity care plan review, and/or activity progress note: 12/25/25-quarterly Requested evidence of activity progress notes, activity assessments, and/or care plan revisions for Resident #9. On 2/19/26 at 2:38 PM, the facility administrator stated quarterly activity progress notes had not been completed. On 2/19/26 at 3:10 PM, the activity director (AD) was interviewed. The AD stated the activity care plan is not changed unless the resident voices a change or if the resident gets a new interest. AD agreed the activity care plan is not reviewed or revised unless there is a significant change. When asked the process to document the effectiveness of activity care plan focus, goals, and/or interventions during MDS reviews, the AD agreed progress is not being documented for the residents as there is not a lot of change with resident activities. This concern was discussed on 2/19/26 at 4:15 PM during the end of day meeting with the administrator, director of nursing, regional director of clinical services, vice president of operations, and regional director of maintenance. Requested a facility policy for activity documentation and/or a facility policy for care plans and was informed by the facility administrator on 2/19/26 at 2:46 PM, that facility staff follow the regulations for care plan documentation and do not have these requested policies. No further information regarding this concern was presented to the survey team prior to the exit on 2/20/26. 3. For Resident #35 the facility staff failed to review, revise, and/or reassess the effectiveness of the interventions of the comprehensive person-centered activity care plan to meet the resident's needs. Resident #35's diagnosis list indicated diagnoses that included but were not limited to, chronic respiratory failure with hypoxia, anoxic brain damage, heart failure, type 2 diabetes mellitus, persistent vegetative state, seizures, tracheostomy, gastrostomy, and osteomyelitis. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/25/25, Section C (Cognitive Patterns) was not coded due to resident being in a persistent vegetative state. A review of the current comprehensive person-centered activity care plan disclosed an initiated date of 4/30/25 for the focus. The goal associated with the focus had an initiated date of 4/30/25. Two interventions had an initiated date of 4/30/25 and one intervention had an initiated date of 4/30/25 with a revision date of 7/15/25. A review of the clinical record did not disclose any evidence of activity progress notes. Further review of the clinical record disclosed a Comprehensive Activity Evaluation dated 4/9/25 and an admission Activity Evaluation dated 10/1/25. A review of the completed MDS schedule revealed the following MDS assessments were completed on the following dates with no evidence of a completed activity assessment, activity care plan review, and/or activity progress note: 4/4/25-quarterly7/4/25-quarterly2/10/26-quarterly Requested evidence of activity progress notes, activity assessments, and/or care plan revisions for Resident #35. On 2/19/26 at 2:38 PM, the facility administrator stated quarterly activity progress notes had not been completed. On 2/19/26 at 3:10 PM, the activity director (AD) was interviewed. The AD stated the activity care plan is not changed unless the resident voices a change or if the resident gets a new interest. AD agreed the activity care plan is not reviewed or revised unless there is a significant change. When asked the process to document the effectiveness of activity care plan focus, goals, and/or interventions during MDS reviews, the AD agreed progress is not being documented for the residents as there is not a lot of change with resident activities. This concern was discussed on 2/19/26 at 4:15 PM during the end of day meeting with the administrator, director of nursing, regional director of clinical services, vice president of operations, and regional director of maintenance. Requested a facility policy for activity documentation and/or a facility policy for care plans and was informed by the facility administrator on 2/19/26 at 2:46 PM, that facility staff follow the regulations for care plan documentation and do not have these requested policies. No further information regarding this concern was presented to the survey team prior to the exit on 2/20/26.