STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495381	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Health and Rehab Center	1300 Enterprise Drive Lynchburg, VA 24502

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 28106 Based on staff interview and clinical record review, the facility staff failed to honor a preference for twice weekly showers for one of thirty residents in the survey sample (Resident #112). The findings include: According to the clinical record, diagnoses for R112 included left femur fracture, osteoarthritis, malnutrition, and anxiety. The most current MDS (minimum data set) was a an admission assessment with an ARD (assessment reference date) of 11/12/24, which assessed R12 as being moderately cognitively impaired. Review of R112's admission MDS, Section F Preferences for Customary Routine-Activities, documented that R112 felt it to be very important to choose how to bathe. Review of shower records documented that R112 only received a shower on 11/10/24. On 5/1/25 at 9:45 a.m. license practical nurse (LPN #4, unit manager) provided a shower schedule for R112 and indicated R112 was supposed to receive a shower every Tuesday and Friday. When asked to evidence that R112 received the showers as scheduled, LPN #4 reviewed bathing logs and indicated that R112 received a bed bath on 11/12/24 and 11/15/24. LPN #4 was unable to find any other evidence to show R112 was received a shower. On 5/1/25 at 5:30 p.m., the above finding was presented to the administrator and director of nursing. No other information was presented prior to exit conference on 5/1/25.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on responsible party interview, staff interviews, clinical record reviews, and facility documents, the facility staff failed to inform the physician and resident or representative timely of a change in condition for two of thirty residents in the survey sample, (Residents #109 and Resident #110). The findings include: 1. For Resident #109 (R109), the facility staff failed to inform the resident or representative timely of a change in condition for one of thirty residents in the survey sample, (Residents #109). According to the clinical record, diagnoses for R109 included urinary tract infection, urine retention, pressure ulcers, and renal insufficiency. The most current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 10/11/24. R109 was assessed with a cognitive score of 13 out of 15, indicating cognitively intact. Review of R109's clinical record revealed the following via progress notes: 10/3/24 - order to obtain urinalysis due to [R109] complaining of urine frequency and burning and overall not feeling well. 10/6/24 - results of urine lab indicates [R109] does have a urinary tract infection with Extended spectrum beta-lactamases (ESBL), will start on intravenous antibiotics and placed on contact isolation. 10/7/24 - PICC [peripheral insertion central catheter] inserted and antibiotic medication started. 10/10/24 - unstageable pressure ulcer to right gluteal fold and and unstageable pressure ulcer to right and left heels. Treatment to heels were betadine dressing daily and apply protective boots. Treatment to gluteal fold was wound cleanser, apply Medihoney, fill with Calcium Alginate and cover with foam dressing daily and as needed, apply air mattress. Until 10/11/24, there was no documentation to evidence that R109 or the responsible party (RP) was informed of the four changes in condition or treatment. A progress note dated 10/11/24 documented the following, Communication with Family/NOK/POA Note Text : This writer spoke with [name of RP/ emergency contact redacted], update on resident current status given, all questions answered at this time. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/25 at 1:00 p.m., license practical nurse (LPN #2, nurse that wrote the progress note) was interviewed in regards to notification of the family. LPN #2 verbalized that the family was notified via telephone of the wounds and intravenous antibiotics for a urinary tract infection, adding that the family member voiced concerns of not being notified timely. LPN #2 verbalized that typically the nurses would notify family members as soon as a change in condition happens. On 5/1/25 at 4:00 p.m. the director of nursing (DON) was made aware of the above finding. The DON presented a form indicating that R109 was her own RP. It was that pointed out that according to the clinical record the daughter was the RP, that the form that was shown was not noted in the clinical record, and that, according to the clinical record, R109 had not been made aware of the changes in condition. No other information was presented prior to exit conference on 5/1/25. 52322 2. For Resident #110 (R110), the facility failed to notify the physician and responsible party of the dislodgement of a enteral feeding tube. Review of the Face Sheet found in R110's EMR under the Profile tab revealed R110 was admitted to the facility on [DATE] with diagnoses of intracranial injury with loss of consciousness of unspecified duration, gastrostomy status, dysphagia, and protein-calorie malnutrition. Review of R110's Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 05/09/24 revealed the resident had short- and long-term memory problems and the resident's cognitive decision making was severely impaired. Further review revealed the resident was dependent on staff for eating and required a feeding tube. Review of R110's Care Plan Report found under the care plan tab revised 07/17/24 revealed .Alteration in nutrition tube feeding provides nutrition & hydration. Risk for malnutrition . Review of the Clinical Physician Orders found in R110's EMR under the Order tab dated 01/27/23 revealed . Enteral Feed Order two times a day Turn on at 1800 [6:00 PM] and off at 0600 [6:00 AM]. Flush before and after hanging . Review of R110's Progress Notes found in the EMR under the Progress note tab dated 06/28/24 at 7:15AM revealed .Res [resident] left for Neuro [neurology] appt [appointment] via transport. Peg tube noted out and dried blood noted on stomach This documentation did not mention that emergency measures had been attempted to replace the feeding tube. Review of R110's Progress Notes found in the EMR under the Progress Note tab, dated 06/28/24 at 9:53 AM, revealed .Patient has returned from Neuro appointment, peg tube noted to be dislodged. This nurse attempted foley placement into peg tube site, attempted x [times] 3 with family at bedside, attempt unsuccessful. NP [Nurse Practitioner] updated; family wants resident sent out for peg tube placement. Call to [named transportation], to provide transportation, [named transport] in route. Call to [named hospital], spoke with ER nurse to give report, nurse verbalize understanding. Medical DX [diagnosis] sheet, and med list sent with resident and family to [named hospital] . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR revealed no documented evidence the family was notified R110's peg tube dislodged. During a telephone interview on 05/01/25 at 7:30 AM, Family Member 1, who was was present for the appointment, stated she found out at a neurology appointment that R110 did not have a peg tube and called the facility. Family Member 1 stated that the CNA that was getting her dress that morning kicked it under the bed and that she had been sent out to the appointment without the peg tube. Family Member 1 stated that it was discovered stoma bleeding at the neurology appointment. Family Member 1 stated that after returning to the facility the Director of Nursing (Former DON) made two attempts to place a foley catheter, an 18 and 16 gauge, but was unsuccessful. When she failed to do that, the DON called the ambulance we had her taken to the emergency room (ER). During an interview on 05/01/25 at 8:56 AM, the Former DON stated, The nurse did not let us know. Transport was at the facility to take the resident to the appointment and they noticed the peg tube on the floor. They did not notify or tell us the peg tube was out. The nurse should have let us know the peg tube was out, and we educated the nurse at that time. During an interview on 05/01/25 at 3:43 PM, the Former Administrator stated, I do recall the incident the peg tube was dislodged. Recall the history with [Family Member 1 name redacted], she did not want her to go the hospital and the hospital did not have the right size enteral feeding tube. When questioned further, the Administrator stated that the expectation was that staff would notify the physician, obtain orders, notify family, and notify administration. Review of the facility's undated policy titled, Change In a Resident's Condition revealed .The facility will promptly notify the resident, his or her physician /practitioner, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes of level of care, billing/payments, resident rights, etc.) . No additional information was provided prior to survey exit.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview, facility document review and clinical record review, the facility staff failed to follow abuse prevention policies for reporting an injury of unknown origin for one of thirty residents in the survey sample (Resident #111). The findings include: Resident #111 (R111) was admitted to the facility with diagnoses that included dementia with psychotic disturbance, hypertension, hypothyroidism, affective mood disorder, depression, gastroesophageal reflux disease, dysphagia, insomnia, chronic kidney disease and protein-calorie malnutrition. The minimum data set (MDS) dated [DATE] assessed R111 with short and long-term memory problems and severely impaired cognitive skills. R111's clinical record documented a nursing note on 12/2/23 stating, .CNA [certified nurses' aide] alerted this nurse that [R111] had bruising around her neck and face at approximately 0930 [9:30 a.m.]. At this time full nursing assessment performed. Moderate amount of bruising noted on left and right side of face and neck. Skin tear on right cheek. resident is able to turn head left and right .Resident unable to state what happened due to baseline confusion .Supervisor DON [director of nursing] notified .[emergency contact] notified . The clinical record documented no recent fall and/or incident involving R111. The record included no known cause of R111's facial bruising and skin tear documented on 12/2/23. There was no immediate report to the state agency or adult protective services (APS) of R111's injury of unknown origin that occurred on 12/2/23. The facility's documentation included an initial facility synopsis form describing the bruising of unknown origin, listing the incident date as 12/2/23, and the report date as 12/3/24. There was no evidence of fax confirmation and/or emails that this form/report was sent to the state agency. The state agency had no record of receiving this initial report. This form documented that APS and department of health professions (DHP) were notified of the injury of unknown origin on 12/2/24. There was no evidence of fax confirmation and/or emails indicating notification to APS or DHP. It was unclear who or what was reported to the department of health professions. The facility's final synopsis findings were documented on 12/8/23 with fax confirmation to the state agency on 12/9/23. A letter dated 1/2/24 from the local APS, that investigated the injuries, documented R111's unexplained injury was reported to APS on 12/6/23. The administrator and DON employed at the time of R111's injury of unknown origin were not available for interview, as they no longer worked at the facility. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 9:21 a.m., the current administrator and DON were interviewed about R111's injury of unknown origin. The administrator and DON reviewed the facility documentation and presented no evidence that the initial report had been sent to the state agency. The administrator stated that the initial form was completed indicating the incident occurred on 12/2/23 with a report date documented as 12/3/23. The administrator stated that he found no confirmations indicating notification to the state agency, APS or DHP. The DON stated the incident should have been reported immediately to the state agency and APS, with the findings reported to the state agency within five days. The administrator stated that there was no record of what was sent to DHP. The administrator stated he found no explanation about the conflicting report dates to local APS (12/2/23 vs. 12/6/23). On 5/1/25 at 10:30 a.m., the administrator stated he searched again, reviewed the investigation documents, and found no further evidence of immediate reporting of R111's injury of unknown source to the state agency, APS or DHP. The administrator stated he was not sure why notification to the stage agency and APS was not done on the day of the incident (12/2/23). The administrator stated there were no faxes, digi-fax or email confirmations about an initial notification to the state agency, APS or DHP. The administrator stated he only had evidence that the investigation/findings were submitted to the state agency on 12/9/23. The facility's policy titled Abuse (revised 10/20/22) documented, .The facility is committed to developing and operationalizing policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property .The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures . These findings were reviewed with the administrator and DON on 5/1/25 at 9:30 a.m. and with the administrator on 5/1/25 at 10:30 a.m., with no further information presented prior to the end of the survey.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview, facility document review and clinical record review, the facility staff failed to immediately report to the state agency and adult protective services (APS), an injury of unknown origin suspicious of abuse for one of thirty residents in the survey sample (Resident #111). The findings include: Resident #111 (R111) was admitted to the facility with diagnoses that included dementia with psychotic disturbance, hypertension, hypothyroidism, affective mood disorder, depression, gastroesophageal reflux disease, dysphagia, insomnia, chronic kidney disease and protein-calorie malnutrition. The minimum data set (MDS) dated [DATE] assessed R111 with short and long-term memory problems and severely impaired cognitive skills. R111's clinical record documented a nursing note on 12/2/23 stating, .CNA [certified nurses' aide] alerted this nurse that [R111] had bruising around her neck and face at approximately 0930 [9:30 a.m.]. At this time full nursing assessment performed. Moderate amount of bruising noted on left and right side of face and neck. Skin tear on right cheek. resident is able to turn head left and right .Resident unable to state what happened due to baseline confusion .Supervisor DON [director of nursing] notified .[emergency contact] notified . The clinical record documented no recent fall and/or incident involving R111. The record included no known cause of R111's facial bruising and skin tear assessed on 12/2/23. There was no immediate report to the state agency or adult protective services (APS) of R111's injury of unknown origin that occurred on 12/2/23. The facility's documentation included an initial facility reported incident form describing the bruising of unknown origin, listing the incident date as 12/2/23 and the report date as 12/3/24. There was no evidence that this form/report was sent to the state agency. The state agency had no record of receiving this initial report. This form documented APS and department of health professions (DHP) were notified of the injury of unknown origin on 12/2/24. There was no evidence of fax confirmation and/or emails indicating notification to APS or DHP. It was unclear who or what was reported to the department of health professions. The facility's investigation findings were documented on 12/8/23 with fax confirmation to the state agency on 12/9/23. A letter from the local APS that investigated the injuries dated 1/2/24 documented R111's unexplained injury was reported to APS on 12/6/23. The administrator and DON employed at the time of R111's injury of unknown origin were not available for interview as they no longer worked at the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 9:21 a.m., the current administrator and DON were interviewed about R111's injury of unknown origin. The administrator and DON reviewed the facility documentation and presented no evidence that the initial report was sent to the state agency. The administrator stated the initial form was completed indicating the incident occurred on 12/2/23 with a report date documented as 12/3/23. The administrator stated he found no confirmations indicating notification to the state agency, APS or DHP. The DON stated the incident should have been reported immediately to the state agency and APS and the findings reported to the state agency within five days. The administrator stated there was no record of what was sent to DHP. The administrator stated he found no explanation about the conflicting report dates to local APS (12/2/23 vs. 12/6/23). On 5/1/25 at 10:30 a.m., the administrator stated he searched again and reviewed the investigation documents and found no further evidence of immediate reporting of R111's injury of unknown source to the state agency, APS or DHP. The administrator stated he was not sure why notification to the stage agency and APS was not done on the day of the incident (12/2/23). The administrator stated there were no faxes, digi-fax or email confirmations about an initial notification to the state agency, APS or DHP. The administrator stated he only had evidence that the investigation/findings were submitted to the state agency on 12/9/23. The facility's policy titled Abuse (revised 10/20/22) documented, .The facility is committed to developing and operationalizing policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property .The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures . These findings were reviewed with the administrator and DON on 5/1/25 at 9:30 a.m. and with the administrator on 5/1/25 at 10:30 a.m. with no further information presented prior to the end of the survey.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview, facility document review and clinical record review, the facility staff failed to provide the resident and/or resident representative with a baseline care plan summary for one of thirty residents in the survey sample (Resident #37). The findings include: Resident #37 (R37) was admitted to the facility with diagnoses that included Parkinson's, sepsis, urinary tract infection, pressure ulcer, respiratory failure, and history of hip fracture. The minimum data set (MDS) dated [DATE] assessed R37 with severely impaired cognitive skills. R37's clinical record documented an admission assessment dated [DATE]. This assessment included a baseline care plan that addressed care areas of catheter care, constipation prevention, hospice services, diet, pressure ulcer care, fall prevention and assistance with activities of daily living. The clinical record documented no evidence that the baseline care plan was reviewed with the resident's representative or that the representative was given a summary or copy of the plan. The sections on the 3/28/25 admission assessment indicating completion of the baseline plan, review of the plan with the resident's representative and provision of the plan summary and medications were not completed. On 4/30/25 at 2:41 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about R37's baseline care plan. LPN #2 reviewed the clinical record and stated she found nothing indicating the resident's representative received a copy of the plan or that the plan was reviewed with the representative. LPN #2 stated the baseline care plan items auto-populated based upon the assessments entered. LPN #2 stated the baseline plan should have been reviewed with the resident's family with the family provided a summary/copy of the plan. LPN #2 stated nurses were able to print the baseline plan from the electronic health record. The facility's policy titled Baseline Care Plans (undated) documented, .The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to .initial goals of the resident .summary of the resident's medications and dietary instructions .Any services and treatment to be administered by the facility and personnel acting on behalf of the facility . This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 4/30/25 at 5:00 p.m. with no further information presented prior to the end of the survey.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for one of thirty residents in the survey sample (Resident #91). The findings include: Resident #91 (R91) was admitted to the facility with diagnoses that included spinal stenosis, cardiomyopathy, chronic respiratory failure, diabetes and depression. The minimum data set (MDS) dated [DATE] assessed R91 as cognitively intact. On 4/29/25 at 12:20 p.m., R91 was interviewed about quality of care/life in the facility. R91 stated during this interview that she preferred female caregivers to provider her personal care and that the facility had honored this preference. R91's plan of care (revised 3/28/25) documented the resident required assistance with activities of daily living that included toileting, incontinence care, and assistance with bathing/dressing. The care plan made no mention of the resident's preference for a female caregiver. On 5/1/25 at 8:13 a.m., the licensed practical nurse unit manager (LPN #2) was interviewed about R91's care plan. LPN #2 stated the MDS coordinators usually updated care plans after assessments and/or discussions from morning meetings. LPN #2 stated the resident's preference for female caregivers should have been added to the plan of care. On 5/1/25 at 8:30 a.m., the registered nurse (RN #7) MDS coordinator responsible for care plan updates was interviewed. RN #7 reviewed the plan of care and stated she found nothing on the care plan about female caregivers. RN #7 stated the resident's last care plan review was completed on 4/3/25. RN #7 stated the female caregiver preference should have been added to the plan. This was reviewed with the administrator and director of nursing on 5/1/25 at 5:45 p.m. with no further information provided prior to the end of the survey.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on staff interviews, record review, and facility documents, the facility failed to ensure that nursing services met the professional standards of quality for five of 30 sampled residents (Resident (R) 11, R70, R76, R84, R159). Findings included: 1. For Residents #84 and Resident #159, the facility failed to ensure that licensed nursing services were not delegated to and performed by an unlicensed staff member. Registered Nurse (RN) 9 delegated administration of oral medications and the performance of a fingerstick blood glucose check to Certified Nurse Aide (CNA) 10. Review of R11's Census and Med Diag (Medical Diagnosis) tabs of the electronic medical record (EMR) revealed R11 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, essential hypertension, and unspecified hypertension. Review of R70's Census and Med Diag tabs of the EMR revealed R70 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, major depressive disorder, and essential hypertension. Review of R76's Census and Med Diag tabs of the EMR revealed R76 was admitted to the facility on [DATE] with diagnoses that included paroxysmal atrial fibrillation, chronic pain, and vascular dementia. Review of a facility synopsis dated 04/22/25 revealed, Report date: 4/22/25 . Incident Date 4/19/25 . Residents involved: [R70] Injuries: [No circled] . Incident Type: . ['Other' written on form] . Describe incident, including location, and action taken: April 21st 4:30 pm CNA reported that on Sat [Saturday] April 19th a nurse delegated a CNA to passed [sic] medication [and] take a blood sugar . Name of employee(s) involved and their positions: RN [RN9][,] CNA [CNA10][,] CNA who reported event [CNA1] . Employee action initiated or taking: RN [and] CNA suspended [and] investigation started . The FRI recorded that the responsible party, physician, Adult Protective Services (APS), and Department of Health Professions (DHP) had been notified on 04/22/25. Review of the facility's investigative file of the incident revealed a letter to the Virginia Department of Health, Office of Licensure and Certification, dated 04/28/25, that recorded, . Incident/Investigation: On 4/21/25 at 4:30 PM, the Director of Nursing [DON] received a report that a RN was allowing a CNA to pass medications and check blood sugars on the unit [NAME] Square on Saturday 4/19/25. The RN pulled the medications and allowed the CNA to pass them to the residents. CNA [CNA1] observed this with several of the residents on 4/19/25 and reported it to her charge nurse on 4/21/25. The director [sic] of nursing reported to the administrator [sic] and notified the provider. Statements were obtained from CNA [CNA1], CNA [CNA10], and RN [RN9]. The director of nursing and administrator spoke with [R70] and [family member name withheld], [R11] and [family member name withheld], and [R76] and [family member name withheld] to inform them of the incident. The provider assessed all residents on [NAME] Square with no adverse effects noted. The RN and CNA involved were put on suspension and educated on delegation and scope of practice. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility documentation included the following: Action Plan: 1. DON and Administrator notified residents, family members, and provider of RN allowing CNA to administer medications and obtain blood sugars. 2. Statements obtained from staff, residents, and family members. 3. OLC, AOS, and Ombudsman notified. 4. Notified Department of Health Professions. 5. Staff members involved suspended. 6. Provider saw all residents to assess for adverse effects. 7. All responsible parties notified of the 3 residents involved. Conclusion: Facility conducted a thorough investigation through interviews. Interviews with staff members involved confirmed that the RN allowed the CNA to pass out medications and obtain blood sugar checks. Interviews with family members could not confirm that it was the CNA giving medication or doing blood sugar checks due to it being different staff on the unit the day this occurred. The provider saw and assessed all of the residents on [NAME] Square with no adverse effects noted. The report of the RN allowing the CNA to pass out medications and obtain blood sugar checks is substantiated as evidenced above . The facility will review this concern to remain preventative and proactive, considering all opportunities to ensure the safety of our residents and any opportunities for improvement . This document was signed by the DON. 2. A copy of an email from RN9 to the DON, dated 04/21/25, which indicated, . On Saturday 4/19, I was working as a nurse on Town Square 7am-7pm. During this time, I did ask a CNA, [CNA10], to check some blood sugars via glucometer. I did not realize this was out of their scope. At another point I did pull some medications for [R70], no narcotics were pulled. I had to go and assist with another patient complaining of difficulty breathing. I handed [R70]'s medication to [CNA10] asking her to take it to the resident for me. I do understand this is unacceptable and will not repeat the poor decisions made that shift . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A copy of an email from CNA10 to the DON, dated 04/21/25, which indicated, . On Saturday, I was working with [RN9]. She had mentioned having to take blood sugars, and I said I would do it for you. She said, 'Yeah, that's fine.' So I went in and took [R11]'s blood sugar. The [RN9] pulled the meds and put them in the cups. I did hand them off. I know [R70] said [I can't move my arms, I need you to dump them in my mouth. One of the aides said, 'Don't leave them on the table because of her [family member],' so I went ahead and dumped them in her mouth. I helped [RN9] in the morning and afternoon with medication, helping pass them out. Due to her having to run downstairs to help them, and next door. I did take [R11]'s blood sugar once, and that was in the afternoon, as well as [R70]'s medication. [R76]'s [family member] had come in and mentioned that her mom was complaining about her legs hurting, and I had told her she refused medication; she said it was too late. I told her I'll go ask the nurse, she told me to go and handed me her medication. I took it to her daughter, and she took it from me. That is when [R76] took her meds. I do not remember all the patients that I gave meds to, but it was two that I was 100% sure of. 4. Progress Notes, dated 04/22/25, detailed the provider's assessments of R11, R70, and R76, with no concerns noted. 5. An In-Service/Education Record, dated 04/22/25, for Delegating and Scope of Practice. The record contained the signatures of nursing staff members who received the education. 6. A copy of an email from RN9 to the DON, dated 04/26/25, which indicated, . please accept this as my resignation from employment immediately . 7. A Notice of Disciplinary Action, dated 04/29/25, which indicated, . CNA [CNA10] gave two residents their medications and took blood sugars of another resident. This is practicing outside of your scope of service as you are not a licensed nurse . The notice indicated CNA10's employment had been terminated by the facility. During an interview on 04/30/25 at 3:27 PM, the DON stated that it was out of the scope of practice for a CNA to administer medications in Virgina. She stated that an RN should not delegate the task to a CNA. The DON stated it was not the policy of the facility to allow CNAs to administer medications and that both CNA10 and RN9 should have known the scope of their practices. The DON stated after she had learned on 04/21/25 of the incident, both CNA10 and RN9 were contacted. The DON stated that CNA10 stated that she had given R70 and R76 their medications and had completed a fingerstick blood glucose check for R11. The DON stated that when she spoke with RN9, RN9 reported that she had allowed CNA10 to administer medications to one resident and perform one fingerstick blood glucose check. The DON stated both staff members were suspended immediately pending investigation, and the investigation was started. The DON stated because of the conflicting information from the emails and the staff's statements, she had asked the provider to complete assessments on all the residents on the Town Square unit, because everyone had the potential to be affected. The DON stated nursing staff had been educated on delegating and scope of practice. The DON stated RN9 had resigned her position and CNA10's employment had been terminated. The DON stated that regional administration, Human Resources, the Administrator, and the physician had been involved determining and implementing corrective measures. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Virginia Administrative Code revealed When staff administers acting as a medication aide, revealed, . Qualifications and supervision of staff administering medications . When staff administers medications to residents, the following standards shall apply . All staff responsible for medication administration shall . Be licensed by the Commonwealth of Virgina to administer medications; or b. Be registered with the Virginia Board of Nursing as a medication aide . https://law.[NAME].virginia.gov/admincode/title22/agency40/chapter73/section670/#:~:text Qualifications and supervision of staff administering medications. Review of the Virginia Administrative Code revealed, . Delegation shall be made only if . Delegated tasks and procedures are within the knowledge, area of responsibility, and skills of the delegating nurse . https://law.[NAME].virginia.gov/admincode/title18/agency90/chapter19/section250/#:~: 21875 2. For Resident #84, facility staff failed to verify the resident's name on a pharmacy supply card prior to preparation for the adminisration of medications during a medication pass observation on The Gardens unit. The medication torsemide 40 mg (milligrams) was pulled for Resident #84 from a pharmacy supply card labeled for Resident #159. On 4/30/25 at 8:00 a.m., a medication pass observation was conducted with licensed practical nurse (LPN #7) administering medications to Resident #84 (R84). Among the medications prepared for R84 were two tablets of torsemide 20 mg. LPN #7 accessed the torsemide tablets from a pharmacy supply card labeled for Resident #159 (R159). The medication pass was paused prior to the administration to R84 and LPN #7 was questioned about the torsemide obtained from R159's supply card. LPN #7 verified that R84 had a current order for torsemide 20 mg - two tablets once daily. LPN #7 stated that she verified the medication dose but did not verify the name on the pharmacy supply card. LPN #7 stated that R159's card was in the medication cart section with R84's other medications. LPN #7 stated, I did not pay attention to the resident name. I just looked at the med [medication] and dose. LPN #7 stated that she should have made sure the medication was obtained from the correct card. On 4/30/25 at 8:56 a.m., the unit manager (LPN #2) was interviewed about LPN #7 obtaining medication for R84 from a card labeled for R159. LPN #2 stated R159 discharged on [DATE] and all the resident's other medications had been returned to pharmacy at the time of discharge. LPN #2 stated it was possible that R159's torsemide card got misplaced in the room slots in the medication cart. LPN #2 stated that she reviewed the incident with LPN #7 and stated that LPN #7 reported she looked at the medication and dosage and did not pay attention to the resident name on the card. LPN #2 stated nurses were expected to verify the correct medication, dose and resident name when giving medications. On 4/30/25 at 9:40 a.m., accompanied by LPN #2 and LPN #7, R84's supply card for torsemide 20 mg tablets was located in the bottom drawer of the medication cart. LPN #7 stated again that she looked at the medication and dose but did not realize the medication was from another resident's card. R84's clinical record documented a physician's order dated 4/8/25 for torsemide 20 mg - two tablets once daily for edema. R159's clinical record documented a physician's order dated 4/21/25 for torsemide 20 mg - two tablets once daily for edema. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy titled General Guidelines for Medication Administration (revised 8-2020) documented, . Medications are administered as prescribed in accordance with good nursing principles and practices . Medications supplied for one resident are never administered to another resident . This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 4/30/25 at 5:00 p.m. with no further information presented prior to the end of the survey.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, record review, and review of facility policy, the facility failed to provide incontinence care for in a timely manner for two of three residents (Resident (R) 36 and R41) reviewed for activities of daily living (ADLs) out of a total sample of 30. Failure to provide timely incontinence care places residents at increased risk of urinary tract infections and skin breakdown. Findings include: 1. For R36, facility failed to provide timely incontinent care, as needed. Review of R36's Profile tab of the electronic medical record (EMR) revealed R36 was admitted to the facility on [DATE] with diagnoses that included vascular dementia, adult failure to thrive, and unspecified sequelae of cerebral infarction. Review of R36's Care Plan, dated 01/08/25 and located under the Care Plan tab of the EMR revealed, . the resident is incontinent of bladder and bowel and is not a candidate for a toileting program . The goal was, . the resident will remain clean and dry as possible thru [sic] the review period . Interventions included, . provide toileting hygiene as needed for incontinent episode . Review of R36's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/08/25 and located under the MDS tab of the EMR, revealed R36 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident was severely cognitively impaired. The MDS documented that R36 had functional limitation in range of motion on both upper and lower extremities, was dependent on staff for transfers and repositioning, and was always incontinent of bladder and bowel. During an observation on 04/29/25 at 10:25 AM, R36 was observed sitting in a Broda (a cushioned and tilting chair that is used for supportive positioning) chair. During observations at 11:04 AM and 11:31 AM, R36 remained in his Broda chair. Beginning at 12:34 PM through 1:09 PM, R36 was observed continuously in his Broda chair. He was not checked for incontinence. At 1:09 PM, Certified Nurse Aide (CNA) 1, who was assigned to R36, pushed a meal tray cart through the unit's dining room and began to deliver meal trays. CNA1 did not check R36 for incontinence while she was delivering meal trays. CNA1 delivered meal trays from 1:09 PM until 1:22 PM, when she sat down by R36 and began to feed him. CNA1 did not check R36 for incontinence before she began to feed him. From 1:22 PM through 2:26 PM, R36 remained in the unit's dining room and was observed continuously. Staff did not check R36 for incontinence. At 2:26 PM, CNA1 transported R36 to his room, transferred the resident to his bed, and provided incontinent care. R36 had been incontinent of bowel. CNA1 described R36's stool as thick and sticky. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/29/25 at 2:41 PM, CNA1 stated that she transferred R36 from his bed to his Broda chair at approximately 8:00 AM on this day. She stated R36 was normally placed at the table after getting out of bed and stayed there until the noon meal was completed. She stated he was taken back to bed and checked for incontinence at that time. CNA1 stated she had taken R36 to the shower room at approximately 11:30 AM to check him for incontinence. CNA1 stated she checked for incontinence by pulling the front of his pants down to see if the wetness indicator on the incontinent brief had changed colors. CNA1 stated that she relied on smells to determine if the resident was incontinent of bowel. CNA1 confirmed that she did not transfer the resident from the Broda chair to check for incontinence or visually look for fecal incontinence. R36 had not been checked for fecal incontinence from 11:30 AM to 2:26 PM, three hours and was found to have had a bowel movement that was thick and sticky per CNA1. 2. For R41, facility failed to provide timely incontinent care, as needed. Review of R41's Profile tab of the EMR revealed R41 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease with late onset, muscle weakness, and bipolar disorder. Review of R41's quarterly MDS, with an ARD of 04/01/25 and located under the MDS tab of the EMR, revealed R41 had long and short-term memory problems and was severely impaired in cognitive skills for daily decision making. It was recorded that R41 was dependent on staff for toileting hygiene, and transfers and was always incontinent of bladder and bowel. Review of R41's Care Plan, revised on 04/03/25 and located under the Care Plan tab of the EMR, revealed, . the resident is incontinent of bladder and bowel and is not a candidate for a toileting program . The goal was, . the resident will remain clean and dry as possible thru [sic] the review period . Interventions included, . provide toileting hygiene as needed for incontinent episodes . During an observation on 04/29/25 at 10:25 AM, R41 was observed sitting in her Broda chair in the unit's dining room. Observationa at 11:00 AM, 11:04 AM, and 11:31 AM revealed that R41 remained in the dining room. Beginning at 12:34 PM through 1:09 PM, R41 was observed continuously in her Broda chair. She was not checked for incontinence. At 1:09 PM, CNA1, who was assigned to R41, pushed a meal tray cart through the unit's dining room and began to deliver meal trays. CNA1 delivered meal trays from 1:09 PM through 1:22 PM. R41 was not checked for incontinence during this time. At 1:22 PM, R41 was provided with her noon meal tray. She was not checked for incontinence. From 1:22 PM through 2:26 PM, R41 remained in the unit's dining room and was observed continuously. Staff did not check R4 for incontinence. R41 remained in the dining room until 2:50 PM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 04/29/25 at 2:50 PM, CNA1 stated that after she had helped R41 out of bed, she had taken her to the unit's dining room for breakfast. She stated she had taken R41 to the shower room to check for incontinence around 11:30, at around the same time she had taken R36. CNA1 was asked how often residents were to be checked for incontinence. CNA1 stated, Every two hours. CNA1 propelled R41 to the shower room and showed the surveyor how she checked the residents for incontinence. CNA1 pulled the front of R41's pants down, exposing the upper portion of the front of the resident's brief. CNA1 stated she looked to see if the stripe on the brief had changed color from wetness. CNA1 was asked how she checked for bowel incontinence. CNA1 stated that she could smell if the resident had been incontinent of bowel. CNA1 confirmed that she had not opened the resident's brief to check for urine or bowel incontinence. According to CNA1, R41 was checked by at 11:30 AM and then again at 2:50 PM, indicating it had been 3 hours and 20 minutes since being for incontinent care. During an interview on 04/30/25 at 2:36 PM, Registered Nurse (RN) 4, who was the Unit Manager for R36 and R41's unit, stated her expectation was for staff to make rounds every two hours and check for incontinence. RN4 stated that sometimes staff took residents to the shower room, pulled their pants down to check for incontinence and sometimes, staff transferred the resident back to bed to check for incontinence. RN4 stated a visual check must be completed for both urinary and bowel incontinence. RN4 stated that she did not know if the residents were transferred from the chairs in order to check for incontinence when they were taken to the shower room. During an interview on 04/30/25 at 3:17 PM, the Director of Nursing (DON) stated that her expectation was for residents to be checked for incontinence at least every two hours. The DON confirmed that residents should be visually checked for both urinary and bowel incontinence. The DON confirmed that residents could be incontinent of urine, and the wetness indicator on the brief would not change color due to how the urine could flow. Review of the facility's undated policy titled, Urinary Continence and Incontinence - Assessment and Management revealed, . The staff and practitioner will appropriately . manage individuals with urinary and/or fecal incontinence . will provide appropriate services and treatment to . prevent infections to the extent possible . Facility staff will provide and/or assist the resident with incontinence care as needed . No additional information was provided prior to survey exit.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. 25225 Based on interview, record review, and job description review, the facility failed to have a certified Activity Director to direct the provision of activities for 114 of 114 residents, as required. Findings include: During an interview on 05/01/25 at 9:03 AM, when asked if she was certified as an Activities Director, the Activity Director (Other Staff (OS) 4) said, No. OS4 stated that she was not informed she needed to be certified when she took the position two years ago. OS4 stated that she had been working at another facility as the Activity Director previously. OS4 stated the previous Administrators had not talked with her about it, but that the current Administrator had informed her certification was necessary. OS4 stated the Administrator had been pushing her to get the certification completed. OS4 stated that she had signed up for the class and was told due to her years of experience she only needed to write an essay. OS4 stated that she had received the book for the class during the previous week, and that the class had been paid for. OS4 stated that she had written the essay, but she had not turned it in yet. During an interview on 05/01/25 at 9:30 AM, when asked if the Activity Director was certified, the Administrator stated, No. The Administrator stated that she had been enrolled in class. The Administrator confirmed knowing that the facility must have a certified Activity Director. The Administrator provided documentation of the Activity Director's enrollment in the certification class. Review of the facility's job description for the Activities Director revealed, . To promote, plan, organize and staff activities and opportunities for facility's residents which best fit their needs to enhance their quality of life and the philosophy of the facility . Appropriate training and/or certification is highly advantageous . No additional information was provided prior to survey exit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 28106 Based on observation, staff interview and clinical record review, the facility staff failed to ensure a wound dressing was intact for one of thirty residents in the survey sample, (Residents #19). Resident #19's (R19) did not have a wound dressing in place. The Findings Include: Diagnoses for R19 included non-pressure chronic ulcer to left calf, adult failure to thrive, and peripheral vascular disease. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/19/25. R19 was assessed with a cognitive score of 15 out of 15, indicating cognitively intact. On 4/29/25 at 12:55 p.m., R19 was interviewed and was asked about having any wounds. R19 verbalized that he had a wound on the left calf that has been there before being admitted and the nurses are taking care of it. At this time, the wound was observed without a dressing and with scant drainage. When asked what happened to the dressing, R19 verbalized it came off when the aides had helped him to get dressed in the morning. On 4/29/25 at 1:16 p.m., registered nurse (RN #6) also observed R19's wound open to air and without a dressing. RN #6 verbalized that no one had reported to her regarding the dressing not being in place and that it should be covered at all times. RN #6 then dressed the wound according to physician orders. Review of physician orders for R19 included: Clean wound with Dakins 1/4 strength, pat dry, apply dermblue to wound bed, and cover with boarded gauze. Every day shift for wound care. On 4/30/25 at 5:00 p.m. the above information was presented to the administrator and director of nursing. No other information was presented prior to exit conference on 5/1/25.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, record review, and review of facility policy, the facility failed to implement interventions to aid in the prevention of pressure ulcers for one of three residents (Resident (R) 36) reviewed for pressure ulcers out of a total sample of 30. Failure to implement interventions placed R36 at increased risk of developing pressure ulcers. Findings include: Review of the facility's undated policy titled, Pressure Injury Prevention and Management revealed, . The intent of this organization is to develop and maintain systems and processes to ensure that the resident does not develop pressure ulcers/injuries (PU/PIs) unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice . Frequent encouragement and assistance with turning, repositioning, shift of weight . Assistance with incontinence care, and application of moisture barrier ointments to protect the skin from contact with urine and/or feces . Review of R36's Profile tab of the electronic medical record (EMR) revealed R36 was admitted to the facility on [DATE] with diagnoses that included vascular dementia, adult failure to thrive, and unspecified sequelae of cerebral infarction. Review of R36's Care Plan, dated 01/08/25 and located under the Care Plan tab of the EMR, revealed . The resident is at risk for pressure ulcers and skin impairment related to history of pressure ulcer development, inability to turn and reposition, incontinence, dx [diagnosis] failure to thrive, impaired healing from PVD [peripheral vascular disease], protein calorie malnutrition. Res [resident] has dry skin. refuses to lie down at times . The documented care plan goal was that R36 would not have any skin impairment through the review period. R36's care plan interventions included assisting the resident in turning and repositioning often and keeping the skin as clean and dry as possible. Review of R36's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/08/25 and located under the MDS tab of the EMR, revealed R36 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident was severely cognitively impaired. The MDS recorded R36 had functional limitation in range of motion on both upper and lower extremities, was dependent on staff for transfers and repositioning, and that R36 was at risk for the development of pressure ulcers but did not have one. During an observation on 04/29/25 at 10:25 AM, R36 was observed sitting in a Broda (a cushioned and tilting chair that is used for supportive positioning) chair. At 11:04 AM and 11:31 AM, R36 remained in the same position in his Broda chair. Beginning at 12:34 PM through 1:09 PM, R36 was observed continuously in his Broda chair. He was not repositioned by staff. At 1:09 PM, Certified Nurse Aide (CNA) 1, who was assigned to R36, pushed a meal tray cart through the unit's dining room and began to deliver meal trays. CNA1 delivered meal trays from 1:09 PM through 1:22 PM, when she sat by R36 and began to feed him. CNA1 did not reposition R36 before she began to feed him. From 1:22 PM through 2:26 PM, R36 was observed continuously. Staff did not reposition R36. At 2:26 PM, CNA1 transported R36 to his room, transferred the resident to his bed, and provided incontinent care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/29/25 at 2:41 PM, CNA1 confirmed she had not repositioned R36 at any other time on this day. During an interview on 04/30/25 at 2:36 PM, Registered Nurse (RN) 4, who was the Unit Manager for R36's unit, stated her expectation was for staff to make rounds every two hours, and reposition the resident if they are unable to reposition themselves. During an interview on 04/30/25 at 3:17 PM, the Director of Nursing (DON) confirmed that R36 was at high risk for pressure ulcers, was unable to reposition himself, and should be repositioned at least every two hours in an effort to prevent pressure ulcer development. No additional information was provided prior to survey exit.

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F 0689 Level of Harm - Minimal harm or potential for 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** 21875 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility failed to ensure the environment was free of accident hazards for one resident (Resident #88) and failed to provide adequate supervision to prevent accidents for two residents (Resident #36 and Resident #69), in a sample of thirty residents. The findings include: 1. For Resident #88, the facility failed to provide safe water temperature at a room sink. Resident #88's room had water temperature at the bathroom sink above the recommended range of 110 degrees (F) to less than 120 degrees (F). Resident #88 (R88) was admitted to the facility with diagnoses that include atrial fibrillation, hypertension, diabetes, hypothyroidism, hypercholesterolemia, edema, rosacea, osteoarthritis and congestive heart failure. The minimum data set (MDS) dated [DATE] assessed R88 as cognitively intact. On 4/29/25 at 1:32 p.m., R88 was interviewed about quality life/care in the facility. When asked about any safety concerns, R88 stated the water at her bathroom sink gets really hot. R88 stated she usually bathed at the sink and ran hot/cold water to get a comfortable water temperature. R88 stated she had experienced no issues with the hot water as she adjusted the temperature, but she thought the hot water seemed hot. On 4/29/25 at 1:38 p.m., accompanied by the maintenance director (other staff #8), the water temperature at R88's bathroom was measured. After allowing the hot water to run for approximately one minute, the maintenance director's digital thermometer read and maintained at 121.3 degrees (F). The maintenance director stated at this time that the desired range for resident room water temperatures was from 110 degrees (F) to 120 degrees (F). The maintenance director stated R88's water temperature . needs to be adjusted a little to be below 120 degrees. On 4/29/25 at 3:00 p.m., the maintenance director (other staff #8) was interviewed by the survey team about the 121.3 degree reading in R88's room. The maintenance director stated the mixing valve was working properly and temperature at the mixing valve could be adjusted if needed. The maintenance director stated the state regulations required water temperatures to be 120 degrees (F) or less. The maintenance director stated seasonal adjustments were required to maintain desired temperatures. The maintenance director stated water temperatures in fifteen resident rooms were checked weekly as part of the preventive maintenance program. The maintenance director presented copies of weekly water temperature checks from 4/1/25 through 4/28/25. All temperatures during this time were below 120 degrees (F). room [ROOM NUMBER] was last checked on 4/15/25 with water temperature recorded at 117.3 degrees (F). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/25 at 10:54 a.m., the administrator was interviewed about the water temperature in R88's room above 120 degrees (F). The administrator stated he talked with the regional maintenance director and the regional director stated outside temperatures had some effect on water temperatures because the water pipes were in the ceiling area that had no temperature control and that boiler temperatures and mixing valve set points had to be adjusted seasonally to maintain desired temperatures. The administrator stated he agreed that the water temperature in rooms needed to be maintained below 120 degrees (F). The facility's instructions for testing water temperatures (Tels - undated) documented, .Test the water at various locations throughout your facility .federal guidelines advise that you keep domestic water temperatures below 120 degrees Fahrenheit . This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 4/30/25 at 5:00 p.m. with no further information presented prior to the end of the survey. The DON stated at this time there had been no complaints from residents about hot water and no incidents/injuries involving hot water in the facility. 25225 Based on observation, interview, record review, and review of facility policy, the facility failed to: 1.) complete 2. For R36, facility staff failed to follow needed supervision during a transfer to reduce the risk of resident injury. Review of R36's Profile tab of the electronic medical record (EMR) revealed R36 was admitted to the facility on [DATE] with diagnoses that included vascular dementia, adult failure to thrive, and unspecified sequelae of cerebral infarction. Review of R36's Care Plan, dated 01/18/25 and located under the Care Plan tab of the EMR, revealed, . the resident is a long term care resident and requires assistance with their ADL's [activities of daily living] related to chronic obstructive pulmonary disease (COPD), hemiplegia of the left side, residual effects from cerebrovascular disease, toes have been amputated to left foot, decreased ROM [range of motion] to both arms/shoulders and legs/knees . Interventions included, . Dependent for transfers requiring two people Date Initiated: 01/18/2025 . Hoyer lift [mechanical lift] for all transfers x 2 staff Date Initiated: 01/18/2025 . Review of R36's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/08/25 and located under the MDS tab of the EMR, revealed R36 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident was severely cognitively impaired. The MDS recorded R36 had functional limitation in range of motion on both upper and lower extremities and was dependent on staff for transfers. Review of R36's undated Visual/Bedside Kardex Report, located under the Care Plan tab of the EMR, revealed, . Dependent for transfers requiring two people . Hoyer lift for all transfers x 2 staff . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/29/25 at 2:26 PM, Certified Nurse Aide (CNA) 1 propelled R36 to his room. CNA3 entered the room. CNA1 and CNA3 stood on each side of R36, placed an arm under R36's arms, and transferred him to his bed. During an observation and interview on 04/30/25 at 3:00 PM, CNA1 and CNA2 were observed transferring R36 from his chair to his bed. CNA1 stood on R36's right side, and CNA2 was on his left side. The CNAs placed an arm under R36's arms and started to transfer him. As they began to raise the resident from his chair, CNA2 stated she could not complete the transfer. CNA1 instructed her to back away, and CNA1 completed the transfer by herself. The CNAs were asked how they knew which transfer method was to be used for a resident. CNA2 stated there was a sheet of paper on the inside of the residents' closets that recorded what transfer method was to be used. CNA2 reviewed the sheet for R36 and stated it was recorded the resident was to be transferred with two people and a Hoyer lift. CNA1 and CNA2 stated that they never used the Hoyer lift to transfer R36. During an interview on 04/30/25 at 3:24 PM, the Director of Nursing (DON) was asked how the method of transfer for a resident was determined. The DON stated that it was through a collaboration between the Interdisciplinary Team and therapy. The DON was asked if she expected a resident's method of transfer to be accurately reflected on the resident's Care Plan and Kardex. The DON stated, Yes. When asked if R36 should be transferred with a Hoyer lift, as per his Care Plan and Kardex, the DON stated, Yes, and added that injury could occur to R36 and the staff members, if he was not transferred using the Hoyer lift. Review of the facility's undated policy titled, Activities of Daily Living (ADLs), revealed, . Residents will be assisted with transfer and mobility as ordered by the physician/practitioner and/or as instructed in the resident's care plan . 52322 3. For Resident #69, facility staff failed to complete an assessment/order related to elopement risks and a wandering device, before applying the wanderguard. Review of the Face sheet found in R69's electronic medical record (EMR) under the Profile tab revealed R69 was admitted to the facility on [DATE] with a diagnosis of dementia without behavioral disturbances. Review of R69's Elopement Risk Assessment found under the Assessment tab dated 12/23/24 revealed the resident was at risk for elopement and was assigned a wander guard bracelet. Further review revealed R69 did not have a current Elopement Risk Assessment Review of R69's Care Plan Report found under the Care plan tab revised 12/23/24 revealed .Elopement: the resident is at risk for elopement related to confusion and disorientation, dementia, exit seeking . Assess elopement risk as needed . wander guard to (SPECIFY) . Review of R69's Significant Change MDS assessment with an ARD date of 03/25/25 revealed the resident had a BIMS score of 00 out of 15, which indicated severe cognitive impairment. Review of the Clinical Physician Orders found in the EMR under the Orders tab revealed that R69 did not have physician orders for the wander guard. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/29/25 at 1:16 PM on the River Unit revealed revealed that R69 had a wander guard to right ankle, wandered around unit with no purpose with a walker, and required staff redirection back to her room. During an interview on 05/01/25 at 1:07 PM, the Director of Nursing (DON) stated, The resident should have a wander guard physician order that describes the location to check placement and expiration date. There should be an elopement assessment, we do them on admission and quarterly and as needed. Review of the facility's policy titled, Medication and Treatment Orders dated 10/01/21 revealed .Drug and biological orders must be recorded on the physician's order sheet in the resident's medical record. Such orders are reviewed by the consultant pharmacist on a monthly basis . Review of the facility's policy titled, Elopement/Unsafe Wandering Risk Evaluations revised 04/18/23 revealed .The Elopement Risk Evaluation in PCC be completed by licensed nurse/designee in admission, readmission, and quarterly and as needed for a change in resident status . No additional information was provided prior to survey exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observations, interviews, clinical record review, and facility policy review, 1.) the facility failed to implement enhanced barrier precautions (EBP) during high contact resident care for two residents (Resident (R) 86 and R63) ; 2.) the facility failed to implement contact precautions measure in posting appropriate signage and ensuring appropriate PPE was readily available in the care of one resident (R7); 3.) the facility staff failed to perform the standard precautions of appropriate hand hygiene with incontinent care and with handling clean linen to prevent risk of cross contamination for one of one resident (R36); and 4.) facility staff failed to perform the required hand hygiene with meal service to prevent cross contamination for seven residents (R66, R22, R51, R70, R23, R35, and R36), out of a total sample of 30 residents, increasing the risk of hospital-acquired infections for all residents. Findings include: 1. For Residents #86 and Resident #7, facility staff failed to implement enhanced barrier precautions (EBP) during high contact resident care. a. Review of R86's Profile and Med Diag (Medical Diagnosis) tab of the electronic medical record (EMR) revealed R86 was admitted to the facility on [DATE] with diagnoses that included spinal stenosis and reflux uropathy. Review of R86's Physician Orders, dated 10/02/24 and located under the Orders tab of the EMR, revealed . Infection precautions - enhanced barrier d/t [due to] foley [urinary catheter]. every shift for infection control per protocol remainder of resident's stay or until foley is removed. Staff is to wear gown/gloves when engaging in high contact activities . Review of R86's Care Plan, dated 01/13/25 and located under the Care Plan tab of the EMR, revealed a focus of, . the resident requires a urinary (Foley) catheter related to obstructive uropathy, urinary retention . Res now has new suprapubic cath [catheter] site . Interventions included, . enhanced barrier precautions . During an observation and interview on 04/29/25 at 12:29 PM, R86 was observed lying in bed. A sign stating to use EBP was observed on the wall in the resident's room, near the head of her bed. No PPE was observed in the resident's room or in her bathroom. The resident had a urinary catheter bag hanging from the left side of her bed. R86 stated she had a suprapubic catheter. R86 was asked if staff wore PPE of gowns and gloves when providing care. She stated, Sometimes they do; depends on what they are doing. No PPE, signage, or markings noting the resident was on EBP were noted near the outside of the resident's room. During an observation and interview on 05/01/25 at 10:50 AM, Licensed Practical Nurse (LPN) 3 was observed providing suprapubic catheter care for R86. LPN3 performed the care without donning a gown. At 11:04 AM, after completing the care, LPN3 was asked if R86 was supposed to be on EBP. She stated, Yes. LPN3 stated she forgot to wear a gown. LPN3 was asked where the PPE was kept. LPN3 showed the surveyor a package of gowns and a supply of gloves located in the supply room behind the nurses' station at the middle of the unit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/01/25 at 1:20 PM, the Director of Nursing (DON) stated it was the facility's policy for EBP signage to be inside the resident's room and for PPE to be in the central supply closet. She stated there was supposed to be a colored dot outside the door to indicate the resident was on EBP. The DON stated her expectation was that staff would wear a gown and gloves for suprapubic catheter care. When asked what color of dot should be outside a resident room to indicate the resident was on EBP, the DON said that she did not know, but the Unit Mangers would know. During an observation and interview on 05/01/25 at 1:24 PM, Certified Nurse Aide (CNA) 3 was asked to show the surveyor the colored dot or other indication that R86 was on EBP. CNA3 looked outside of R86's room and confirmed that there was no colored dot or anything in place to indicate in any way that R86 was on EBP. On 05/01/25 at 1:30 PM, the DON was informed that the surveyor could not find a colored dot outside of R86's room. The DON stated, Yes and acknowledged that the Unit Managers had told her that there were not any dots posted. b. Review of the Face sheet found in R63's EMR under the Profile tab revealed R63 was admitted to the facility on [DATE] with a diagnosis of anoxic brain damage and gastrostomy. Review of R63's Care Plan Report found under the care plan tab revised 02/25/25 revealed the resident is at risk for weight loss, malnutrition or poor hydration status related to need for supplemental enteral nutrition . Provide enteral feedings as ordered . Review of R63's Quarterly MDS assessment with an ARD date of 04/15/25 revealed the resident had a BIMS score of 14, which indicated no cognitive impairment. Further review revealed R63 required a feeding tube while in the facility. Review of the Clinical Physician Orders found in R63's EMR under the Order tab dated April 2025 revealed . Infection precautions- enhanced barrier every shift for infection . guaifenesin (expectorant medication) tablet 400 mg [milligrams] give 1 tablet via PEG [percutaneous endoscopic gastrostomy]-Tube every 6 hours for cough and congestion .Sennosides-Docusate (laxative and stool softener) Sodium Tablet 8.6-50 mg give 1 tablet via PEG-Tube three times a day for Constipation . acetaminophen (pain and reduce fever) Tablet 325 mg Give 2 tablet via PEG-Tube three times a day for right shoulder pain . Per observation on 04/30/25 at 1:05 PM, Registered Nurse (RN) 1 washed hands donned gloves but did not put on a PPE gown. Per observation on 04/30/25 at 1:07 PM, RN1 assessed for enteral tube placement on R63. Per observation 04/30/25 from 1:08 PM to 1:15 PM, RN1 prepared medications and administered them to R63. Observation on 04/30/25 at 1:17 PM in R63's room revealed signage for enhanced barrier precautions hanging in on the cork board. Further observation revealed no other PPE besides gloves were near the door or in the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/30/25 at 1:17 PM, when asked if R63 was on any precautions RN1 stated, She is not on enhanced barrier precautions. When questioned further, RN1 stated that she did not notice signage in the room. When asked if signage was placed somewhere else would she notice it, RN1 stated that she would she look to the door where she was used to seeing that. When questioned about available PPE, RN1 confirmed that there were gloves in the bathroom but did not see any gowns available. Review of the facility's policy titled, Enhanced Barrier Precautions (EBP) Policy, dated 03/28/24, revealed, . The purpose of this policy is to outline the guidelines for implementing Enhanced Barrier Precautions (EBP) in order to reduce the transmission of multidrug-resistant organisms (MDROs) within our facility. EBP will be utilized in conjunction with standard precautions to provide targeted gown and glove use during high-contact resident care activities . EBP should be employed in the following scenarios: . Has a wound or indwelling medical device, without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO . High-Contact Resident Care Activities Requiring EBP . Device Care or use (e.g., . urinary catheter, feeding tube .PPE [personal protective equipment] and alcohol-based hand rub should be readily accessible to staff, and their placement may be adjusted as needed . 2. For Resident R7, being treated for a contagious, multiple drug resistant urinary tract infection, the facility staff failed to follow contact precautions with posting the required signage and ensuring PPE was readily available near the doorway. Review of the Face sheet found in R7's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease. Review of R7's Significant Change MDS assessment with an ARD date of 04/13/25 revealed the resident had a BIMS score of 15 out of 15, which indicated no cognitive impairment. Further review revealed R7 required touch assistance for toileting while in the facility. Review of the Clinical Physician Orders found in R7 EMR under the Orders tab dated 04/29/25 revealed . contact precautions related to ESBL [Extended-Spectrum Beta-Lactamases] (enzymes that render certain antibiotics ineffective) every shift . Review of R7's Care Plan Report found under the care plan tab revised 04/29/25 revealed UTI [Urinary Tract Infection] The resident has developed a urinary tract infection, ESBL Observation and interview on 04/29/25 at 1:35 PM, revealed no signage on R7's door to describe the type of precautions the resident was on or to see the nurse. Neither was a supply of gloves, gowns, or masks observed readily available near the room entrance. LPN 8 stated that the facility had orange signage to let someone know if the resident is on precautions. LPN 8 stated that R7 had ESBL and that EBP signage was posted in the room, but no contact precautions signage was posted on the door or in the room. During an interview on 05/01/25 at 10:52 AM, ADON stated, We typically put the precaution signage outside the door with the cart and the gowns. I notify the managers and set up precautions. From what I was taught, we put the EBP signage in the room for privacy and dignity purposes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. For R36, the facility failed to provide standard precautions in performing the required hand hygiene with the provision of incontinent care and handling of linen to decrease the risk of cross-contamination. Review of R36's Profile tab of the EMR revealed R36 was admitted to the facility on [DATE] with diagnoses that included vascular dementia and adult failure to thrive. During an observation on 04/29/25 at 2:26 PM, Certified Nurse Aide (CNA) 1 was observed performing incontinent care for the resident. Without performing hand hygiene, CNA1 donned gloves and provided incontinent care to R36, who had notably been incontinent of bowel. CNA1 cleaned R36, placed a clean brief on the resident, and adjusted the resident's clothing. She then removed her gloves, and without performing hand hygiene, left the room to retrieve a clean incontinent pad for the bed. CNA1 returned to the room, placed the incontinent pad under the resident, adjusted the pillows and bed linens, and then adjusted the height of the bed. CNA1 retrieved the trash from the trash can and the soiled linens and left the room. CNA1 placed the soiled linens in the soiled linen closet at the nurses' station and then washed her hands. During an interview on 04/29/25 at 2:41 PM, CNA1 was asked if she had changed her gloves or performed hand hygiene after performing incontinent care for R36. CNA1 confirmed she had washed her hands after she had placed the soiled linens in the soiled linen cart but not after cleaning the resident or prior to obtaining a pad from the clean linen. CNA1 stated that she had not observed her gloves to be contaminated, and if she had, she would have changed her gloves. During an interview on 04/30/25 at 2:41 PM, Registered Nurse (RN) 4 stated that staff was expected to perform hand hygiene with incontinent care after cleaning bowel movement. RN4 stated staff should remove their gloves, perform hand hygiene, and then reglove. During an interview on 04/30/25 at 3:17 PM, the Director of Nursing was asked what the expectation was for staff performing hand hygiene during incontinent care. The DON stated that the expectation was for staff to remove their gloves, perform hand hygiene, and reglove when moving from a contaminated area to a clean area. 4. For R66, R22, R51, R70, R35, R23, and R36, the facility staff failed to perform the required hand hygiene to prevent cross-contamination during meal tray delivery. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Health and Rehab Center	1300 Enterprise Drive Lynchburg, VA 24502

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04/29/25 at 1:03 PM, CNA1 was observed passing meal trays on the Town Square unit. CNA1 entered R66's room, placed the meal tray on the overbed table, repositioned the resident's overbed table, helped the resident with her sweater, and then left the room. Without performing hand hygiene, CNA1 retrieved a meal tray for R22. CNA1 entered R22's room, uncovered the resident's food and left the room. At 1:06 PM, CNA1 poured coffee for R51, entered the room, placed the meal tray on the resident's overbed table, repositioned the resident's wheelchair and locked the wheels. Without performing hand hygiene, CNA1 left the room, called the kitchen to place an order, and then pushed the tray cart down the hall. At 1:10 PM, without performing hand hygiene, CNA1 retrieved a tray for R70, placed the tray on the resident's table in the hallway, and helped the resident prepare her food. CNA1 put butter on the potatoes and then entered room [ROOM NUMBER] and left with the same gloves. After removing her gloves, CNA1 was observed putting on gloves without performing hand hygiene and continued to help R70 with her food. At 1:14 PM, CNA1 removed her gloves, and without performing hand hygiene, entered R23's room, placed a clothing protector on the resident, and adjusted the resident's position in bed. At 1:16 PM, CNA1 retrieved a meal tray from the cart, entered R35's, placed the tray on the resident's overbed table, and adjusted the table. At 1:17 P M, CNA1 left the room and called the kitchen to place an order. At 1:19 PM, without performing hand hygiene, CNA1 re-entered R23's room, put on gloves, wet a washcloth, and washed the resident's face. CNA1 then removed her gloves, went back to R23, and handed the resident her spoon to eat with, without performing hand hygiene. At 1:22 PM, CNA1 approached R36 in the unit's dining area, sat down, and without performing hand hygiene, began to feed the resident. During an interview on 04/29/25 at 2:41 PM, CNA1 was asked if she performed hand hygiene while delivering the meal trays. CNA1 stated, No. CNA1 stated that she only needed to perform hand hygiene if she was touching the residents' food. CNA1 was asked if she should perform hand hygiene if she had touched items in the residents' rooms, such as wheelchairs and overbed tables. CNA1 stated that she did not think so. During an interview on 04/30/25 at 2:40 PM, RN4 stated staff should wash their hands before beginning to pass meal trays and perform hand hygiene after each tray that was delivered, especially if items in the residents' rooms were moved. During an interview on 04/30/25 at 3:17 PM, the DON stated her expectation was for staff to perform hand hygiene before passing meal trays and between each meal tray that was passed. Review of the facility's undated policy titled, Hand Hygiene revealed, . The facility promotes hand hygiene as a simple and effective method for preventing the spread of infections. Glove use is not a substitute for hand hygiene. All staff are to perform hand hygiene during all care activities and while working in all locations within the facility . 'Hand hygiene' means to clean one's hands with either a sanitizer product or with soap and water . All staff are responsible for following hand hygiene procedures . After contact with . body fluids or excretions . After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident . When hands move from a contaminated-body site to a clean body site during resident care . Before and after wearing gloves No additional information was provided prior to survey exit.