STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495425	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehab Center at Bristol	301 Village Circle Bristol, VA 24201

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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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. Based on staff interview and clinical record review, the facility staff failed to provide notice of rights and services prior to or upon admission for 1 of 6 residents, Resident #1. The findings include. The facility staff failed to provide Resident #1 with a notice of rights and services upon their admission to the facility or prior to admit. This paperwork was not provided to Resident #1 until 3 days after their admission to the facility. This was a closed record review. Resident #1's diagnoses included, but were not limited to, atrial fibrillation, traumatic brain injury, epilepsy, and anxiety disorder. Section C (cognitive patterns) of Resident #1's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/22/24 included a brief interview for mental status (BIMS) score of 5. Per the MDS manual a score of 5=severe impairment in cognitive skills for daily decision making. Resident #1 had been admitted to the facility on a Friday. The clinical record included signed copies of Resident #1's admission paperwork to include, resident rights and responsibilities. Resident #1 signed and dated these documents on the Monday three days after their admission to the facility. On 02/25/25 at 11:30 a.m., during an interview with the admissions staff, this staff stated they worked Monday-Thursday and Resident #1 was not provided their admission paperwork until the Monday after their admission on the previous Friday. On 02/25/25 at 4:10 p.m., during a meeting with the Administrator, Director of Rehab, Director of Nursing, and Assistant Director of Nursing the Administrator stated they had resident rights posted throughout the facility. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify the responsible party (RP) of a change in a residents antipsychotic medication for 1 of 6 residents in the survey sample, Resident #3. The findings include. The facility staff failed to notify the RP when Resident #3's antipsychotic medication Seroquel was discontinued. This was a closed record review. Resident #3's diagnoses included, but were not limited to, Alzheimer's disease, dementia, anemia, hypertension, anxiety, and restlessness and agitation. Section C (cognitive patterns) of Resident #3's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/17/23 included a brief interview for mental status (BIMS) score of 00. Per the MDS manual a score of 00=severe impairment in cognitive skills for daily decision making. Resident #3's comprehensive care plan included the focus areas at risk for falls potential side effects of psychotropic medications. Uses antipsychotic medications related to behaviors. Resident #3's clinical record included a provider order for Seroquel 25 mg at bedtime for psychophysiologic insomnia. Date of order 02/09/23. This medication had been discontinued on 07/06/23. During the clinical record review, the surveyor was unable to find any evidence to indicate the RP had been notified that Resident #3's Seroquel had been discontinued. On 02/24/25 at 4:50 p.m., during an interview with the Assistant Director of Nursing (ADON) this staff stated they were unable to find any documentation to indicate the RP had been notified that the Seroquel had been discontinued and it would have been the responsibility of the hall nurse to report this. On 02/24/25 at 5:35 p.m., during an interview with Registered Nurse (RN) #1 this staff stated they had not made a note regarding RP notification when the Seroquel had been discontinued, they usually made a note and always notified the RP. On 02/25/25 at 8:15 a.m., during an interview with Nurse Practitioner (NP) #3 regarding this residents Seroquel the NP stated they had reviewed their notes and per their documentation the Seroquel was discontinued due to falls. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/25/25 the Administrator provided the survey team with a copy of their policy titled, Resident Representative. This policy read in part, The facility treats the decisions of the resident representative as the decisions of the resident .resident representative is defined as an individual chose by the resident to act on behalf of the resident in order to support the resident in decision-making .or receive notifications . On 02/25/25 at 4:10 p.m., during a meeting with the Administrator, Director of Nursing, ADON, and Director of Rehab the issue with the RP not being notified when Resident #3's Seroquel was discontinued was reviewed. The consensus of this group was that the RP was difficult to get in touch with. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. Based on staff interview, clinical record review and facility document review the facility staff failed to ensure the required documentation related to hospital transfer was included in the clinical record for 2 of 6 residents, Resident #2 and Resident #6. The findings included: 1. For Resident #2 the facility staff failed to document what paperwork was sent with resident, failed to document who was contacted at the emergency department, and failed to document name of facility being transferred to. Resident #2's clinical record listed diagnoses which included but not limited to acute and chronic respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia, obstructive sleep apnea, and chronic obstructive pulmonary disease. Resident #2's most recent minimum data set with an assessment reference date of 10/14/24 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident was cognitively intact. Resident #2's comprehensive care plan was reviewed and contained a plan for Resident is at risk for complications r/t (related to) Asthma, Chronic Respiratory Failure, seasonal allergies, pulmonary HTN (hypertension), COPD (chronic obstructive pulmonary disease) and OSA (obstructive sleep apnea). Resident #2's progress notes were reviewed and contained a note which read in part, 1/2/2025 18:47 This nurse was called to this resident's room when the cna (certified nurse's aide) went to room she found resident unresponsive and foaming at the mouth nasal cannula off cna stated she tried sternum rub and resident still didn't respond; this nurse told the cna to go get help while this nurse got the resident on the side and called the DON (director of nursing) told her that we were calling 911 then after calling 911 called family and then the ER (emergency room) to give report; when the ambulance arrived the resident was still unresponsive. Surveyor spoke with the DON on 02/25/24 at 12:55 pm regarding what should be documented when a resident is transferred to the hospital. DON stated, Some nurses chart well, some don't. DON stated that all information from the facility Transfer to Hospital Checklist should be documented in the clinical record. Surveyor requested and was provided with a facility document entitled Transfer to Hospital Checklist which read in part, Bed Hold Policy sent to Hospital with resident. Transfer Observation. Careplan printed and sent out with patient. Print MAR/TAR (medication/treatment administration record). Print Facesheet. Send Copy of DNR (do not resuscitate) form. Make sure you call report to ER with exactly why you are sending the patient to ER. Document who you called report to at the hospital in your progress note. Make a Progress Note and include why the resident is being transferred out of facility, include that all of the above was sent with resident to hospital such as (bed hold policy, transfer form, SBAR, MAR). Time that symptoms occurred and family and doctor notification. Include what hospital resident is being transferred to. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concern of not ensuring proper documentation was included in the clinical record related to a hospital transfer was discussed with the administrator, DON, assistant director of nursing and director of rehabilitation services on 02/25/25 at 4:10 pm. No further information was provided prior to exit. 2. For Resident #6 the facility staff failed to include required documentation related to a hospital transfer in the resident's clinical record. Resident #6's clinical record listed diagnoses which included but not limited to essential primary hypertension, dementia, and other chronic pain. Resident #6's most recent minimum data set with an assessment reference date of 12/12/24 assigned the resident a brief interview for mental status score of 6 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #6's comprehensive care plan was reviewed and contained a plan for Resident has a potential for cardiovascular complications r/t (related to) HTN (hypertension) and Hyperlipidemia. Resident #6's nurse's progress notes were reviewed and contained a note which read in part, 12/29/2024 08:15 Resident c/o (complaint of) crushing chest pain requested to go to ER for evaluation and treatment. Daughter notified. 911 notified. Surveyor could not locate any other documentation related to hospital transfer. Surveyor spoke with the DON on 02/25/24 at 12:55 pm regarding what should be documented when a resident is transferred to the hospital. DON stated, Some nurses chart well, some don't. DON stated that all information from the facility Transfer to Hospital Checklist should be documented in the clinical record. Surveyor requested and was provided with a facility document entitled Transfer to Hospital Checklist which read in part, Bed Hold Policy sent to Hospital with resident. Transfer Observation. Careplan printed and sent out with patient. Print MAR/TAR (medication/treatment administration record). Print Facesheet. Send Copy of DNR (do not resuscitate) form. Make sure you call report to ER with exactly why you are sending the patient to ER. Document who you called report to at the hospital in your progress note. Make a Progress Note and include why the resident is being transferred out of facility, include that all of the above was sent with resident to hospital such as (bed hold policy, transfer form, SBAR, MAR). Time that symptoms occurred and family and doctor notification. Include what hospital resident is being transferred to. The concern of not ensuring proper documentation was included in the clinical record related to a hospital transfer was discussed with the administrator, DON, assistant director of nursing and director of rehabilitation services on 02/25/25 at 4:10 pm. No further information was provided prior to 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. Based on staff interview, clinical record review, and facility document review, the facility staff failed to follow the providers orders for 2 of 6 residents in the survey sample, Resident #1 and #3. The findings include. 1. For Resident #1, the facility nursing staff failed to transcribe an order for the seizure medication Lamictal onto the residents admission paperwork from the discharge instructions from the admitting hospital. This was a closed record review. Resident #1's diagnoses included, but were not limited to, epilepsy, atrial fibrillation, traumatic brain injury and anxiety disorder. Section C (cognitive patterns) of Resident #1's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/22/24 included a brief interview for mental status (BIMS) score of 5. Per the MDS manual a score of 5=severe impairment in cognitive skills for daily decision making. Resident #1's comprehensive care plan included the focus area has a seizure disorder. Interventions included, give seizure medication as ordered. Resident #1's hospital discharge instructions/summary with a discharge date of 10/18/24 included an order for Lamictal 100 mg take 11 tablets a day. A review of Resident #1's clinical record revealed that this order had not been transcribed into the clinical record upon admission. The clinical record did include provider orders for this medication dated the day after admission. During an interview with the physician on 02/25/25 at 1:45 p.m. the physician stated the Lamictal was probably missed on the admission paperwork. On 02/25/25 at 2:00 p.m., the interview with the physician was shared with the Director of Nursing (DON). The DON stated the missing Lamictal order was probably caught on a chart review. The clinical record included Lamotrigine (Lamictal) laboratory tests results dated 10/22/24. The results of this laboratory test were documented as 12.7 the reference range was 2-20. The surveyor did not find any information to indicate this resident had any seizures during their stay at the facility. No further information regarding this issue was provided to the survey team prior to the exit conference. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #3, the facility staff failed to follow provider orders for Seroquel and failed to apply provider ordered geri-sleeves. This was a closed record review. Resident #3's diagnoses included, but were not limited to, Alzheimer's disease, dementia, anemia, hypertension, anxiety, and restlessness and agitation. Section C (cognitive patterns) of Resident #3's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/17/23 included a brief interview for mental status (BIMS) score of 00. Per the MDS manual a score of 00=severe impairment in cognitive skills for daily decision making. Resident #3's comprehensive care plan included the focus areas at risk for falls potential side effects of psychotropic medications. Uses antipsychotic medications related to behaviors. Risk for impaired skin integrity, comfort sleeves to arms as skin preventative. Resident #3's clinical record included a provider order for Seroquel 12.5 mg one time a day for mood for 7 days. Date of order 07/13/23. On 07/18/23 Licensed Practical Nurse (LPN) #7 revised the Seroquel order. Under reason the nursing staff had added hold for sedation. A review of the medication administration records (MARs) indicated this medication was scheduled to be administered beginning on 07/14/23 at 8:00 p.m. The nursing staff documented they had administered this medication on 07/14/23 and 07/17/23. For 07/15/23 and 07/16/23 the facility nursing staff documented a 9. Per the preprinted code on the MAR a 9=other/see progress notes. For both these dates the nursing staff documented not given due to family's request. When the order was revised on 07/18/23 the nursing staff blocked out 7 additional days on the MARs for the administration of the Seroquel indicating there was an opportunity for Resident #3 to be administered 11 doses of Seroquel and not 7 as ordered by the provider. For 07/18/23 and 07/19/23 the nursing staff documented a 9. On 07/18/23 the nursing staff documented hold for sedation and on 07/19/23 they documented held at family request. The nursing staff documented they had administered this medication at 8:00 p.m. from 07/20/23-07/24/23. LPN #7 no longer worked at the facility and could not be interviewed. On 02/25/25 at 4:10 p.m., during a meeting with the Administrator, Director of Nursing (DON), Director of Rehab and Assistant Director of Nursing the issue with the Seroquel being available for 11 administrations instead of 7 as ordered by the provider was reviewed. The DON stated Resident #3 should have received the 12.5 mg dose of Seroquel for 7 days. Resident #3's clinical record included a provider order dated 09/26/23 for geri-sleeves to arms as tolerated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the treatment administration records (TARs) for 10/01/23-01/12/24 revealed that for day shift on October 10, 19, and 24, November 24 and 25, December 5, 19, and 22-26, and January 6, 2024, there was no documentation to indicate the geri-sleeves had been applied. The TAR included codes the nursing staff should have used if the resident had refused to wear the geri-sleeves. The facility policy titled, Charting and Documentation read in part, All services provided to the resident .shall be documented in the resident's medical record . No further information regarding these issues were provided to the survey team prior to the exit conference.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on staff interview and clinical record review, the facility staff failed to provide evidence that they had obtained a provider ordered laboratory test for 1 of 6 residents, Resident #1. The findings include. The facility staff failed to provide evidence that they had obtained the provider ordered laboratory test urinalysis (UA). This was a closed record review. Resident #1's diagnoses included, but were not limited to, atrial fibrillation, traumatic brain injury, epilepsy, and anxiety disorder. Section C (cognitive patterns) of Resident #1's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/22/24 included a brief interview for mental status (BIMS) score of 5. Per the MDS manual a score of 5=severe impairment in cognitive skills for daily decision making. Section GG (functional abilities) was coded to indicate a toilet transfer was not attempted with this resident due to medical conditions or safety concerns. Section H (bladder/bowel) was coded to indicate this resident was always incontinent of urine. Resident #1's comprehensive care plan included the focus area has an activities of daily living self-care performance deficit. The clinical record included a provider progress note with a date of service of 10/24/24 that included the following documentation .seen today at the request of the facility .has complaints today of dysuria and recently finished her antibiotics. Vital signs stable and no fever reported. Staff without any other acute concerns to report today .Orders for this Visit UA C/S [culture and sensitivity] send out .DIAGNOSES . Urinary tract infection, site not specified . The clinical record included an order summary report that included the order UA C/S for confusion. The order date was documented as 10/25/24 and the order status read completed. During the clinical record review, the surveyor was unable to find the results of the UA. The clinical record included documentation on 10/24/24, 10/25/24, and 10/26/24 by the nursing staff that Resident #3 was continent of bladder, their urine was clear yellow, and the resident denied any urinary complaints. The nursing staff also documented on 10/25/24 that the resident was incontinent of urine, urine yellow in color, no urinary complaints, and the resident uses adult briefs. On 02/25/25 at 2:55 p.m., during an interview with Registered Nurse (RN) #4 this staff was asked the procedure for collecting a UA. RN #4 stated they would put the order in the computer, complete the lab slip, attempt to collect the urine sample, if unable to collect report it to the oncoming shift, and if still unable to collect notify the provider. RN #4 stated if the staff were unable to collect the urine sample they would expect to see a progress note. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/25/25 at 3:00 p.m., the surveyor interviewed RN #3 regarding the collection of a urine sample. RN #3 stated if the resident was continent, they would supply them with a urine collection device hat or use a specimen cup provided by the laboratory company. If someone was incontinent, they would reach out to the provider for an order for a straight catheterization, hydrate the resident, once the specimen was obtained it was put in the refrigerator, and the courier called. On 02/25/25 at 5:35 p.m., during a meeting with the Administrator, Director of Nursing, Assistant Director of Nursing and Director of Rehab the issue with the missing UA results was reviewed. The Administrative staff stated the resident was sent out per the spouse's request either prior to the UA being collected or it may have been tossed out once the resident had been sent out. When the surveyor stated the status beside the UA order said completed the Administrator stated the urine may have been collected but the laboratory company that they were using went out of business and there was no one to contact. No further information regarding this issue was provided to the survey team prior to the exit conference.