STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bowling Green Health & Rehabilitation Center	120 Anderson Avenue Bowling Green, VA 22427

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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 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. Based on observation, interview, staff interview, facility document review, and clinical record review, the facility staff failed to implement the care plan for one of 12 residents in the survey sample, Resident #10. The findings include: For Resident #10 (R10), the facility staff failed to implement Resident #10's care plan on 5/28/25 during incontinence care. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 416/25, R10 was coded as being cognitively intact. She was coded as being completely dependent on staff for bed mobility. On 5/28/25 at 1:18 p.m., R10 was observed lying in bed. She was awake and alert. She stated only one CNA (certified nursing assistant) was in the room earlier that morning to provide incontinence care for her. She stated the CNA was standing on R10's left, pulled the draw sheet too far, and the resident fell out of bed on the right side, landing on her knees. She stated she was still in a great deal of pain in both of her knees. She stated sometimes there are two CNAs when they provide incontinence care, and sometimes there is only one. A review of R10's care plan dated 4/10/25 revealed, in part: The resident is at risk for falls related to muscle weakness, related to recent hospitalization .The resident requires assistance with ADLs (activities of daily living) related to .weakness, recent hospitalization .2 person assist for bed mobility. A review of R10's Kardex for caregivers revealed, in part: Bed Mobility .2 person assist for bed mobility .draw sheet for turning and repositioning while in bed .lift sheet for turning and repositioning while in bed. A review of R10's clinical record revealed the following: (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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(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	5/28/2025 08:02 (8:02 a.m.) Fall Note Description of the fall/V/S (vital signs) /injuries if any: Per CNA (certified nursing assistant) during perineal care, Resident slipped down to the floor. After assessment on Resident, there was no physical injuries, but Resident c/o (complained of) lateral knee pains .What interventions were in place at the time of the fall?: bed rails up, call bell, and personal belongings within reach, and bed in the lowest position. What are the risk factors that could have contributed to the fall?: Resident needs wide air mattress for comfort, and bed mobility. What new interventions were implemented in response to the fall?: Turned, repositioned, pain med administered, wired air mattress for comfort, and bed mobility ASAP (as soon as possible). On 5/29/25 at 9:03 a.m., LPN (licensed practical nurse) #3 was interviewed. He stated nurses and CNAs (certified nursing assistants) know how many staff members are required to provide care to a resident from the Kardex. After reviewing R10's Kardex, he stated the resident's care plan required two staff members at the bedside when incontinence care was being given because the resident was required to turn back in forth in bed for the care. He stated a care plan is developed to meet each resident's individual needs. He stated the charge nurse is responsible to oversee the CNAs and floor nurses to make sure the care plan is followed. On 5/29/25 at 10:10 a.m., CNA #2 was interviewed. She stated she provided incontinence care to R10 on 5/28/25 early in the morning. She stated she was in the process of changing the resident and grabbed the draw sheet. As she grabbed the draw sheet, R10 reached out to grab the grab bar. CNA #2 stated R10 let go of the grab bar and fell over the right side of the bed. She stated R10 should always have two staff members when she is being changed for safety. She stated all other staff members were busy with other things because it was almost time for shift change. She stated she was aware that the resident fell because there was not a second staff member on the resident's right side of the bed. On 5/28/25 at 10:32 a.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns. A review of the facility policy, Care Planning, revealed, in part: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient.

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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 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. Based on observation, interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide safety during incontinence care for one of 12 residents in the survey sample, Resident #10. The facility staff failed to utilize two staff members to change Resident #10's soiled brief on 5/28/25. Resident #10 fell out of bed and sustained a broken femur. The facility's failure resulted in harm to Resident #10. The findings include: For Resident #10 (R10), the facility staff failed to utilize two staff members to change Resident #10 on 5/28/25. The resident fell out of bed and suffered a fractured femur. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 416/25, R10 was coded as being cognitively intact. She was coded as being completely dependent on staff for bed mobility. On 5/28/25 at 1:18 p.m., R10 was observed lying in bed. She was awake and alert. She stated only one CNA (certified nursing assistant) was in the room earlier that morning to provide incontinence care for her. She stated the CNA was standing on R10's left, pulled the draw sheet too far, and the resident fell out of bed on the right side, landing on her knees. She stated she was still in a great deal of pain in both of her knees. She stated sometimes there are two CNAs when they provide incontinence care, and sometimes there is only one. A review of R10's care plan dated 4/10/25 revealed, in part: The resident is at risk for falls related to muscle weakness, related to recent hospitalization .The resident requires assistance with ADLs (activities of daily living) related to .weakness, recent hospitalization .2 person assist for bed mobility. A review of R10's Kardex for caregivers revealed, in part: Bed Mobility .2 person assist for bed mobility .draw sheet for turning and repositioning while in bed .lift sheet for turning and repositioning while in bed. A review of R10's clinical record revealed the following: 5/28/2025 08:02 (8:02 a.m.) Fall Note Description of the fall/V/S (vital signs) /injuries if any: Per CNA (certified nursing assistant) during perineal care, Resident slipped down to the floor. After assessment on Resident, there was no physical injuries, but Resident c/o (complained of) lateral knee pains .What interventions were in place at the time of the fall?: bed rails up, call bell, and personal belongings within reach, and bed in the lowest position. What are the risk factors that could have contributed to the fall?: Resident needs wide air mattress for comfort, and bed mobility. What new interventions were implemented in response to the fall?: Turned, repositioned, pain med administered, wired air mattress for comfort, and bed mobility ASAP (as soon as possible. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	5/28/2025 12:40 p.m. Medical Visit .patient seen per nursing request s/p (after) fall. Pt (patient) seen and examined at bedside and reports pain to bilat (bilateral) knees. Denies hitting her head or any pain/ injury elsewhere. Denies hip pain. no abnormal bruising or injury noted to bilateral knees .Assessment and plan . c/w (continue with) Percocet (opioid pain medication) for pain .stat (immediate) x-rays of bilateral knees. 5/28/2025 16:30 (4:30 p.m.) COMMUNICATION - with Resident .Per follow up investigation from resident's fall on 5/28/25, spoke with resident regarding x-ray results still pending and resident's pain management not effective despite receiving scheduled and breakthrough interventions nonpharmacological interventions were implemented and ineffective as well, resident was offered to be sent to ER (emergency room) for further evaluation and accepted. NP (nurse practitioner) .made aware of resident wanting to go out and order was given to be sent to ER. 5/28/2025 16:57 (4:57 p.m.) Health Status Note .Resident sent to [name of local hospital] per request via 911 (emergency services). A review of R10's May 2025 MAR (medication administration record) revealed she received Percocet 5-325 mg (milligrams) one tablet at 11:07 a.m. and 3:25 p.m. with no pain relief experienced by R10. A review of R10's left knee X-ray result dated 5/28/25 revealed, in part: A fracture of the distal femur is identified. On 5/29/25 at 9:03 a.m., LPN (licensed practical nurse) #3 was interviewed. He stated nurses and CNAs (certified nursing assistants) know how many staff members are required to provide care to a resident from the Kardex. After reviewing R10's Kardex, he stated the resident required two staff members at the bedside when incontinence care was being given because the resident was required to turn back in forth in bed for the care. On 5/29/25 at 10:10 a.m., CNA #2 was interviewed. She stated she provided incontinence care to R10 on 5/28/25 early in the morning. She stated she was in the process of changing the resident and grabbed the draw sheet. As she grabbed the draw sheet, R10 reached out to grab the grab bar. CNA #2 stated R10 let go of the grab bar and fell over the right side of the bed. She stated R10 should always have two staff members when she is being changed for safety. She stated all other staff members were busy with other things because it was almost time for shift change. She stated she was aware that the resident fell because there was not a second staff member on the resident's right side of the bed. On 5/28/25 at 10:32 a.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns, and was informed of the concern for harm to R10. A review of the facility policy, Fall Prevention, revealed no information related to the circum-stances of R10's fall.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide nutritional care and services consistent with a resident's comprehensive plan of care for one of 12 residents in the survey sample, Resident #12. The findings include For Resident #12 (R12), the facility staff failed to accurately monitor and document the resident's breakfast meal intake on 5/29/25. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/4/25, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. R12's comprehensive care plan revised on 3/4/25 documented, Nutrition Risk r/t (related to) therapeutic diet orders, hx/o (history of) sepsis, copd (chronic obstructive pulmonary disease [lung disease]), gerd (gastroesophageal reflux disease), bipolar. Hx/o sig (significant) wt (weight) gain .Interventions: monitor intake and record each meal . R12's meal ticket for breakfast on 5/29/25 documented the tray contained scrambled egg substitute with vegetables, wheat toast, orange juice, and grits. On 5/29/25 at 9:16 a.m., R12's breakfast tray was observed. R12 had drank coffee and juice but did not eat any of the food (the eggs, grits, or toast). R12 stated he did not feel like eating. CNA (certified nursing assistant) #8 entered the room, removed R12's tray, and did not open the plate cover to observe how much food the resident had consumed. A review of R12's May 2025 ADL (activities of daily living) records revealed CNA #8 documented R12 consumed 51% to 75% of his breakfast. On 5/29/25 at 1:33 p.m., an interview was conducted with CNA #8. CNA #8 stated she monitors residents' meal intakes by watching what the residents eat and documenting accordingly. CNA #8 stated she picked up R12's tray that morning and the resident ate about 75% of his meal. On 5/29/25 at 1:37 p.m., in the presence of CNA #8, R12 stated he did not eat breakfast that morning. CNA #8 stated R12's wife eats food off the resident's tray. On 5/29/25 at 1:39 p.m., another interview was conducted with CNA #8 (not in the presence of R12). CNA #8 stated that although she knew R12's wife eats food off the resident's plate, she documented according to her observation of the resident's plate and did not ask R12 how much food he consumed. On 5/29/25 at 1:41 p.m., another interview was conducted with R12. R12 stated his wife did not eat any food off his plate that morning. On 5/29/25 at 2:05 p.m., an interview was conducted with OSM (other staff member) #8 (the registered dietician). OSM #8 stated he reviews residents' meal intakes when completing their nutritional assessments. On 5/29/25 at 2:50 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, Meal Intake documented, Meal intake will be documented after each meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was presented prior to exit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a resident was free from an unnecessary medication for one of 12 residents in the survey sample, Resident #9. The findings include: For Resident #9 (R9), the facility staff failed to hold the medication hydralazine (medication for high blood pressure) per the physician ordered parameter of a systolic blood pressure less than 140. A review of R9's clinical record revealed a physician's order dated 2/27/25 for hydralazine 50mg (milligrams)-one tablet by mouth two times a day for hypertension (high blood pressure). Hold for SBP (systolic blood pressure) less than 140. A review of R9's March 2025 MAR (medication administration record) revealed the resident was administered hydralazine on 3/4/25 at 9:00 a.m. although the resident's systolic blood pressure was 134, administered hydralazine on 3/4/25 at 10:00 p.m. although the resident's systolic blood pressure was 137, and administered hydralazine on 3/5/25 at 9:00 a.m. although the resident's systolic blood pressure was 138 (as evidenced by check marks on the MAR). A nurse's note dated 4/8/25 documented, NP (Nurse Practitioner), (name) and (name) and RP (Responsible Party), (name) aware on 3/4 at 2200 (10:00 p.m.) and on 3/5 at 0900 (9:00 a.m.), resident was given hydralazine outside of prescribed parameters, no adverse reactions or abnormalities noted at the time, BP (Blood Pressure) continued to be monitored. On 5/28/25 at 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the nurse who documented the above note). LPN #1 stated on certain days, she runs a report and looks to see if medications were administered out of physician ordered parameters. LPN #1 stated that on 3/4/25 and 3/5/25, the nurses gave R9 hydralazine without paying attention to the parameter. LPN #1 stated the parameter was to hold the medication if the resident's systolic blood pressure was less than 140. LPN #1 stated that on those dates the medication was administered and should not have been. On 5/29/25 at 2:50 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, General Guidelines for Medication Administration documented, II. Administration. 2. Medications are administered in accordance with written orders of the prescriber. No further information was presented prior to exit.

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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 and facility document review, it was determined that the facility staff failed to follow infection control practices during ADL (activities of daily living) care for one of 12 residents in the survey sample, Resident #4. The findings include: For Resident #4 (R4), the facility staff failed to follow enhanced barrier precautions when providing ADL care including incontinence care, dressing and linen change on 5/29/25. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/6/25, the resident was assessed as being dependent for toileting, dressing and transfers. The assessment documented one venous or arterial ulcer present with dressing applications completed. Observation of R4's room on 5/28/25 at 11:53 a.m. revealed a sign located outside of the door which documented in part, Stop Enhanced Barrier Precautions . Wear gown and gloves when entering room to provide the following high-contact resident care activities: *Dressing *Bathing/Showering *Transferring *Changing Linens *Providing Hygiene *Changing briefs or assisting with toileting . A plastic bin located outside of R4's doorway contained yellow isolation gowns and gloves. The comprehensive care plan for R4 documented in part, The resident has a venous/stasis ulcer of the Right inner Lateral leg r/t (related to) PVD (peripheral vascular disease). Created on: 08/26/2021. Revision on: 04/20/2023. On 5/29/25 at 11:30 a.m., an observation was made of CNA (certified nursing assistant) #6 providing ADL care to R4. CNA #6 was observed providing incontinence care, changing a soiled brief, dressing R4 and changing soiled bed linens. CNA #6 was observed to wear gloves but failed to wear a gown during the care provided. After performing ADL care, LPN (licensed practical nurse) #7 assisted CNA #6 to transfer R4 from the bed to the wheelchair. Neither staff member wore a gown during the care provided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/25 at 11:43 a.m., an interview was conducted with LPN (licensed practical nurse) #8, infection preventionist. LPN #8 stated that the criteria for residents to be on enhanced barrier precautions (EBP) was for chronic wounds with drainage, PICC (peripherally inserted central catheters) or anything that could cause an infection were an indication for EBP. She stated that the criteria was basically driven from the facility policy. LPN #8 stated that when on EBP, the staff wore gown and gloves when providing care such as wound care, bed baths, and ADL care. On 5/29/25 at 1:21 p.m., an interview was conducted with CNA #8 who stated that when a resident was on EBP there was a sign on the door and a bin outside of the room that held the gowns and gloves for them. She stated that they wore the gowns and gloves when they were providing care such as baths and incontinence care. The facility policy Enhanced Barrier Precautions (EBPs) effective 3/26/24, documented in part, Employees providing high-contact patient care activities will follow Enhanced Barrier Precautions (EBPs) for patients who meet the criteria . EBPs require the use of gown and gloves by staff during high-contact patient care activities as defined below: a. Dressing, b. Bathing/showering, c. Transferring, d. Changing linens, e. Providing hygiene, f. Changing briefs or assisting with toileting . On 5/29/25 at 2:51 p.m., ASM (administrative staff member) #1, the administrator and ASM #5, regional director of clinical services were made aware of the concern. No further information was provided prior to exit.