STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495352	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee Health and Rehab Center	208 Health Care Drive Pennington Gap, VA 24277

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on staff interview, clinical record review and facility document review the facility staff failed to notify the resident's representative of a change in condition requiring medical intervention for 1 of 3 residents, Resident #1.The findings included:Resident #1's clinical record listed diagnoses which included but not limited to metabolic encephalopathy, aphasia and dysphagia.Resident #1's face sheet did not list an authorized representative/responsible party but did list four emergency contacts.Resident #1's most recent minimum data set with an assessment reference date of 11/03/25 assigned the resident brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident was severely cognitively impaired. Resident #1's comprehensive care plan was reviewed and contained a plan for .requires tube feeding r/t (related to) nutritional needs. Interventions for this plan included Observe/document/report to MD PRN (as needed): Aspiration-fever SOB (shortness of breath), Tube dislodged, Infection at tube site, Self-extubation, tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distention, tenderness and Check tube for placement and gastric contents/residual volume per facility protocol or MD orders. See orders.Resident #1's progress notes were reviewed and contained a note which read in part, Date of Service: 11/06/2025. Visit Type: Post Acute Care Visit 5 .Chief Complaint/Reason for this Visit: Dislodges gastrostomy tube .HPI (history of present illness) Relating to this Visit: The patient is an . presenting with a dislodged gastrostomy tube. The gastrostomy tube, which is a 20 FR (French) was initially placed in the hospital for feeding purposes. The patient is currently undergoing treatment for cancer outside of the facility. She receives Glucerna at a rate of 60 ml per hour for 16 hours a day. The staff reported that they found the patient had pulled out the tube with the balloon still intact. The abdomen was cleaned and dried, and the tube was reinserted without difficulty, with minimal bleeding at the site. Placement was confirmed with auscultation and aspiration, and a KUB (kidneys, ureter, bladder) was ordered to check the tube placement. The patient has positive bowel sounds and even, unlabored respirations .Assessment and Plan: Assessment: The patient experienced a dislodged gastrostomy tube, which was reinserted without difficulty. The placement was confirmed with auscultation and aspiration, and a KUB was ordered to verify the tube's position. There was minimal bleeding at the site, and the patient has positive bowel sounds. Plan: Continue monitoring the gastrostomy tube site for any signs of infection or further dislodgement. Await results of the KUB to confirm proper placement. Educate staff on ensuring the tube remains secure to prevent future dislodgement. There is no documentation that the resident's emergency contact was notified of the gastrostomy tube dislodgement and subsequent replacement. Spoke with registered nurse (RN) #1 on 04/08/26 at 3:30 pm. RN #1 stated that resident had pulled out her gastrostomy tube and the FNP (family nurse practitioner) had reinserted it. RN #1 was asked if anyone notified the resident's emergency contact that tube had been dislodged and replaced and RN #1 stated, Not that I know of, I know I didn't.Spoke with facility administrator on 04/08/26 at 4:15 pm. Administrator stated the facility had completed an action plan related to failure to notify the resident's emergency contact. Administrator provided a copy of the facility corrective action plan related to failure to notify, which read in part, Corrective Action Plan. Problem identified: (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Failed to follow notification of change policy to RP (responsible party) and failure to document in medical record. Plan Start Date: 11/17/25. Plan Completion Date: 2/23/26. Root Cause Analysis: Licensed nurse failed to document her assessment, observations and services provided in the medical record and failed to notify legal representative of the change .Why did the problem occur? Licensed nurse advised UM (unit manager) and NP (nurse practitioner) of Gastrostomy tube dislodgement but failed to document in the medical record and notify the legal representative of the change and reinsertion Gastrostomy tube by NP .How will corrective action be accomplished for those patients affected by the problem: 24-hour report summary will be reviewed by nursing management for accurate documentation in medical record of assessments, interventions and RP notification of change in condition per policy. Education will be completed with licensed nurses regarding documentation in medical record policy and notification of change policy to legal representative. UM's (unit managers) educated on duties to review 8/24/72 hour summary report for accuracy of documentation based on their rounds. How will the Center identify other patients having the potential to be affected by the same problem: All residents are at risk of being potentially affected if licensed nurses do not follow documentation in medical records and notification of change policy. What measures and systemic changes will be put into place to ensure that the problem will not recur: 24/72-hour report will be scrubbed Mon-Fri for ACCURATE DOCUMENTATION OF CHANGE IN CONDITION IN MR (medical record) AND RP notification. Any concerns identified will be addressed immediately. How will the center monitor its performance to make sure that solutions are sustained: The DON (director of nursing) or Designee view 24-hour summary for accurate documentation in change in conditions including legal representative notification 5x a week for 2 weeks, then 3 x week x 2 weeks then weekly for 2 weeks then monthly x 2 and report findings to QAPI (quality assurance and performance improvement committee.Requested and was provided with a facility policy entitled Notification of Changes which read in part, The purpose of this policy is to ensure the Center promptly informs the patient, consults the patient's physician/physician extender; and notifies the patient's legal representative when there is a change requiring notification.1a. Circumstances requiring notification include: i. Accidents resulting in injury or accidents that require emergent/urgent physician/physician extender intervention .2a. ii. When a patient is mentally competent, a designated family member should be notified of significant changes in the patient's health status because the patient may not be able to notify them personally, especially in the case of sudden illness or accident.Surveyor reviewed credible evidence and confirmed that each item had been completed and on-going monitoring was confirmed. Interviews with staff were conducted and it was confirmed staff were knowledgeable regarding provider and/or resident representative notification of significant changes in resident condition. A review of the current sampled residents revealed no concerns with provider and/or resident representative notification of significant changes in resident condition.The concern of not notifying the resident's emergency contact was discussed with the administrator, director of nursing and regional director of clinical services on 04/08/26 at 5:30 pm.No further information was provided prior to exit.This is a past non-compliance deficiency.