STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495207	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Health and Rehabilitation Center	720 Orchard Avenue Rocky Mount, VA 24151

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 0689 Level of Harm - 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 staff interviews, clinical record review, and facility document review, the facility staff failed to ensure the resident environment remained free of accident hazards as is possible for (1) one of (3) three current sampled residents, Resident #1, resulting in harm. While operating a motorized wheelchair in the facility parking lot on 4/03/26, Resident #1 struck a curb which caused the motorized wheelchair to tilt resulting in Resident #1 falling from the motorized wheelchair. Resident #1 sustained bilateral subdural hematomas, first/second cervical vertebral fractures, a scalp laceration, multiple abrasions, and a hematoma of the scalp resulting in transfer to a higher level of care and surgical intervention. The findings included: Resident #1's diagnosis list indicated diagnoses that included, but were not limited to, Parkinson's disease, unspecified hearing loss - bilateral, spinal stenosis, osteoarthritis, spondylosis, anxiety disorder, weakness, depression, nondisplaced fracture of first cervical vertebra, nondisplaced fracture of second cervical vertebra, traumatic subdural hemorrhage, and adult failure to thrive.The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 4/27/26, assigned the resident a brief interview for mental status (BIMS) summary score of 13 out of 15 for cognitive abilities, indicating the resident was cognitively intact.A review of Resident #1's clinical record disclosed the following documentation:A medical provider follow-up note dated 04/03/2026 indicated Resident #1 was seen for altered mental status with increased confusion. A urinalysis was ordered on 4/02/2026 and results were pending. Resident #1 had agreed to postpone discharge for now due to the altered mental status. A fall progress note dated 04/03/2026 at 3:36 PM revealed Resident #1 was observed outside of the facility in his power wheelchair and flipped the power wheelchair on the sidewalk hitting his head causing a laceration. The resident was sent to the emergency room for evaluation, and the power-wheelchair would be sent home with the resident's family and no longer allowed back at the facility. A review of Resident #1's clinical record failed to reveal evidence of a safety skills assessment for use of a motorized power chair or education regarding safe use while residing at the facility. On 05/11/2026 at 3:28 PM, the Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) were interviewed and the DON stated Resident #1 was admitted to the facility with the motorized wheelchair. When asked if the resident was evaluated for wheelchair safety upon/after admission, the RDCS stated, No, that was part of our plan of correction.On 5/11/26 at 4:38 PM, the Director of Rehab (DoR) was interviewed and stated Resident #1 admitted to the facility with a power wheelchair. The DoR stated she had worked in the facility since 2021, and this was the only power wheelchair that's been in the facility since that time. The DoR stated PT did evaluate Resident #1 upon admission to the facility and the resident was able to use the power chair at their baseline. Resident #1 used the power wheelchair daily throughout the facility and had no prior incidents/accidents with the chair and therapy worked with the resident on obstacle courses with the chair up until the day of the incident. She stated Resident #1's discharge was put on hold related to altered mental status.On 5/11/26 at 4:46 PM, the DON was interviewed again, and stated Resident #1 was on antibiotics for a urinary tract infection at the time of the incident. The DON stated the resident (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	had been assessed to be safe to go outside in the motorized wheelchair prior to the incident and believed the resident to be cognitively appropriate to be independent in the motorized wheelchair.On 05/11/2026 at 3:50 PM the RDCS provided a facility synopsis of events file and corrective action plan for the incident that occurred on 4/3/26 with Resident #1 and stated there were no other residents in the facility with motorized wheelchairs.A review of a hospital Discharge summary dated [DATE] read in part, .status post fall from motorized scooter at.living facility.was found to have b/l SDH (bilateral subdural hematomas), C1/C2 fx (first/second cervical vertebra fractures) and taken to OR (operating room) with NSGY (neurosurgery) on 4/6 (4/6/26) for C1-5 PCDF (posterior cervical decompression and fusion involving the cervical vertebrae from C1 to C5).noted to have a scalp laceration requiring staples.This concern was discussed on 5/11/26 at 5:02 PM at the end of day meeting with the Interim Administrator, Director of Nursing, and Regional Director of Clinical Services.The Plan of Correction (POC) had a completion date of 4/10/26 and read as follows:1. What was done immediately for problem identified:Resident was assessed for injuries, EMS (emergency medical services) activated, MD (medical doctor) notified, MD order to send resident to the Emergency Department. Resident family notified of incident and imminent transport to hospital. Investigation of incident initiated, including lookback into resident EHR (electronic health record), staff interviews, etc.2. How were other residents that had potential to be affected by the problem identified:All current residents were reviewed to determine if power wheelchairs were in use.3. Education - what was done to prevent reoccurrence:admission process was initiated that all resident referrals requesting admission with their power wheelchair or scooter will be evaluated by Therapy using the Safety Skills Assessment Supplement.4. How is this going to be monitored ongoing:All admissions will be reviewed by admissions/nursing to ensure that there are orders or requests for power wheelchair/scooter.5. QA (quality assurance) Statement:The Admissions Director will alert the DON and DOR (Director of Rehab) of any admissions requesting the use of power wheelchairs/scooters. The PT (Physical Therapy) Assessment ProcessPT will conduct a pre-admission or early-admission evaluation that includes:-Review of medical records and wheelchair specifications-Cognitive/safety screening-Physical examination of motor function and control-Environmental assessment of the unit-Determination of: Approve use as-is / Approve with modifications / Restrict use pending further evaluation / Recommend manual wheelchair instead-PT will communicate findings to the admissions team and DON/Charge Nurse with an agreed-upon timeframe (48-72 hours of admission if pre-admission evaluation is not feasible).Responsible Parties: admission Director, DON, DOR 6. Completion Date4/10/2026 and ongoing.A review of the credible evidence for the POC on 4/10/26 disclosed education had been completed addressing the utilization of power wheelchairs in the facility including notification, assessment/evaluation, potential for injuries, and the PT Assessment Process.On 5/11/26 at 12:18 PM, an initial walk-through/observation of the facility was conducted. No motorized wheelchairs were observed to be in any resident rooms or within the areas of the facility that were observed.On 5/11/26 at 2:39 PM, Resident #1 was observed in room sitting in a standard wheelchair. A motorized wheelchair was not visible in the resident's room.On 5/11/26 at 4:33 PM, the Admissions Director (AD) was interviewed and asked about the process for potential admissions with requests for motorized wheelchairs. The AD stated the family and/or resident are informed the resident will be put into a regular wheelchair until PT can evaluate for a power wheelchair. PT does an evaluation/assessment and the resident can use a power chair if PT determines the resident is safe. The AD stated she has spoken with the hospital liaisons about the facility's protocol for potential admissions that may have power wheelchairs.On 5/11/26 at 4:38 PM, the Director of Rehab (DoR) was interviewed and stated the process now is to utilize the power wheelchair assessment and if a new admission would want a power wheelchair therapy has to do an evaluation. A BIMS (brief interview for mental status) has to be completed and determinations have to be made to see if the resident is safe or not safe in a power wheelchair. The DoR stated that facility staff are also to be aware of any change in condition that could arise and new assessments and/or (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	re-evaluations would have to be completed. The DoR stated if a resident and/or family would request a power wheelchair after they are admitted , they have a contracted service that would bring a power wheelchair for demonstration and therapy would evaluate the resident in the demo chair for measurement, fit, safety, and would complete an evaluation at that time. On 5/11/26 at 4:46 PM, the DON was interviewed and a process has been put into place and prior to admission a potential resident is assessed for appropriateness for a power wheelchair and therapy completes an evaluation to determine if the resident would be safe. The DON stated nursing staff complete assessments as well for cognitive function and other factors for determination for power wheelchair use. The DON stated the same steps would be utilized for a resident that is already at the facility and concluded the facility staff attempt to deter power wheelchairs from coming into the facility, they want residents to be mobile but also want to consider all the residents safety.The other staff member who was included in the staff education, was out of the facility on leave at the time of the survey and was unavailable for interview.No further information was provided prior to exit on 5/12/26.This deficiency was cited as past non-compliance.