STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emporia Rehabilitation and Healthcare Center	200 Weaver Avenue Emporia, VA 23847

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 - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emporia Rehabilitation and Healthcare Center	200 Weaver Avenue Emporia, VA 23847

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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and clinical record review, the facility staff failed to notify the Nurse Practitioner and resident's Responsible Party immediately of a significant change condition for 1 resident (Resident #1) in a survey sample of 6 residents. The findings included: The facility staff failed to notify the Nurse Practitioner and the Responsible Party of decrease in urinary output and fluid intake for Resident #1.Resident #1 was admitted to the facility on [DATE] after a hospitalization from 7/16/25 to 8/6/25 for nausea and vomiting coffee-ground emesis. He presented with a persistent ileus (a temporary condition where one's intestine cannot push food and waste out of the body) with abdominal pain and distention. He was treated conservatively after small bowel obstruction was ruled out. The hospital discharge summary revealed his overall prognosis was guarded. Resident #1's diagnoses included but not limited to Ogilvie's Syndrome (a rare condition that causes a severe dilation of the large intestine without any physical obstruction. This leads to symptoms similar to bowel obstruction, despite the absence of an actual blockage), history of complete intestinal obstruction, unspecified as to cause, unspecified dementia with psychotic disturbance, gastro-esophageal reflux disease, history of kidney stones, abnormal urinalysis, history of bladder cancer with placement of an ileostomy, femur fracture surgically repaired, acute and chronic kidney disease and hypertension. Resident #1's admission assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/13/2025 coded the resident as having a Brief Interview of Mental Status (BIMS) score of 02 out of a possible 15 indicating resident had severe cognitive impairment and was not able make decisions independently. Section GG of the MDS coded the resident as requiring maximum assistance or being totally dependent for turning/repositioning, lying to sitting, sitting to stand, chair/bed to chair transfer, toileting, bathing and dressing. He required assistance with feeding. Resident #1 had a urostomy (surgically created opening in the abdomen to divert urine from the kidneys to an external bag due to his diagnosis of bladder cancer). Resident #1 was incontinent of bowel.On 10/21/25, a review of the clinical record revealed:On 8/22/25, Resident #1 was transferred to hospital for nausea, vomiting, abdominal pain due to concerns that he may be obstructed again. He was treated with intravenous fluids (fluids administered via his veins), pain medications and antibiotics to finish on 8/30/25. A CT scan (computerized tomography which is a medical imaging that uses x-rays to create detailed images of the body's internal organs) was completed at the hospital which revealed mild thickening indicating possible colitis, no obstruction. On 9/13/25, per the nurse's notes an order was given from the Nurse Practitioner {name redacted} to obtain a urine sample due to cloudy urine with sedimentation. The nurse's note revealed the nurse attempted to contact Resident #1's Responsible Party, his daughter {name redacted.Results of the 9/13/25 Urinalysis Culture and sensitivity revealed: greater than 100, 000 CFU/ML mixed flora - No predominant microorganisms present On 9/15/25, the progress notes of the Nurse Practitioner {name redacted} revealed urine sample results no microorganisms, urostomy draining yellow urine with sediment noted, bowel sounds in all four (4) quadrants, well nourished, in no acute distress, encourage oral (by mouth) fluids.There was no evidence in the clinical record that the Responsible Party, his daughter, was ever reached via phone regarding the urinalysis and culture and sensitivity results.On 10/7/25 at 12:23 PM, the Nurse Practitioner {name redacted} documented in her progress notes acute visit for increased confusion and amber, malodorous urine, Patient seen lying in bed in no acute distress, no complaints of pain, very confused at this time. Plan: Encourage hydration, urinalysis with culture and sensitivity ordered and pending.10/7/25 Urinalysis culture and sensitivity results: greater than 100, 000 CFU/ML mixed flora - No predominant microorganisms are present.On 10/8/25, a progress note written by the Social Services Director {name redacted) revealed that Resident #1 had been accepted to transfer to another facility closer to family. Transport scheduled for 10/09/2025 @ 11AM. Resident's daughter, {name redacted} was notified.There was no evidence in the clinical record that Resident #1's Responsible Party was notified of change in resident's condition which prompted a visit from the Nurse Practitioner on 10/7/25 where resident presented with confusion, amber, malodorous urine via ileostomy, urine sample ordered for urinalysis and culture and sensitivity and order to encourage hydration. On 10/9/25, LPN-E caring for Resident #1 notified the Nurse Practitioner and the resident's Responsible Party, his daughter of an emergent change in condition requiring transfer to the emergency room. At 9:36 AM, the Resident's responsible party, his daughter, was notified of residents change in condition and informed that this nurse wasn't comfortable transferring resident to another facility in his present condition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emporia Rehabilitation and Healthcare Center	200 Weaver Avenue Emporia, VA 23847

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emporia Rehabilitation and Healthcare Center	200 Weaver Avenue Emporia, VA 23847

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 0658 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 interviews and clinical record review, the facility staff failed to ensure appropriate resident care and services were provided in accordance with accepted professional standards of care for 1 resident (Resident #1) in a survey sample of 6 residents. The findings included: For Resident #1, the facility staff failed to assess for signs and symptoms of dehydration.Resident #1 was admitted to the facility on [DATE] after a hospitalization from 7/16/25 to 8/6/25 for nausea and vomiting, coffee-ground enemies. He presented with a persistent ileus (a temporary condition where one's intestine cannot push food and waste out of the body) with abdominal pain and distention. He was treated conservatively after small bowel obstruction was ruled out. The hospital discharge summary revealed his overall prognosis was guarded. Resident #1's diagnoses included but not limited to Ogilvie's Syndrome (a rare condition that causes a severe dilation of the large intestine without any physical obstruction. This leads to symptoms similar to bowel obstruction, despite the absence of an actual blockage), history of complete intestinal obstruction, unspecified as to cause, unspecified dementia with psychotic disturbance, gastro-esophageal reflux disease, history of kidney stones, abnormal urinalysis, history of bladder cancer with placement of an ileostomy, femur fracture surgically repaired, acute and chronic kidney disease and hypertension. Resident #1's admission assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/13/2025 coded the resident as having a Brief Interview of Mental Status (BIMS) score of 02 out of a possible 15 indicating resident had severe cognitive impairment and was not able make decisions independently. Section GG of the MDS coded the resident as requiring maximum assistance or being totally dependent for turning/repositioning, lying to sitting, sitting to stand, chair/bed to chair transfer, toileting, bathing and dressing. He required assistance with feeding. Resident #1 had a urostomy (surgically created opening in the abdomen to divert urine from the kidneys to an external bag due to his diagnosis of bladder cancer). Resident #1 was incontinent of bowel. On 10/21/25, a review of the clinical record revealed: On 8/22/25, Resident #1 was transferred to the hospital for nausea, vomiting, abdominal pain due to concerns that he may be obstructed again. He was treated with intravenous fluids (fluids administered via his veins), pain medications and antibiotics and discharged back to the facility on 8/26/25 with order to complete antibiotic course on 8/30/25. A CT scan (computerized tomography which is a medical imaging that uses x-rays to create detailed images of the body's internal organs) was completed at the hospital which revealed mild thickening indicating possible colitis, no obstruction. On 9/13/25, per nurse's notes an order was given from the Nurse Practitioner {name redacted} to obtain a urine sample due to cloudy urine with sedimentation. The nurse's note revealed the nurse attempted to contact Resident #1's Responsible Party, his daughter {name redacted}.9/13/25 Urinalysis and C & S results: The results of the culture and sensitivity revealed: greater than 100, 000 CFU/ML mixed flora - No predominant microorganisms present. On 9/15/25, the Nurse Practitioner {name redacted} progress notes revealed urine sample results no microorganisms, urostomy draining yellow urine with sediment noted, bowel sounds in all four (4) quadrants, well nourished, in no acute distress, encourage oral (by mouth) fluids.On 10/3/25, the Nurse Practitioner {name redacted} progress notes revealed resident (Resident #1) observed lying in bed, in no acute distress, no complaints of pain, no new nursing concerns; ileostomy in place draining yellow urine with sediment noted, bladder non-distended, bowel sounds present in all four (4) quadrants On 10/7/25, the Nurse Practitioner {name redacted} documented in her progress notes acute visit for increased confusion and amber, malodorous urine via ileostomy, patient seen lying in bed in no acute distress, no complaints of pain, very confused at this time. Plan: Encourage hydration, urinalysis with culture and sensitivity ordered and pending.On10/8/25 results of the Urinalysis culture and sensitivity lab test revealed: Greater than 100, 000 CFU/ML mixed flora - No predominant microorganisms present.On 10/9/25, Nurse LPN-E caring for Resident #1 documented in a nurse progress note: during morning rounds at the start of the shift, Resident #1 was noted to be pale for baseline color, noted increased respirations. When spoken to, he was responsive to voice and spoke to this nurse. The Nurse Practitioner was in the building at this time and was asked to come to room to assess resident. She ordered a one-time Albuterol 0.083% nebulizer treatment (a rescue medication used to treat or prevent bronchospasm, a condition where the muscles around the airways tighten, causing breathing difficulty) after she assessed lung sounds. Resident #1 was administered the nebulizer treatment with no issues. Per the residents' medication administration record he was to receive Rocephin (an antibiotic) intramuscularly (IM) and an oral antibiotic for reported urinary tract infection. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emporia Rehabilitation and Healthcare Center	200 Weaver Avenue Emporia, VA 23847

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure residents are free from significant medication error for 1 resident (#2) in a survey sample of 6 residents.For Resident #2 the facility staff failed to follow the physician orders for parameters on administering the drug Midodrine (an alpha-Adrenergic Agonist used to raise blood pressure).Resident #2 was admitted to the facility on [DATE] with diagnoses that included but were not limited to Interstitial pulmonary disease, generalized anxiety disorder, major depressive disorder, unspecified dementia, dysphagia, Barretts esophagus, and generalized weakness. Resident #2's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/9/25 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 8 out of possible 15 indicating moderate cognitive impairment.On 10/21/25 a review of the clinical record revealed that Resident #2 had orders that included the medication Midodrine for hypotension (low blood pressure). A review of the MAR (Medication Administration Record) for September and October 2025 revealed the following orders: Midodrine HCL Tablet 5 mg. Give 5 mgt by mouth three times per day for low bp HOLD FOR SYSTOLIC GREATER THAN 130. Order date 10/7/25The MAR revealed the following regarding the administration of Midodrine:10/10/25 - bp was 139/73 medication marked as administered at 2 pm.10/12/25 - bp was 132/76 medication marked as administered at 9 pm.10/19/25 - bp was 145/71 medication marked as administered at 9 pm. On 10/20/25 the order was changed to read: Midodrine HCL Tablet 5 mg. Give 5 mgt by mouth three times per day for low bp HOLD FOR SYSTOLIC GREATER THAN 120. Order date 10/7/25A review of the MAR revealed the following:10/20/25 - bp was 131/75 and medication marked as administered at 9 pm. On 10/22/25 an interview was conducted with LPN # who stated that the importance of paying attention to the parameters on a medication is that in this case you can either cause a blood pressure to be too high if you give it when you should hold it, but also cause someone to bottom out if you hold it when you should have given it, either way it could cause negative outcomes for the resident. On 10/22/25 at approximately 3:30 p.m the DON was asked about the expectation of the nurses following physician orders, and she stated nurses are expected to follow physician orders exactly as they are prescribed. On 10/22/25 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.