STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pulaski Hlth & Rehab Cntr	2401 Lee Highway Pulaski, VA 24301

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. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to consistently implement the comprehensive care plan for one of six residents in the survey sample, resident # 4.The findings included: For resident #4 the facility staff failed to ensure fall mats were in place on each side of the bed per the residents individualized comprehensive care plan. Resident #4's diagnoses included but were not limited to dementia, repeated falls, muscle weakness, anxiety and osteoporosis. On 11/6/25 at 9:15 AM this surveyor visited with resident #4 in their room. The resident was lying in bed and was alert and pleasant. There was no fall mat noted on the left side of the bed where the surveyor stood to speak with resident. The minimum data set (MDS) assessment with an assessment reference date of 10/24/25 assigned the resident a brief interview for mental status (BIMS) score of 2, which is an indication of severe cognitive impairment. The MDS stated the resident #4 did have 2 falls since the prior assessment, one with no injury and one with minor injury.According to the progress notes, resident #4 fell on 8/4/25 at 11:45 AM while toileting independently. On 9/21/25 at 3:45 AM resident rolled out of bed to the floor and sustained a skin tear to the top of the right hand. The progress note dated 9/21/25 at 4:17 AM read, Description of the fall/V/S/injuries if any: Resident attempting to self-toilet, after fall alarm in bed sounded, staff entered room, resident in floor on buttocks, has skin tear to right posterior hand. What Interventions were in place at the time of the fall: bed low to floor, had removed no-slip socks, alarm on and working properly. What are the risk factors that could have contributed to the fall? resident continent and attempting to self-toilet- [NAME] fast. What new Interventions were implemented in response to the fall? concave mattress. Was the Provider/resident and RP notified at the time of the fall? YES. Additional Comments: resident swift in walking. There was no mention of fall mats being in place anywhere in the documentation.The comprehensive care plan included a problem statement that read, The resident is at risk for falls related to weakness and deconditioning with an actual fall. The interventions included an intervention dated 7/18/25 that read, Fall mats on each side of the bed. On 11/6/25 at 10:00 AM this surveyor interviewed Registered Nurse (RN) #3 who stated they were the unit manager. When asked if resident #4 was supposed to have bilateral fall mats they stated, Yes, they should be there. Surveyor and RN #3 went to the resident's room. RN #3 stated, They are both over there. Indicating that both fall mats were on the right side of the bed between the bed and window. This surveyor asked if that was the expectation and RN #3 stated, No, there should be one on each side.The policy entitled, Falls Management Program with an effective date of 1/24/24 was requested and provided. The document read in part, The Center considers all residents to be at risk for falls and provides an environment as safe as practicable for all patients. The Center utilizes a systematic approach with evidence-based interventions to develop individual strategies. Under the heading entitled, Prevention, item #3 read, Incorporate any identified interventions into the care plan as applicable. Under the heading, Fall Occurrence item #3 read, A licensed nurse will review, revise, and implement interventions to the care plan based on: Post Fall Investigation findings, Review of Device Assessment, Review of Fall Risk Scoring Tool. The most recent Device assessment dated [DATE] was reviewed. The only devices listed as currently in use were side rails. The Device assessment dated [DATE] was reviewed. Devices listed as current included bilateral fall mats, chair/bed alarm, side rails, and a specialty bed/mattress. On 11/6/25 at 10:30 AM this surveyor met with the Director of Nursing, (DON) and Regional Director of Clinical Services (RDCS) to discuss this concern. The DON reported that the certified nursing assistant assigned to resident #4 had gotten the resident up to the toilet after breakfast and forgot to put the mat back in place.The survey team met with the Administrator, the DON and the RDCS at 12:22 PM and this concern was reviewed with them at that time. No further information was provided to the survey team prior to the exit conference.

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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. **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 maintain a complete and/or accurate clinical record for (1) one of (2) two closed record reviews, Resident #1. The findings included:For Resident #1 the facility staff failed to accurately document a skin assessment and/or nursing progress note on 6/20/25 after an allegation of staff to resident abuse was reported and a nurse performed a skin assessment of the resident. Resident #1's diagnosis list indicated diagnoses that included, but were not limited to, Congestive Heart Failure, Altered Mental Status, Aphasia, Cerebral Infarction, and Cognitive Communication Deficit. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 5/30/25, assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A Skin assessment dated [DATE] read in part, .Large areas of bruising noted to bilateral buttocks/hip areas d/t (due to) medication injections. Generalized bruising noted to bilateral upper extremities from blood draws .No other skin impairments noted at this time. An Encounter Note dated 6/20/25, read in part, .Periods of agitation reported. has had increase in behaviors, has accused the staff of dragging her across floor to cause bruising, bruising is actually from IM (intramuscular) injections. A review of a facility synopsis of events included an investigative reporting statement from registered nurse #2 (RN#2) dated 6/20/25 which read in part, .Skin assessment completed, no new areas were observed. A Skin assessment dated [DATE] read in part, . Bruising noted to bilateral buttocks. no change from previous assessment completed on 6/17/2025. On 11/6/25 at 9:13 AM, surveyor interviewed RN#2 and she informed this surveyor she did a skin assessment on Resident #1 after learning of an abuse allegation. This surveyor inquired about the protocol when conducting a skin assessment after an allegation of abuse and RN#2 stated she did not document it because she did not find anything new, if she had found something new, she would have documented a skin assessment. On 11/6/25 at 9:44 AM, this surveyor interviewed the director of nursing (DON) and she informed this surveyor her expectation when there is an allegation of abuse is a head-to-toe skin assessment to be documented in the clinical record under the assessments tab or in a nursing progress note. This concern was discussed at the pre-exit meeting on 11/6/25 at 12:25 PM with the administrator, director of nursing, and regional director of clinical services. This surveyor requested but did not receive a facility policy regarding accuracy of documentation in the clinical record. This surveyor did receive a facility policy titled Nursing Care & Services which read in part, .Nursing staff will provide nursing care and services following current standards of practice. No further information was provided to the survey team prior to exit on 11/6/25.