STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495202	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gretna Health and Rehabilitation Center	595 Vaden Drive Gretna, VA 24557

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 the provider orders for wound care and failed to obtain provider orders for a fracture for 1 of 5 closed record reviews, Resident #94. Findings included:1. The facility staff failed to complete provider ordered treatments for a hematoma on Resident #94's left calf. Resident #94 experienced a fall prior to admission to the facility. A hematoma is a localized collection of blood outside blood vessels, usually caused by injury or trauma, which can lead to swelling, pain, and discoloration. Resident #94's diagnoses included contusion of lower leg, Parkinson's disease, and muscle weakness. Section C (cognitive patterns) of Resident #94's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 05/28/2024 included a Brief Interview for Mental Status (BIMS) score of 9, indicating Resident #94 was moderately impaired in cognitive skills for daily decision making. The Comprehensive Care Plan (CCP), initiated on 05/22/2024, identified impaired skin integrity of the left lower leg related to hematoma and included the intervention treatment as ordered. The clinical record included provider orders dated 05/22/2024 to cleanse the outer left calf with dermal wound cleanser, cover with Xeroform, ABD gauze pad, and Kerlix every day. The order was revised on 05/26/2024 with no changes other than documentation of a vascular diagnosis. Further review of the clinical record revealed that on 05/23/2024 and 05/30/2024, the facility staff documented a 9 (other/see progress notes) in the administration blocks on the Treatment Administration Record (TAR) for the left calf treatment. On 05/25/2024, staff documented a 14 (resident unavailable), the administration block for 05/26/2024 was left blank. Documentation on 05/23/2024, 05/25/2024, and 05/30/2024 indicated that Resident #94 was out of the facility for an appointment. No documentation was found for 05/26/2024. On 04/29/2026 at 5:00 PM, during an end of the day meeting with the Interim Administrator, Interim DON, Regional Nurse Consultant #1, and Regional [NAME] President of Operations, the issue with the missed provider ordered treatments for Resident #94 was reviewed. On 04/30/2026 at 8:56 AM, during an interview with the current wound care nurse Registered Nurse (RN) # 1, this staff stated if a resident had a scheduled appointment, wound care would typically be completed either before the appointment or upon the resident's return, unless the resident refused. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gretna Health and Rehabilitation Center	595 Vaden Drive Gretna, VA 24557

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This nurse confirmed they would have completed the treatment upon the resident's return to the facility. On 04/30/2026 at 9:15 AM, during an interview, the Interim Director of Nursing (DON) stated they probably would have waited until this resident returned from their appointment to complete the dressing change unless it was soiled but the treatment would have been completed. On 04/30/2026 at 9:29 AM, the surveyor attempted to contact Licensed Practical Nurse (LPN) #3 regarding the missed treatments. The call went to voicemail, and a message was left, no return call was received prior to completion of the survey. On 04/30/2026 at 1:15 PM, the Interim Administrator provided the survey team with a copy of their policy titled, Wound/Skin Impairments (effective 07/17/2024). This policy read in part, .Provide treatments as ordered . No additional information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #94, the facility staff failed to obtain a medical provider orders to address the care and/or treatment of a right pinky finger fracture. Resident #94's diagnosis list indicated a fracture of unspecified phalanx of unspecified finger, subsequent encounter for fracture with routine healing. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 5/28/24, assigned the resident a brief interview for mental status (BIMS) summary score of 9 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. Section I (Active Diagnoses) was coded (I4000) at Other Fracture. A review of a medical provider orders did not disclose any treatment, care, and/or follow-up appointment orders for Resident #94's right pinky finger fracture. A review of the September 2024 TAR (treatment administration record) did not disclose any treatment and/or plan for care of Resident #94's right pinky finger fracture. A review of Resident #94's clinical record disclosed the following documentation: A hospital progress note dated 5/19/24, which read in part, .Fracture of finger on right hand.Now on a splint, appreciate orthopedics.Follow-up in 1 to 2 weeks after discharge. A medical provider progress note dated 5/22/24 read in part, .ASSESSMENT AND PLAN.Fracture of finger of right hand - proximal phalanx of 5th digit (pinky finger); continue supportive care. A skilled nursing progress note dated 5/29/24 read in part, .Splint to right pinky finger is in place. A review of the comprehensive person-centered care plan did not disclose a focus area, goal, and/or interventions related to Resident #94's fracture of the right pinky finger. On 4/29/26 at 10:44 AM, the Medical Provider (MP) was interviewed via phone conversation and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated he never saw that ortho (orthopedics) saw Resident #94 in the hospital about the fracture of the right pinky finger. The MP recalled he saw Resident #94's bandaged finger at the facility and it was splinted. On 4/30/26 at 8:56 AM, the Wound Care Nurse (WCN) was interviewed and stated she was not employed at the time of Resident #94's admission. When asked the process if there was no order for care/treatment of a fractured finger, the WCN stated she would ask the medical provider for orders about a splint and/or treatment of a fractured finger. On 4/30/26 at 9:14 AM, the Interim Director of Nursing (IDON) was interviewed and stated she did not recall a splint being on Resident #94's fractured right pinky finger. A nursing progress note dated 5/29/26 written by the IDON was reviewed and the IDON stated she did not recall documenting the information. When asked what the protocol is for an admission with a fractured finger, the IDON stated the protocol would be to notify the medical provider to make them aware and to wait for an order. On 4/30/26 at 10:34 AM, the TCU (transitional care unit) UM (Unit Manager) was interviewed and stated she looked at Resident #94's picture in the clinical record but could not recall the resident. When asked what the protocol was if a new admission entered the facility with a fractured finger, the UM stated she would review the admission paperwork and look for any recommendations from ortho and would look for any follow-up ortho appointments related to the fracture. The UM stated she would call ortho if it was not clear for a treatment plan to make sure the fracture was treated/cared for appropriately. Four other nurses who were identified that cared for Resident #94 were no longer employed at the facility and were not available for interviews. This concern was discussed at the end of day meeting on 04/29/26 at 5:00 PM with the Interim Administrator, Assistant Administrator, Interim Director of Nursing, Regional Director of Clinical Services, and the Regional [NAME] President of Operations. Requested and received a facility policy titled, Physician's Orders with an effective date of 1/29/24 which read in part, .admission Physician's Orders must be provided for every patient at the time of admission.to activate a medical plan of care.1. Upon every patient's admission.a licensed nurse will notify the physician requesting.physician's orders.2.b. admission orders should include.10. Other orders as indicated by patient's condition with specific directions. No further information was provided prior to exit on 4/30/26.