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

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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 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. 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, (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 mobility, transfers, and toilet use. The level of assistance or number of staff required for bathing was not addressed on the Kardex Report. Resident #101's Physical Therapy PT Therapy Progress Report with service dates from 04/18/2025 to 04/30/2025 indicated on 04/30/2025, Resident #101's dynamic sitting ability was at a fair-minus level, and the resident required moderate assistance with transfers. Resident #101's Physical Therapy (PT) Discharge Summary with service dates from 03/07/2025 to 05/02/2025, indicated upon discharge from therapy services on 05/02/2025, Resident #101's ability for dynamic sitting balance remained at a fair-minus level and the resident continued to require moderate assistance with transfers. An undated facility document titled, Sitting Balance Grades defined fair-minus as indicating the resident was able to sit unsupported for short periods but may lose balance easily without support; was able to sit with upper extremity support; could not perform dynamic tasks safely; could reach to the ipsilateral side (same side of the body); and was unable to weight shift. A Physiatry Progress Note dated 04/30/2025 at 8:01 PM indicated Resident #101 had decreased muscle strength in their left lower extremity and had a flaccid tone in the left upper extremity, which was supported with the use of a sling. A nursing Discharge Summary Note, dated 05/04/2025 at 9:40 AM, revealed Resident #101 was sent to the emergency room for radiological studies of the head on the left side. The nursing Discharge Summary Note revealed Resident #101 had slipped and fallen in the shower and experienced bleeding from the eyebrow with the presence of two small cuts and a lump that developed over their left eye. A late entry nursing Progress Note, dated 05/04/2025 at 10:37 AM and written by LPN #24, revealed CNA #1 provided Resident #101 a shower, during which the resident slipped off the shower seat and fell to the floor while being dried by CNA #1. The note indicated when the writer arrived to the resident's room, the resident was lying on the floor on their left side and was determined to have hit their forehead on the floor. The note indicated during an assessment, Resident #101 denied injury, but due to bleeding of the left eye, the resident's use of blood-thinning medications, elevated blood pressure, and the resident striking their head on the floor, the resident was transferred to the local hospital for evaluation. A nursing Progress Note dated 05/04/2025 at 1:10 PM, revealed Resident #101 was admitted to the hospital after the resident's blood pressure was unable to be stabilized after their transfer to the hospital. A review of a statement, handwritten by CNA #1, dated 05/07/2025, indicated on 05/04/2025 about 9:45 AM, the CNA was giving the resident a shower. The resident told the CNA that it was the first shower the resident had received since she had been admitted to the facility. The CNA indicated the resident was sitting in [the] shower and CNA #1 turned around to get a towel off the sink. The CNA wrote that the resident just went off [the] shower seat in the floor. She described (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the resident as having a hematoma on the left upper side of the resident's head, above their eye. A late entry Post Fall Evaluation note dated 05/04/2025 at 10:40 AM identified CNA #1 as a direct witness to Resident #101's fall. During a telephone interview on 09/25/2025 at 3:14 PM, CNA #1 stated she recalled providing Resident #101 a shower on 05/04/2025. CNA #1 stated following the resident's shower, the resident was sitting on the shower bench. The CNA turned around to get a towel from the nearby sink, and the resident fell to the floor. CNA #1 stated when she turned around, Resident #101 just leaned over and fell. CNA #1 stated she alerted the nurse, and she and the nurse transferred Resident #101 into the wheelchair, then CNA #1 dressed the resident. CNA #1 stated following the fall, the resident had a spot over their eye. CNA #1 stated she thought Resident #101 may have struck their head on a nearby commode during the fall. She stated the resident remained highly alert at the time of transfer to the hospital. Attempts to contact LPN #24, who was identified as the nurse on duty at the time of Resident #101's fall, were unsuccessful during the survey.A review of a statement, dated 05/04/2025 and handwritten by LPN #24, indicated she was called to the resident's room by CNA #1, who said the resident was on the floor. CNA #1 stated she gave the resident a shower and the resident slipped in the floor. LPN #24 entered the resident's bathroom to see the resident lying flat on the floor, facedown, on the resident's left side. The LPN wrote that the resident had a small knot forming over the left eyebrow and was bleeding from the area over the left eyebrow. Vital signs were obtained, and the resident's blood pressure was 179/108. Emergency medical services (EMS) was called and the resident was sent to the hospital. LPN #24 further wrote in her statement that she had called the emergency department to obtain an update on Resident #101 and was informed the resident would be admitted because they were unable to get the resident's blood pressure down. During an interview on 09/25/2025 at 3:02 PM, Physical Therapist (PT) #2 stated Resident #101 was able to sit and perform some reaching activities but needed physical support. During a follow-up interview on 09/26/2025 at 9:55 AM, PT #2 stated Resident #101 was able to sit in a wheelchair without falling to the side because the wheelchair had armrests. He stated the resident was able to sit, but if the resident reached for anything, the resident was likely to fall over. PT #2 stated it would not have been safe for staff to turn their back to Resident #101 while providing care because the resident was at risk of falling over quickly and easily. During an interview on 09/26/2025 at 2:28 PM, Registered Nurse (RN) #12 stated she remembered the incident with Resident #101 happened over the weekend, but she did not have firsthand knowledge of what happened. RN #12 stated that she knew Resident #101 leaned some, but she could not say if the resident needed one or two people for assistance with bathing. During an interview on 09/26/2025 at 2:28 PM, the Assistant Director of Nursing (ADON) stated she was aware Resident #101 had fallen. She said she recalled the resident's fall occurred in the shower on a weekend day. The ADON stated while CNA #1 was providing the resident a shower, CNA #1 turned around to retrieve a towel to dry the resident off and the resident fell. She said the resident was transferred to the hospital and did not return to the facility. The ADON stated CNAs were expected to know each resident's mobility needs by using the Kardex system. She stated if Resident #101 did not have the Kardex available, the CNA should have asked the nurse. The ADON stated she was unable to determine the number of staff members required to provide bathing assistance for Resident #101 on 05/04/2025. The ADON stated she expected CNA #1 to have knowledge of each resident's transfer status, physical ability, and limitations and if the resident had any safety concerns with transfers. During an interview on 09/27/2025 at 10:40 AM, Therapy Staff #29 stated she had limited knowledge of Resident #101 and recalled that the resident received physical therapy and occupational therapy and was very motivated in their treatment plan. She stated Resident #101 had hemiparesis on one side and needed maximal assistance for mobility. Therapy Staff #29 stated Resident #101 was extensively evaluated for their mobility and the assistance they required. She said the physical and occupational therapists were expected to communicate the level of care needed for each resident to the nursing staff. She indicated she would consider moderate assistance to be assistance of one person and maximal assistance times two (x 2) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	would have indicated the resident required the assistance of two people. During an interview on 09/27/2025 at 4:20 PM, LPN #3 stated she recalled Resident #101. She stated the resident had weakness on the left side and sometimes was observed to lean to the left side while seated in the wheelchair. LPN #3 stated she occasionally had to prop the resident up in the wheelchair. LPN #3 stated Resident #101 required the assistance of two staff members for bed mobility. LPN #3 stated she was trained that moderate assistance indicated the resident required one-person physical assistance, and maximal assistance indicated the resident required the assistance of two people to perform care. During an interview on 09/28/2025 at 9:21 AM, CNA #34 stated she knew how much assistance a resident needed by looking at the print-outs at the nurses' station. She stated these documents were printed by the night shift nurse and were kept at the nurses' station. She walked over to the nurses' station and provided a copy from a drawer and stated, They are shredded at the end of the day and that they were a working document, so there are no old copies. During an interview on 09/28/2025 at 9:41 AM, RN #12, the Unit Manager for the Rehab Unit, stated she was unsure if the staff had a report sheet that they used to communicate resident care needs. During an interview on 09/28/2025 at 11:23 AM, MDS Coordinator #11 stated residents' Kardex information was derived from the information he entered into the MDS assessments. He reviewed the Kardex Report for Resident #101 and acknowledged the section for bathing was blank. He stated he thought the resident would have required two people to transfer to the shower and one person to perform the shower. During an interview on 09/28/2025 at 11:48 AM, the ADON reviewed the Kardex for Resident #101. She acknowledged Resident #101's Kardex contained a section designated to address bathing assistance but that this section was blank; therefore, she was unsure how much assistance was required to provide bathing assistance for Resident #101. She was unable to explain how staff would have been able to determine the number of staff required to assist the resident with bathing. The ADON indicated she was unfamiliar with Resident #101 but stated if a resident leaned in their wheelchair, the resident was at risk to fall if not supported on that side of their body. During an interview on 09/28/2025 at 12:00 PM, the Administrator (ADM) stated she was not on duty at the time of Resident #101's fall. The ADM stated when she returned to work after that weekend, both she and the Director of Nursing (DON) spoke with CNA #1, who told them Resident #101 fell when she turned away to retrieve a towel. When asked what steps were taken to investigate the fall, the ADM stated she obtained written witness statements from CNA #1 and LPN #24 and determined that the fall was an accident. The ADM stated the fall was not reported to the state agency because it was not an incident/injury of unknown origin. Review of the facility's investigation documentation for Resident #101's fall revealed the investigation consisted only of obtaining witness statements from CNA #1 and LPN #24. The facility's investigation contained no evidence that the facility reviewed Resident #101's need for assistance or support while sitting and did not identify that CNA #1 turning her back, and leaving the resident unsupported on their weak/flaccid side created a situation in which the resident was at risk for experiencing a fall. As a result, the resident experienced a fall that resulted in a head injury requiring hospitalization.

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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** Based on facility policy review, record review, and interview, the facility failed to develop and implement a baseline care plan for 1 (Resident #97) of 21 sampled residents.Findings included:A facility policy titled, Care Plans - Baseline, revised 03/2022, revealed A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Resident #97's admission Record indicated the facility admitted the resident on 08/05/2025. According to the admission Record, the resident had a medical history that included diagnoses of noninfective gastroenteritis and colitis. The admission Record indicated the resident discharged home on [DATE]. A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/11/2025, revealed Resident #97 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for all activities of daily living (ADLs) and mobility. Resident #97's Care Plan Report indicated, no data found.During an interview on 09/26/2025 at 10:22 AM, Certified Nursing Assistant (CNA) #9 stated that a baseline care plan was needed for her to review what kind of care the resident required.During an interview on 09/26/2025 at 10:25 AM, Registered Nurse (RN) #10 stated the nurses were responsible for initiating baseline care plans. RN #10 stated the unit manager also checked to see if the baseline care plans were completed.During an interview on 09/26/2025 at 12:28 PM, MDS Coordinator #11 stated nursing staff should complete baseline care plans within 24 hours of admission and were handled by unit managers specifically.During an interview on 09/26/2025 at 12:33 PM, RN #12 stated she was the unit manager on the first floor. RN #12 stated baseline care plans should be completed within 24 hours of admission by the charge nurse. She stated the baseline care plan included the resident's name, the resident's representative, and code status. RN #12 stated the baseline care plan included the resident's ADL care needs prior to admission. She stated she reviewed every new admission the day after they came in.During an interview on 09/26/2025 at 12:54 PM, RN #13 stated she was the unit manager on the second floor. RN #13 stated the baseline care plan should be completed within 24 hours after admission, and they entailed what kind of care residents needed. She stated that when a new resident was admitted , she completed the admission assessment. RN #13 stated the day shift nurse went through and put orders in, and the night shift nurse double checked and made sure all assessments were completed. RN #13 stated she triple checked and made sure the assessments and orders were in. RN #13 stated she was on vacation during the week Resident #97 was admitted .During an interview on 09/26/2025 at 1:39 PM, the Assistant Director of Nursing (ADON) stated baseline care plans were completed for new admissions by MDS coordinators within the first 24 hours of admission. The ADON stated the baseline care plan was a basic initial plan of care.During an interview on 09/24/2025 at 9:49 AM, the Administrator (ADM) stated she could not find a baseline care plan for Resident #97.During a follow-up interview on 09/26/2025 at 1:47 PM, the ADM stated baseline care plans should be completed on admission. The ADM stated she would have to look at the regulations but believed baseline care plans should be completed within 24 hours. The ADM stated the admissions nurses and unit managers oversaw the process and stated that the unit manager at the time of Resident #97's admission was on vacation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on facility policy review, record review, interview, and observation, the facility failed to develop and implement comprehensive person-centered care plans for 5 (Residents #2, #4, #7, #34, and #45) of 21 sampled residents. Specifically, the facility failed to develop care plans to address indwelling urinary catheters, intravenous (IV) catheters, or oxygen therapy.Findings included: A facility policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy revealed, 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. A facility policy titled, Oxygen Administration, revised October 2010, revealed, Preparation included, 2. Review the resident's care plan to assess for any special needs of the resident. 1. An admission Record revealed the facility admitted Resident #7 on 01/30/2025. According to the admission Record, the resident had a medical history that included a diagnosis of cerebral infarction (a stroke). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/14/2025, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had an indwelling urinary catheter. Resident #7's Order Summary Report, with active orders as of 09/29/2025, contained an order, dated 09/09/2025, for an indwelling urinary catheter. Resident #7's Care Plan Report revealed it did not include a focus area or interventions related to the resident having an indwelling urinary catheter. 2. An admission Record revealed the facility admitted Resident #4 on 08/18/2025. According to the admission Record, the resident had a medical history that included diagnoses of dementia, dependence on supplemental oxygen, blindness in the right eye, 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 08/24/2025, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident had an indwelling urinary catheter. The MDS indicated Resident #4 received oxygen therapy. The MDS Care Area Assessment (CAA) Summary indicated that the Urinary Incontinence and Indwelling Catheter care area triggered and indicated that a care plan decision was made. Resident #4's Order Summary Report, with active orders as of 09/24/2025, contained an order, dated 09/15/2025, for an indwelling urinary catheter. The Order Summary Report also contained an order, dated 09/15/2025, for continuous oxygen at two liters per minute (L/min) via nasal cannula (flexible tubing to deliver oxygen directly to the nostrils). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4's nursing Progress Note, dated 09/15/2025 at 6:23 PM, revealed that upon admission to the facility, Resident #4 received oxygen therapy and had an indwelling urinary catheter. Observations on 09/23/2025 at 8:49 AM and on 09/25/2025 at 9:06 AM revealed Resident #4 received supplemental oxygen. Resident #4's Care Plan Report revealed it did not include a focus area or interventions related to the resident's indwelling urinary catheter. The Care Plan Report revealed that it also did not include a focus area or interventions related to the resident receiving supplemental oxygen. 3. An admission Record revealed the facility admitted Resident #34 on 08/01/2019. According to the admission Record, the resident had a medical history that included diagnoses of dementia, peripheral vascular disease, and type 2 diabetes mellitus. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/29/2025, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. Resident #34's Order Summary Report, with active orders as of 09/30/2025, contained an order, dated 09/17/2025, for a midline IV catheter to administer IV antibiotics. Resident #34's Care Plan Report revealed it did not include a focus area or interventions related to the resident's midline IV catheter. 4. An admission Record revealed the facility admitted Resident #45 on 05/15/2025. According to the admission Record, the resident had a medical history that included diagnoses of benign prostatic hyperplasia without lower urinary tract symptoms and dependence on supplemental oxygen. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/13/2025, revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated Resident #45 received oxygen therapy. The MDS indicated the resident had an indwelling urinary catheter. The MDS Care Area Assessment (CAA) Summary indicated that the Urinary Incontinence and Indwelling Catheter care area triggered and indicated that a care plan decision was made. Resident #45's nursing Progress Note, dated 09/29/2025 at 1:25 AM, revealed the resident's indwelling urinary catheter was changed. During an observation on 09/26/2025 at 1:04 PM, Resident #45 received supplemental oxygen. Resident #45's Care Plan Report revealed it did not include a focus area or interventions related to the resident's indwelling urinary catheter. The Care Plan Report revealed that it also did not include a focus area or interventions related to the resident receiving supplemental oxygen. 5. An admission Record revealed the facility originally admitted Resident #2 on 09/12/2024 and most recently readmitted the resident on 06/25/2025. According to the admission Record, the resident had a medical history that included diagnoses of malignant neoplasm of the breast (breast cancer), and weakness. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. Resident #2's Order Summary Report, with active orders as of 09/22/2025, contained an order, dated 09/09/2025, for the use of supplemental oxygen at 2 liters per minute (L/min) continuously via nasal cannula (a flexible tubing used to deliver oxygen through the nostrils). Resident #2's September 2025 Medication Administration Record [MAR] included a transcription of the physician's order, dated 09/09/2025, for supplemental oxygen at 2 L/min via nasal cannula. An observation on 09/22/2025 at 11:13 AM revealed Resident #2 received supplemental oxygen. Resident #2's Care Plan Report revealed that it did not include a focus area or interventions related to the resident's use of oxygen. During an interview on 09/24/2025 at 2:13 PM, Registered Nurse (RN) #13 stated that the MDS nurses were responsible for ensuring the care plans were updated to include the use of supplemental oxygen. During an interview on 09/26/2025 at 9:44 AM, MDS Coordinator #11 stated that the use of supplemental oxygen needed to be care planned, and he was in the process of updating all the care plans. During an interview on 09/26/2025 at 12:10 PM, MDS Coordinator #11 stated that comprehensive care plans began to be developed upon a resident's admission to the facility. He stated that when the MDS was completed, the care plan was updated with any additional information identified through the MDS assessment. MDS Coordinator #11 stated that care plans were updated following clinical meetings and risk meetings, if needed. He stated that if he was not informed of a change in a resident's care or condition, then he would not know to update the care plan. During an interview on 09/24/2025 at 2:20 PM, the Assistant Director of Nursing (ADON) stated she expected that care plans were updated and accurate. The ADON stated oxygen use should have been care planned. During an interview on 09/26/2025 at 2:05 PM, the ADON stated that if a resident had an indwelling catheter, then it should be addressed in the resident's care plan. During an interview on 09/26/2025 at 11:39 AM, the Administrator (ADM) stated that the Director of Nursing (DON), unit managers, and MDS nurses were responsible for ensuring the care plans were updated. The ADM stated she expected care plans to meet regulatory requirements and to be updated to provide a guide for the residents' care. During an interview on 09/27/2025 at 1:15 PM, the ADM stated she expected care plans to be updated as needed.

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

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on facility policy review, record review, observation, and interview, the facility failed to ensure respiratory care and services were provided in accordance with professional standards of practice for 2 (Resident #2 and Resident #49) of 5 residents reviewed for respiratory therapy. Specifically, the facility failed to change oxygen tubing weekly according to physician orders for Resident #2 or Resident #49.Findings included: A facility policy titled, Departmental (Respiratory Therapy) - Prevention of Infection, revised November 2011, revealed, 7. Change the oxygen cannulae [sic] [a flexible tubing used to deliver oxygen through the nostrils] and tubing every seven (7) days, or as needed. 1. An admission Record revealed the facility originally admitted Resident #2 on 09/12/2024 and most recently readmitted the resident on 06/25/2025. According to the admission Record, the resident had a medical history that included diagnoses of malignant neoplasm of the breast (breast cancer), and weakness. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. Resident #2's Order Summary Report, with active orders as of 09/22/2025, contained an order, dated 09/09/2025, for the use of supplemental oxygen at 2 liters per minute (L/min) continuously via nasal cannula. The Order Summary Report also included an order, with a start date of 09/14/2025, for the oxygen tubing to be changed weekly on the night shift. Resident #2's September 2025 Medication Administration Record [MAR] indicated staff documented that Resident #2's oxygen tubing was changed on 09/21/2025. An observation on 09/22/2025 at 11:13 AM revealed Resident #2's oxygen tubing was dated 09/15/2025. On 09/23/2025 at 11:41 AM, Licensed Practical Nurse (LPN) #17 observed Resident #2's oxygen tubing and stated the resident's tubing was dated 09/15/2025. LPN #17 stated that the nightshift nurses were responsible for changing the oxygen tubing, and Registered Nurse (RN) #13 checked to ensure the night nurses changed the tubing. During an interview on 10/01/2025 at 7:56 AM, LPN #18, whose initials matched the initials of the staff member who documented changing Resident #2's oxygen tubing on the MAR, stated that oxygen tubing was supposed to be changed every Sunday night. LPN #18 stated there was no reason the tubing would not be changed, and the tubing should be labeled every time it was changed. LPN #18 stated she must have missed Resident #2 when she was changing oxygen tubing. 2. An admission Record, revealed the facility admitted Resident #49 on 06/02/2025. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD), shortness of breath, and dependence on supplemental oxygen. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/17/2025, revealed Resident #49 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #49 received oxygen therapy during the assessment timeframe. Resident #49's Care Plan Report included a focus area, initiated 07/22/2025, that indicated the resident was at risk for impaired gas exchange. Interventions directed staff to administer supplemental oxygen as ordered (initiated 07/22/2025). Resident #49's Order Summary Report, with active orders as of 09/22/2025, contained an order, dated 07/18/2025, for the use of supplemental oxygen at 3 liters per minute (L/min) as tolerated via nasal cannula. The Order Summary Report also contained an order, dated 07/18/2025, that indicated oxygen tubing should be changed weekly on every Sunday nightshift. Resident #49's, September Medication Administration Record [MAR] revealed staff documented that Resident #49's oxygen tubing was changed on 09/21/2025. An observation on 09/22/2025 at 11:32 AM revealed Resident #49's oxygen tubing was dated 09/01/2025. An observation on 09/23/2025 at 11:25 AM revealed Resident #49's oxygen tubing was dated 09/01/2025. On 09/23/2025 at 11:27 AM, Licensed Practical Nurse (LPN) #17 observed Resident #49's oxygen tubing and stated that the resident's oxygen tubing was dated 09/01/2025. During an interview on 10/01/2025 at 7:56 AM, LPN #18, whose initials matched the initials of the staff member who documented changing Resident #18's oxygen tubing on the MAR, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated oxygen tubing was supposed to be changed every Sunday night. LPN #18 stated there was no reason the tubing would not be changed, and the tubing should be labeled every time it was changed. LPN #18 stated she must have missed Resident #49 when she was changing oxygen tubing. During an interview on 09/24/2025 at 2:13 PM, Registered Nurse (RN) #13 stated oxygen tubing was supposed to be changed every Sunday night, and she checked each room to ensure the oxygen tubing was changed. During an interview on 09/24/2025 at 2:20 PM, the Assistant Director of Nursing (ADON) stated that the unit managers were responsible for monitoring that oxygen tubing was changed. The ADON stated that she expected oxygen tubing to be changed weekly. During an interview on 09/26/2025 at 11:39 AM, the Administrator (ADM) stated the unit managers were responsible for monitoring to ensure that oxygen tubing was changed, and the charge nurses were expected to change the tubing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, Centers for Disease Control and Prevention (CDC) guidance review, record review, observation, and interview, the facility failed to implement enhanced barrier precautions (EBP) for 1 (Resident #4) of 21 sampled residents. Specifically, the facility failed to post signage to communicate with staff about the need for EBP.Findings included: A facility policy titled, Policies and Practices-Infection Control, revised 10/2018, revealed, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of disease and infections. The policy revealed, 2. The objectives of our infection control policies and practices are to, which included c. establish guidelines for implementing isolation precautions, including standard and transmission-based precautions. CDC guidance titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 07/12/2022, revealed Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. The guidance revealed, Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. Per the guidance, The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Implementation revealed, When implementing Contact Precautions or Enhanced Barrier Precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. The guidance revealed, To accomplish this included Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g. [exempli gratia; for example], gown and gloves). The guidance continued, For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. The guidance continued, Make PPE, including gowns and gloves, available immediately outside of the resident room. An admission Record revealed the facility admitted Resident #4 on 08/18/2025 with a recent readmission on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of dementia, urinary tract infection, and need for assistance with personal care. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/24/2025, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had an indwelling urinary catheter. Resident #4's Order Summary Report, with active orders as of 09/24/2025, contained an order, dated 09/15/2025, for an indwelling urinary catheter. Resident #4's Progress Note, dated 09/15/2025 at 6:23 PM, revealed Resident #4 had an indwelling urinary catheter at the time of admission. Observations on 09/23/2025 at 8:49 AM and 09/25/2025 at 9:06 AM revealed the door to Resident #4's room contained no posted signage to indicate the resident was on EBP nor was PPE readily available in or around the resident's room. During an interview on 09/25/2025, at 12:28 PM, Licensed Practical Nurse (LPN) #5 stated that any resident who had an indwelling urinary catheter should be placed on EBP. LPN #5 stated that staff used signage posted on resident doors to determine what PPE was required to be worn for providing care. LPN #5 stated she did not think Resident #4 was currently on EBP, but acknowledged the resident had an indwelling urinary catheter. During an interview on 09/26/2025 at 2:05 PM, the Assistant Director of Nursing stated that any resident who had an indwelling urinary catheter needed to be placed on EBP. During an interview on 09/27/2025 at 1:15 PM, the Administrator stated she referred her expectation of EBP to her clinical team.