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	10/01/2025

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

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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, facility document review, and interview, the facility failed to ensure an allegation of abuse was reported within two hours, which affected 1 (Resident #98) of 8 residents reviewed for abuse or neglect prohibition. Findings included: A facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 09/2022, revealed All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. The policy revealed, 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The policy revealed, 3. 'Immediately' is defined as, which included a. within two hours of an allegation involving abuse or result in serious bodily injury. An admission Record indicated the facility admitted Resident #98 on 12/11/2024 and readmitted the resident on 12/27/2024. According to the admission Record, the resident had a medical history that included diagnoses of anemia; acute embolism and thrombosis of unspecified deep veins of an unspecified lower extremity; anxiety disorder; long term (current) use of anticoagulants (blood thinning medication); depression; edema; muscle weakness; and difficulty in walking, not elsewhere classified. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/17/2024, revealed Resident #98 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #98's Care Plan Report, included a focus area initiated 12/12/2024, that indicated the resident had a deep vein thrombosis (DVT; a blood clot) of the lower extremity, was on anticoagulant therapy, and had edema. Interventions initiated 12/12/2024 directed staff to assess the resident's fingers and toes for warmth and color, obtain the resident's vital signs, and notify the medical doctor of significant abnormalities. Resident #98's hospital Discharge Summary, dated 12/27/2024 at 12:21 PM, indicated the residents' admission diagnoses included swelling and anemia and discharge diagnoses included a right thigh hematoma. Per the summary, a repeat sonogram of the lower extremity did not show any DVTs. A Grievance Form dated 01/13/2025, completed by the Social Services Director (SSD), revealed Resident #98 reported a grievance regarding concerns with therapy staff. The document indicated that the resident expressed that a recent hospitalization was allegedly due to a therapist, who attempted to manipulate the resident's knee. The form also indicated that according to the resident, on one occasion when therapy staff assisted the resident out of bed, they removed the resident's sheets and instructed the certified nursing assistants (CNAs) to not make the bed until the resident remained seated in a chair for an extended period of time. Per the form, Resident #98 felt they were neglected by therapy staff and was getting minimal time with them. The Nature of Resolution section of the Grievance Form indicated that on 12/31/2024, Therapy Staff #29 was notified of the concern related to the resident's blood clots. The form revealed no documented evidence that staff notified the Administrator or the state survey agency (SSA) of the resident's allegation at the time of the grievance. A facility document titled, Facility Reported Incident (FRI) indicated that the facility reported an allegation of neglect involving Resident #98 to the SSA. The FRI indicated that the resident was complaining of their leg being numb and painful, and alleged that a blood clot was dislodged by a therapist, causing the resident to be hospitalized . Per the FRI, Resident #98 alleged that on 12/18/2024, a physical therapist aggressively messaged behind the resident's knee, cutting off blood flow to the resident's leg, and resulted in the resident going to the hospital. Per the FRI, the resident made the allegation on 12/31/2024 to an occupational therapist. The FRI indicated that concerns were addressed with the facility providers, who stated that treatment could not have caused numbness or pain. The FRI indicated that the pain was related to a blood clot and hematoma for which the resident was previously admitted to the hospital. The FRI indicated that it was explained to the resident's family member, there was no further discussion, and the team felt everything was okay until Resident #98 complained again to the SSD on 01/13/2025. The FRI indicated that the facility completed a grievance form; however, the resident then stated that they felt neglected. Per the FRI, the Incident date was 12/18/2024, and the report date was 01/14/2025. A Facility Reported Incident Fax Cover Sheet indicated that the facility submitted an initial report for an allegation of neglect to the SSA on 01/14/2025 at 8:14 PM, a day after Resident #98 voiced allegations of abuse/neglect and the SSD completed the Grievance Form. A typed statement signed by Physical Therapist

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, facility document review, and interview, the facility failed to have evidence that allegations of abuse were thoroughly investigated for 4 (Residents #13, #92, #52, and #98) of 8 residents reviewed for abuse/neglect prohibition. The facility also failed to implement interventions to prevent further potential abuse/neglect while an investigation was in progress for 1 (Resident #98) of 8 residents reviewed for abuse/neglect prohibition.Findings included: A facility policy titled, “Abuse, Neglect, Exploitation or Misappropriation – Reporting and Investigating,” revised September 2022, revealed, “All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.” The policy further revealed “Investigating Allegations” included “1. All allegations are thoroughly investigated. The administrator initiates investigations,” “2. Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations,” “3. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation,” “5. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility,” “6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete,” and “7. The individual conducting the investigation as a minimum,” which included “a. reviews the documentation and evidence;” “b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident;” “c. observes the alleged victim, including his or her interactions with staff and other residents;” “d. interviews the person(s) reporting the incident;” “e. interviews any witnesses to the incident;” “f. interviews the resident (as medically appropriate) or the resident's representative;” “g. interviews the resident's attending physician as needed to determine the resident's condition;” “h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;” “i. interviews the resident's roommate, family members, and visitors;” “j. interviews other residents to whom the accused employee provides care or services;” “k. reviews all events leading up to the incident; and” “l. documents the investigation completely and thoroughly.” 1. An “admission Record” revealed the facility admitted Resident #13 on 03/20/2025. According to the admission Record, the resident had a medical history that included diagnoses of rheumatoid arthritis, pain in the right hip, depression, anxiety disorder, long term (current) use of anticoagulants (blood thinners), muscle weakness (generalized), and the need for assistance with personal care. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/08/2025, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident was dependent on staff to provide toileting hygiene and to roll left and right in bed. The MDS also indicated that the resident took antiplatelet medications during the assessment look-back period. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13's “Care Plan Report” included a focus area initiated 03/24/2025, that indicated the resident was on anticoagulant therapy. Interventions directed staff to observe the resident for side effects and effectiveness (initiated 03/24/2025). The Care Plan Report included a focus area initiated on 03/24/2025, that indicated the resident had an activity of daily living (ADL) self-care performance deficit related to the need for assistance with personal care. Interventions directed staff to encourage the resident to discuss their feelings about the self-care deficit (initiated 03/24/2025). A “Facility Reported Incident Investigation and conclusion,” dated 04/06/2025 to 04/11/2025, revealed that on 04/06/2025, Resident #13 reported to a day shift certified nursing assistant (CNA), CNA #14, that an overnight CNA, CNA #22, was “rough” when changing Resident #13's brief and “pulled” on the resident's leg. The investigation revealed the resident pointed to the location where the CNA pulled on the resident, and there was bruising present. Per the investigation, the resident reported that they thought the CNA was aggravated, and that the CNA stated she had difficulty cleaning feces off the resident. According to the Facility Reported Incident Investigation and conclusion, CNA #22 was suspended during the investigation. The facility concluded that there was no harm intended to the resident; however, the facility decided that CNA #22 would not provide care to the resident during the remaining days of the resident's stay, unless there was an emergency. The investigation revealed no documented evidence that the facility interviewed/assessed other residents to whom the accused employee (CNA #22) provided care. The facility's investigation included written statements from CNA #22 and Licensed Practical Nurse (LPN) #21. Per their statements, they were providing incontinence care for Resident #13 when CNA #22 noticed “a small sore” and redness to the resident's “bottom.” According to LPN #21's statement, after they noticed the reddened area, the CNA got wipes to clean the resident because she thought wipes would be softer on the resident's skin. Per the investigation, CNA #22 and LPN #21 also reported that Resident #13 made no complaints and that they had a “pleasant” and “polite” conversation with the resident while they provided care. A typed statement dated 04/07/2025, signed by Registered Nurse (RN) #12, who was also a unit manager, revealed she spoke to Resident #13 regarding the allegation and observed the bruising to the resident's thigh. RN #12's statement revealed that she interviewed other residents who resided in the hall about their care on the night of 04/05/2025, and no one had any complaints of anyone being rough or rude with them. During an interview on 09/25/2025 at 8:58 A.M, RN #12 stated that once she learned of Resident #13's allegation, she initiated an investigation. She stated she and the Social [NAME] Director (SSD) interviewed Resident #13, and they each interviewed some of the residents who lived on the same hallway. RN #12 stated that she thought she documented the resident interviews that she conducted. Per RN #12, she and the SSD also talked to residents or families of residents who were not alert and oriented. She stated that if they felt like more than one resident was affected or if another resident had a concern, they would conduct skin assessments for all residents on the floor. RN #12 stated they gave all their information to the Administrator (ADM) and that she, the ADM, the Director of Nursing (DON), and the SSD concluded the allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/25/2025 at 9:37 AM, the SSD stated that she and RN #12 interviewed Resident #13 and CNA #22. She stated that she also interviewed residents to determine whether CNA #22 was rough with them but did not remember which residents she spoke with. The SSD stated that the residents who were not cognitively intact were not interviewed; however, she stated they would know if nonverbal residents were abused because the families kept an eye on them, and therapy staff were very involved in the residents' care. During an interview on 09/25/2025 at 3:51 PM, the ADM stated she did not speak to Resident #13 about the incident because the DON was responsible for the investigation of the 04/06/2025 incident. The ADM revealed that for nonverbal residents, they assessed the potential risk for abuse by asking nearby residents or staff members if they had noticed any changes in residents; however, the ADM stated there was no documentation of resident interviews. The ADM stated that the ADM and DON were responsible for monitoring the investigative process, and the expectation was for a thorough investigation to be conducted. 2. An “admission Record” revealed the facility admitted Resident #92 on 10/03/2022. According to the admission Record, the resident had a medical history that included diagnoses of depression, anxiety, other chronic pain, muscle weakness, difficulty in walking, a need for assistance with personal care, and unspecified osteoarthritis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/12/2025, revealed Resident #92 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS revealed Resident #92's vision and hearing were adequate. The MDS indicated the resident did not exhibit any behavioral symptoms, hallucinations, or delusions during the assessment look-back period. Resident #92's “Care Plan Report” included a focus area initiated 04/27/2023, that indicated the resident had bladder incontinence and impaired mobility. Interventions directed staff to observe and report signs and symptoms of a urinary tract infection (UTI), such as altered mental status and changes in behavior (initiated 04/27/2023). An “admission Record” revealed the facility admitted Resident #52 on 03/01/2024. According to the admission Record, the resident had a medical history that included diagnoses of major depressive disorder, unspecified dementia, and unspecified hearing loss. A quarterly MDS, with an ARD of 09/08/2025, revealed Resident #52 had a BIMS score of 7, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had adequate vision. The MDS indicated the resident was always incontinent of bowel and bladder and was dependent on staff to provide toileting hygiene. Resident #52's “Care Plan Report” included a focus area initiated 12/05/2024, that indicated the resident had a psychosocial well-being problem related to dementia. Interventions directed staff to explain all procedures and treatments (initiated 12/05/2024). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A “Facility Reported Incident Investigation and conclusion,” dated 05/06/2025, revealed Resident #92 reported that Certified Nursing Assistant (CNA) #15 kicked the resident's leg when it was hanging off the resident's bed, and also kicked the resident's hairbrush across the floor when the resident asked the CNA to pick it up for them. The document indicated that Resident #92 also reported that CNA #15 had gotten into bed with Resident #52, Resident #92's roommate. Per the report, Resident #92 felt the relationship between Resident #52 and CNA #15 was inappropriate and “sexual” in nature because the CNA was on their knees on Resident 52's bed while the resident was in bed. Per the facility investigation, Resident #52 stated that no one had ever been inappropriate towards them and denied having any sexual relationships. According to the investigation, the facility concluded that there was no evidence to suggest that either resident was physically or sexually abused, assaulted, or exploited. The report revealed that CNA #15 was suspended and although abuse could not be proven, the facility felt it would be best for “all involved” if CNA #15 were no longer employed at the facility. Per the report, CNA #15's employment would be terminated. The investigation revealed no documented evidence that the facility staff interviewed or obtained statements from staff members who had contact with the residents during the period of the alleged incident; family members/visitors, or other residents to whom the accused employee provided care or services. There was also no documented evidence that the facility staff assessed Resident #52 or Resident #92 for injury. During an interview on 09/26/2025 at 9:55 AM, Registered Nurse (RN) #13, who was also a unit manager, stated that the 05/06/2025 allegation was the first allegation that she had investigated, and she was still learning at that time. RN #13 stated she interviewed Resident #92, who initially stated that CNA #15 kicked a hairbrush, and the brush hit the resident's leg, but did not say anything about Resident #52. RN #13 stated she thought the Administrator (ADM) and Therapy Staff #29 talked to Resident #92, which was when the resident told them that CNA #15 had their knees on the side of Resident #52's bed. She stated she assessed Resident #92's leg and there was no bruising or redness. RN #13 stated that she also assessed Resident #52 and there was no bruising or bleeding. According to RN #13, staff assessed the skin of all residents that CNA #15 had worked with to ensure there were no issues but was not sure whether they documented the assessments. Per RN #13, the ADM told her to interview everyone that was cognitively intact on the floor where Resident #52 and Resident #92 resided and ask the residents how CNA #15 and other staff were doing and if there was anything they would like to talk about. RN #13 stated that she did not remember whether she documented what the residents said. RN #13 also stated she thought she obtained staff statements but did not recall who the statements were from. Further, RN #13 stated staff interviewed CNA #15 via speaker phone, and the CNA denied the allegations. During an interview on 09/26/2025 at 10:33 AM, the ADM stated that she and Therapy Staff #29, who was the Director of Rehabilitation and an administrator in training, conducted the investigation together. She stated that they were interviewing Resident #52 about being kicked when the resident said they saw CNA #15 with their knees on the side of Resident #52's bed. The ADM stated Resident #92 told them the curtain was pulled, and the resident did not know what was going on but felt that it was sexual in nature. She stated they interviewed Resident #52, who stated that no one had touched them inappropriately. Per the ADM, Resident #52's family member did not want to send the resident to the hospital for evaluation. The ADM also stated that they interviewed the CNA who was taking care of the residents, and the CNA said there were no issues. She stated they also spoke with CNA #15, who denied the allegations. The ADM stated she did not document which staff were interviewed or obtain statements. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 09/25/2025 at 3:51 PM, the ADM stated that she and the Director of Nursing (DON) were responsible for monitoring the investigation process, and the expectation was for a thorough and fair investigation to be conducted. 3. An “admission Record” indicated the facility admitted Resident #98 on 12/11/2024 and readmitted the resident on 12/27/2024. According to the admission Record, the resident had a medical history that included diagnoses of anemia; acute embolism and thrombosis of unspecified deep veins of an unspecified lower extremity; anxiety disorder; long term (current) use of anticoagulants (blood thinning medication); depression; edema; muscle weakness; and difficulty in walking, not elsewhere classified. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/17/2024, revealed Resident #98 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #98's “Care Plan Report” included a focus area initiated 12/12/2024, that indicated the resident had a deep vein thrombosis (DVT; a blood clot) of the lower extremity, was on anticoagulant therapy, and had edema. Interventions initiated 12/12/2024 directed staff to assess the resident's fingers and toes for warmth and color, obtain the resident's vital signs, and notify the medical doctor of significant abnormalities. A facility document titled, “Facility Reported Incident (FRI),” dated 01/14/2025, revealed Resident #98 alleged that on 12/18/2024, a physical therapist “aggressively messaged” behind the resident's knee, “cutting off blood flow” to the resident's leg, and resulted in the resident going to the hospital. Per the FRI, the resident made the allegation on 12/31/2024 to an occupational therapist. The FRI indicated that concerns were addressed with the facility providers, who stated that treatment could not have caused numbness or pain. The FRI indicated that the pain was related to a blood clot and hematoma for which the resident was previously admitted to the hospital. The FRI indicated that it was explained to the resident's family member, there was no further discussion, and the team felt everything was okay until Resident #98 complained again to the SSD on 01/13/2025. The FRI indicated that the facility completed a grievance form; however, the resident then stated that they felt neglected. The “Employee action initiated or taken” section of the document indicated that Physical Therapist (PT) #8 “has not treated [Resident #98] since [their] return from the hospital.” The facility's investigation revealed no evidence that other residents were interviewed regarding the treatment they received from PT #8 or interventions implemented to protect other residents from abuse from PT #8 during the investigation. During an interview on 09/26/2025 at 9:17 AM, PT #8 stated Physical Therapy Aide (PTA) #6 voiced concerns about Resident #98's leg and asked him to look at the resident. PT #8 stated that he assessed the resident and assessed the resident again upon readmission from the hospital, which was when the resident made an allegation of abuse. According to PT #8, he was not suspended from work but did not treat Resident #98 during the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/26/2025 at 11:58 AM, Therapy Staff #29, who was the Director of Rehabilitation, stated PT #8's employment was not suspended during the investigation, and she could not recall how they protected Resident #98 or other residents from further potential abuse during the investigation. During an interview on 09/26/2025 at 12:48 PM, the Assistant Director of Nursing (ADON) stated she would have to review the facility's policy to determine whether PT #8 should have been suspended because she did not know the whole situation. During an interview on 09/26/2025 at 1:49 PM, the Administrator (ADM) revealed that Resident #98 alleged that PT #8 caused them to go to the hospital. The ADM stated that she was not sure if any other residents were interviewed. According to the ADM, PT #8 was not suspended pending the investigation but was removed from Resident #98's assignment and did not take care of the resident anymore.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on observation, record review, interview, and facility document and policy review, the facility failed to provide adequate supervision to prevent accidents for 1 (Resident #101) of 4 residents reviewed for falls. Specifically, the facility failed to provide the appropriate level of supervision for Resident #101 during bathing. The resident was left unsupported on a shower bench while a staff member stepped away to retrieve a towel. As a result, the resident fell from the shower chair and hit their head, causing a head injury that required hospitalization. Findings included:A facility policy titled Falls-Clinical Protocol, revised 03/2018, indicated, 1. The physician will help identify individuals with a history of falls and risk factors for falling. The policy also specified, 5. The staff will evaluate and document falls that occur while the individual is in the facility, for example, when and where they happen, any observations of the events, etc. [et cetera]. The policy also included a section titled, Cause Identification that specified, 1. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall; a. Often, multiple factors contribute to a falling problem; 2. If the cause of a fall is unclear, or if a fall may have significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors and, 3. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. An admission Record revealed the facility admitted Resident #101 on 03/06/2025. According to the admission Record, the resident had a medical history that included diagnoses of transient cerebral ischemic attack, unspecified symptoms and signs involving cognitive functions following other cerebrovascular disease, muscle weakness, difficulty in walking and need for assistance with personal care. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/10/2025, revealed Resident #101 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required substantial/maximal assistance to shower/bathe self and for upper body dressing and was dependent for lower body dressing. According to the MDS, the resident was not assessed for tub/shower transfers during the assessment period. The MDS indicated the resident had functional limitation in range of motion in the upper extremity on one side and the lower extremities on both sides. Resident #101's Care Plan Report included the following: - A focus area, initiated on 03/11/2025, indicated the resident was at risk for falls related to deconditioning. Interventions directed staff to anticipate and meet the resident's needs and be sure the resident's call light was within reach, encourage the resident to use the call light for assistance, and provide prompt response to all requests for assistance. - A focus area, initiated on 03/11/2025, indicated the resident had a cerebral vascular accident which affected the resident's left side. Interventions directed staff to assist the resident with activities as tolerated, get the resident out of bed into a chair if tolerated, give medications as ordered by the physician, and observe for side effects and effectiveness. - A focus area, initiated on 03/11/2025, indicated the resident was on anticoagulation therapy. Interventions directed staff to administer anticoagulant medication as ordered by the physician, observe for medication side effects, and observe/report adverse reactions of anticoagulant therapy, to include blood-tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, and significant or sudden changes in vital signs. - A focus area, initiated on 03/11/2025, indicated the resident had an ADL self-care performance deficit related to activity intolerance and stroke. Interventions directed staff to encourage the resident to participate to the fullest extent possible with each interaction and encourage the resident to use a bell to call for assistance. The interventions did not address the level of care or number of staff required to assist the resident with bathing or other ADLs. A Fall Risk Evaluation, dated 03/06/2025 at 1:31 PM, indicated Resident #101 was at high risk for falls. The Fall Risk Evaluation indicated the resident was chairbound, had a change of condition in the last 14 days, and had a recent hospitalization in the last 30 days. The evaluation indicated an assessment of the resident's gait and balance could not be performed. A Baseline Care Plan, dated 03/06/2025 and completed by Licensed Practical Nurse (LPN) #27, indicated Resident #101 was assessed to require two or more persons' physical assistance for bathing. The Baseline Care Plan did not indicate the resident utilized a mobility device. An undated MDS Kardex Report (used to communicate residents' care needs to CNA staff) revealed Resident #101 required the extensive physical assistance of two people for bed