STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	**120 ANDERSON AVENUE BOWLING GREEN, VA 22427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 5/28/25 through 5/29/25. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four complaints were investigated during the survey (VA00064187-unsubstantiated, VA00064130-unsubstantiated, VA00064036-unsubstantiated, and VA00063630-substantiated with deficiency). The census in this 120 certified bed facility was 111 at the time of the survey. The survey sample consisted of 12 resident reviews.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		6/24/25

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

Electronically Signed | 06/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, staff interview, facility document review, and clinical record review, the facility staff failed to implement the care plan for one of 12 residents in the survey sample, Resident #10. The findings include: For Resident #10 (R10), the facility staff failed to implement Resident #10's care plan on 5/28/25 during incontinence care. On the most recent MDS (minimum data set), an	F 656	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilitys allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F656 Develop/Implement Comprehensive Care Plan 1. The comprehensive care plan for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 2 admission assessment with an ARD (assessment reference date) of 416/25, R10 was coded as being cognitively intact. She was coded as being completely dependent on staff for bed mobility. On 5/28/25 at 1:18 p.m., R10 was observed lying in bed. She was awake and alert. She stated only one CNA (certified nursing assistant) was in the room earlier that morning to provide incontinence care for her. She stated the CNA was standing on R10's left, pulled the draw sheet too far, and the resident fell out of bed on the right side, landing on her knees. She stated she was still in a great deal of pain in both of her knees. She stated sometimes there are two CNAs when they provide incontinence care, and sometimes there is only one. A review of R10's care plan dated 4/10/25 revealed, in part: "The resident is at risk for falls related to muscle weakness, related to recent hospitalization...The resident requires assistance with ADLs (activities of daily living) related to...weakness, recent hospitalization...2 person assist for bed mobility." A review of R10's Kardex for caregivers revealed, in part: "Bed Mobility...2 person assist for bed mobility...draw sheet for turning and repositioning while in bed...lift sheet for turning and repositioning while in bed." A review of R10's clinical record revealed the following: "5/28/2025 08:02 (8:02 a.m.) Fall Note Description of the fall/V/S (vital signs) /injuries if any: Per CNA (certified nursing assistant) during perineal care, Resident slipped down to the floor. After assessment on Resident, there was no	F 656	Resident #10 was implemented with resident-specific interventions for bed mobility; bariatric concave mattress and wider mattress for comfort and bed mobility on 05/28/2025. 2. Current residents have the potential to be affected. The MDS Coordinator or designee will conduct an audit of all current residents to ensure that specific interventions for bed mobilityparticularly those requiring two-person assistanceare accurately reflected in both the care plan and the Kardex. 3. The Regional MDS Coordinator or designee will educate MDS staff and unit managers on the care planning process for residents requiring assistance with bed mobility. This includes ensuring that care plans are reviewed and updated with appropriate interventions to help prevent injuries. The MDS staff will perform audits weekly for four weeks, then monthly for two months, to ensure that care plans for current and new residents include updated interventions for two-person bed mobility assistance. 4. The results of these audits will be presented to the QAPI Committee for further review and recommendations. Once the committee determines that the issue has been resolved and sustained, ongoing reviews will occur on a random basis. 5. Date of compliance: 6/24/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 3	F 656		

physical injuries, but Resident c/o (complained of) lateral knee pains...What interventions were in place at the time of the fall?: bed rails up, call bell, and personal belongings within reach, and bed in the lowest position. What are the risk factors that could have contributed to the fall?: Resident needs wide air mattress for comfort, and bed mobility. What new interventions were implemented in response to the fall?: Turned, repositioned, pain med administered, wired air mattress for comfort, and bed mobility ASAP (as soon as possible)."

On 5/29/25 at 9:03 a.m., LPN (licensed practical nurse) #3 was interviewed. He stated nurses and CNAs (certified nursing assistants) know how many staff members are required to provide care to a resident from the Kardex. After reviewing R10's Kardex, he stated the resident's care plan required two staff members at the bedside when incontinence care was being given because the resident was required to turn back in forth in bed for the care. He stated a care plan is developed to meet each resident's individual needs. He stated the charge nurse is responsible to oversee the CNAs and floor nurses to make sure the care plan is followed.

On 5/29/25 at 10:10 a.m., CNA #2 was interviewed. She stated she provided incontinence care to R10 on 5/28/25 early in the morning. She stated she was in the process of changing the resident and grabbed the draw sheet. As she grabbed the draw sheet, R10 reached out to grab the grab bar. CNA #2 stated R10 let go of the grab bar and fell over the right side of the bed. She stated R10 should always have two staff members when she is being changed for safety. She stated all other staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 4 members were busy with other things because it was almost time for shift change. She stated she was aware that the resident fell because there was not a second staff member on the resident's right side of the bed. On 5/28/25 at 10:32 a.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns. A review of the facility policy, "Care Planning," revealed, in part: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient.	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide safety during incontinence care for one of 12 residents in the survey sample, Resident #10. The facility staff failed to utilize two staff members to change Resident #10's soiled brief on 5/28/25. Resident	F 689	F689- Free of Accident Hazards/Supervision/Devices 1. Resident #10 continues to reside in the facility. However, the timeframe to correct has passed. The CNA was re-educated on the importance of following the residents Plan of Care and	6/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 #10 fell out of bed and sustained a broken femur. The facility's failure resulted in harm to Resident #10. The findings include: For Resident #10 (R10), the facility staff failed to utilize two staff members to change Resident #10 on 5/28/25. The resident fell out of bed and suffered a fractured femur. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 416/25, R10 was coded as being cognitively intact. She was coded as being completely dependent on staff for bed mobility. On 5/28/25 at 1:18 p.m., R10 was observed lying in bed. She was awake and alert. She stated only one CNA (certified nursing assistant) was in the room earlier that morning to provide incontinence care for her. She stated the CNA was standing on R10's left, pulled the draw sheet too far, and the resident fell out of bed on the right side, landing on her knees. She stated she was still in a great deal of pain in both of her knees. She stated sometimes there are two CNAs when they provide incontinence care, and sometimes there is only one. A review of R10's care plan dated 4/10/25 revealed, in part: "The resident is at risk for falls related to muscle weakness, related to recent hospitalization...The resident requires assistance with ADLs (activities of daily living) related to...weakness, recent hospitalization...2 person assist for bed mobility." A review of R10's Kardex for caregivers revealed,	F 689	Kardex, specifically the requirement for two-person assistance during bed mobility. 2. Current residents in the facility may be at risk. The MDS Coordinator or designee will conduct an audit to identify all residents requiring two-person assistance for bed mobility. The audit will ensure that care plans and the Kardex are updated to accurately reflect each residents bed mobility status. 3. The Staff Development Coordinator (SDC) or designee will educate facility staff on the proper procedures for residents requiring two-person assistance. Training will emphasize adherence to the Care Plan and the Kardex to prevent potential injuries. The Unit Manager or designee will conduct weekly audits for four weeks, focusing on 10 residents who have care plans indicating a need for two-person assistance with bed mobility. These audits will confirm compliance and ensure interventions are being followed to prevent injury. Any identified issues will be addressed promptly. 4. The results of these audits will be presented to the QAPI Committee for further review and recommendations. Once the QAPI Committee determines that the issue has been resolved and sustained, audits will transition to a random review process. The Administrator or Director of Nursing will be responsible for implementing and ensuring compliance with this Plan of Correction. 5. Date of compliance: 6/24/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

in part: "Bed Mobility...2 person assist for bed mobility...draw sheet for turning and repositioning while in bed...lift sheet for turning and repositioning while in bed."

A review of R10's clinical record revealed the following:
"5/28/2025 08:02 (8:02 a.m.) Fall Note Description of the fall/V/S (vital signs) /injuries if any: Per CNA (certified nursing assistant) during perineal care, Resident slipped down to the floor. After assessment on Resident, there was no physical injuries, but Resident c/o (complained of) lateral knee pains...What interventions were in place at the time of the fall?: bed rails up, call bell, and personal belongings within reach, and bed in the lowest position. What are the risk factors that could have contributed to the fall?: Resident needs wide air mattress for comfort, and bed mobility. What new interventions were implemented in response to the fall?: Turned, repositioned, pain med administered, wired air mattress for comfort, and bed mobility ASAP (as soon as possible."

"5/28/2025 12:40 p.m. Medical Visit...patient seen per nursing request s/p (after) fall. Pt (patient) seen and examined at bedside and reports pain to bilat (bilateral) knees. Denies hitting her head or any pain/ injury elsewhere. Denies hip pain. no abnormal bruising or injury noted to bilateral knees...Assessment and plan...c/w (continue with) Percocet (opioid pain medication) for pain...stat (immediate) x-rays of bilateral knees."

"5/28/2025 16:30 (4:30 p.m.) COMMUNICATION - with Resident...Per follow up investigation from resident's fall on 5/28/25, spoke with resident regarding x-ray results still pending and resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7	F 689		

pain management not effective despite receiving scheduled and breakthrough interventions nonpharmacological interventions were implemented and ineffective as well, resident was offered to be sent to ER (emergency room) for further evaluation and accepted. NP (nurse practitioner) ...made aware of resident wanting to go out and order was given to be sent to ER."

"5/28/2025 16:57 (4:57 p.m.) Health Status Note...Resident sent to [name of local hospital] per request via 911 (emergency services)."

A review of R10's May 2025 MAR (medication administration record) revealed she received Percocet 5-325 mg (milligrams) one tablet at 11:07 a.m. and 3:25 p.m. with no pain relief experienced by R10.

A review of R10's left knee X-ray result dated 5/28/25 revealed, in part: "A fracture of the distal femur is identified."

On 5/29/25 at 9:03 a.m., LPN (licensed practical nurse) #3 was interviewed. He stated nurses and CNAs (certified nursing assistants) know how many staff members are required to provide care to a resident from the Kardex. After reviewing R10's Kardex, he stated the resident required two staff members at the bedside when incontinence care was being given because the resident was required to turn back in forth in bed for the care.

On 5/29/25 at 10:10 a.m., CNA #2 was interviewed. She stated she provided incontinence care to R10 on 5/28/25 early in the morning. She stated she was in the process of changing the resident and grabbed the draw sheet. As she grabbed the draw sheet, R10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 reached out to grab the grab bar. CNA #2 stated R10 let go of the grab bar and fell over the right side of the bed. She stated R10 should always have two staff members when she is being changed for safety. She stated all other staff members were busy with other things because it was almost time for shift change. She stated she was aware that the resident fell because there was not a second staff member on the resident's right side of the bed. On 5/28/25 at 10:32 a.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns, and was informed of the concern for harm to R10. A review of the facility policy, "Fall Prevention," revealed no information related to the circum-stances of R10's fall.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to	F 692		6/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 9 maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide nutritional care and services consistent with a resident's comprehensive plan of care for one of 12 residents in the survey sample, Resident #12. The findings include For Resident #12 (R12), the facility staff failed to accurately monitor and document the resident's breakfast meal intake on 5/29/25. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/4/25, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. R12's comprehensive care plan revised on 3/4/25 documented, "Nutrition Risk r/t (related to) therapeutic diet orders, hx/o (history of) sepsis, copd (chronic obstructive pulmonary disease [lung disease]), gerd (gastroesophageal reflux disease), bipolar. Hx/o sig (significant) wt (weight) gain...Interventions: monitor intake and record each meal..." R12's meal ticket for breakfast on 5/29/25 documented the tray contained scrambled egg substitute with vegetables, wheat toast, orange	F 692	F692- Nutrition/Hydration Status Maintenance 1. Resident #12 continues to reside in the facility. However, the timeframe to correct the previously inaccurate meal intake documentation has passed. The CNA was educated on proper meal intake documentation. 2. Current residents have the potential to be affected. The Director of Nursing (DON), or designee will audit current residents to ensure that accurate meal intake percentages are documented. Any discrepancies identified will be corrected promptly. 3. The Staff Development Coordinator (SDC), or designee will educate licensed nurses and CNAs on the proper process for documenting meal intake percentages accurately. The DON or designee will conduct weekly audits for four weeks, followed by monthly audits for two months, to verify accurate documentation of meal intake percentages for 10 selected residents. Any findings will be corrected immediately. 4. All audit findings will be reported to the Quality Assurance (QA) Committee, and the action plan will be revised as necessary. Results will also be presented to the QAPI Committee for review and further recommendations. Once the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 10 juice, and grits. On 5/29/25 at 9:16 a.m., R12's breakfast tray was observed. R12 had drank coffee and juice but did not eat any of the food (the eggs, grits, or toast). R12 stated he did not feel like eating. CNA (certified nursing assistant) #8 entered the room, removed R12's tray, and did not open the plate cover to observe how much food the resident had consumed. A review of R12's May 2025 ADL (activities of daily living) records revealed CNA #8 documented R12 consumed 51% to 75% of his breakfast. On 5/29/25 at 1:33 p.m., an interview was conducted with CNA #8. CNA #8 stated she monitors residents' meal intakes by watching what the residents eat and documenting accordingly. CNA #8 stated she picked up R12's tray that morning and the resident ate about 75% of his meal. On 5/29/25 at 1:37 p.m., in the presence of CNA #8, R12 stated he did not eat breakfast that morning. CNA #8 stated R12's wife eats food off the resident's tray. On 5/29/25 at 1:39 p.m., another interview was conducted with CNA #8 (not in the presence of R12). CNA #8 stated that although she knew R12's wife eats food off the resident's plate, she documented according to her observation of the resident's plate and did not ask R12 how much food he consumed. On 5/29/25 at 1:41 p.m., another interview was conducted with R12. R12 stated his wife did not eat any food off his plate that morning. On 5/29/25 at 2:05 p.m., an interview was conducted with OSM (other staff member) #8 (the registered dietician). OSM #8 stated he reviews residents' meal intakes when completing their	F 692	committee determines that the issue has been resolved and sustained, future reviews will be conducted on a random basis. 5.Date of compliance: 6/24/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 11 nutritional assessments. On 5/29/25 at 2:50 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, "Meal Intake" documented, "Meal intake will be documented after each meal." No further information was presented prior to exit.	F 692		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 757		6/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 12 Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a resident was free from an unnecessary medication for one of 12 residents in the survey sample, Resident #9. The findings include: For Resident #9 (R9), the facility staff failed to hold the medication hydralazine (medication for high blood pressure) per the physician ordered parameter of a systolic blood pressure less than 140. A review of R9's clinical record revealed a physician's order dated 2/27/25 for hydralazine 50mg (milligrams)-one tablet by mouth two times a day for hypertension (high blood pressure). Hold for SBP (systolic blood pressure) less than 140. A review of R9's March 2025 MAR (medication administration record) revealed the resident was administered hydralazine on 3/4/25 at 9:00 a.m. although the resident's systolic blood pressure was 134, administered hydralazine on 3/4/25 at 10:00 p.m. although the resident's systolic blood pressure was 137, and administered hydralazine on 3/5/25 at 9:00 a.m. although the resident's systolic blood pressure was 138 (as evidenced by check marks on the MAR). A nurse's note dated 4/8/25 documented, "NP (Nurse Practitioner), (name) and (name) and RP (Responsible Party), (name) aware on 3/4 at 2200 (10:00 p.m.) and on 3/5 at 0900 (9:00 a.m.), resident was given hydralazine outside of prescribed parameters, no adverse reactions or abnormalities noted at the time, BP (Blood Pressure) continued to be monitored."	F 757	F757- Drug Regimen is Free from Unnecessary Drugs 1. Resident #9 continues to reside in the facility. The NP was notified on April 8, 2025, that hydralazine was administered outside the prescribed parameters on March 4 and March 5, 2025. 2. Current residents receiving hydralazine with specific parameters have the potential to be affected. The Director of Nursing (DON) or designee will audit these residents to verify that hydralazine is being administered according to the physician's orders. Any discrepancies will be corrected, and the provider will be notified if medications are unavailable or not administered as ordered. 3. The Staff Development Coordinator (SDC) will educate licensed nurses on the proper process for administering hydralazine with specific parameters. Training will emphasize the importance of adhering to physician orders and notifying the physician when blood pressure falls outside prescribed parameters. The DON or designee will conduct weekly audits for four weeks, followed by monthly audits for two months, to ensure compliance with physician orders for hydralazine administration and appropriate physician notification when blood pressure readings fall outside the prescribed range. 4. All findings will be addressed and corrected. Results will be reported to the Quality Assurance (QA) Committee, and the action plan will be revised as needed. Results will be presented to the QAPI Committee for review and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 13 On 5/28/25 at 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the nurse who documented the above note). LPN #1 stated on certain days, she runs a report and looks to see if medications were administered out of physician ordered parameters. LPN #1 stated that on 3/4/25 and 3/5/25, the nurses gave R9 hydralazine without paying attention to the parameter. LPN #1 stated the parameter was to hold the medication if the resident's systolic blood pressure was less than 140. LPN #1 stated that on those dates the medication was administered and should not have been. On 5/29/25 at 2:50 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, "General Guidelines for Medication Administration" documented, "II. Administration. 2. Medications are administered in accordance with written orders of the prescriber." No further information was presented prior to exit.	F 757	recommendations. Once the committee determines that the issue has been resolved and sustained, future reviews will be conducted on a random basis. 5. Date of compliance: 6/24/2025	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		6/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to follow infection control practices during ADL (activities of daily living) care for one of 12 residents in the survey sample, Resident #4. The findings include: For Resident #4 (R4), the facility staff failed to follow enhanced barrier precautions when providing ADL care including incontinence care, dressing and linen change on 5/29/25. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/6/25, the resident was assessed as being dependent for toileting, dressing and transfers. The assessment documented one venous or arterial ulcer present	F 880	F880 Infection Prevention & Control 1. Resident #4 continues to reside in the facility. However, the timeframe to correct has passed. The CNA involved has been re-educated on the proper use of enhanced barrier precautions (EBP) while providing resident care. 2. Current residents in the facility have the potential to be impacted. The Infection Preventionist (IP) conducted an audit to identify residents receiving care under EBP guidelines, ensuring that appropriate signage is clearly visible and that Personal Protective Equipment (PPE) is accessible at the point of care. 3. The Staff Development Coordinator (SDC) or designee will provide education to licensed nurses, CNAs, and therapy staff on identifying residents under EBP protocols. This education will include	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16 with dressing applications completed. Observation of R4's room on 5/28/25 at 11:53 a.m. revealed a sign located outside of the door which documented in part, "Stop Enhanced Barrier Precautions... Wear gown and gloves when entering room to provide the following high-contact resident care activities: *Dressing *Bathing/Showering *Transferring *Changing Linens *Providing Hygiene *Changing briefs or assisting with toileting..." A plastic bin located outside of R4's doorway contained yellow isolation gowns and gloves. The comprehensive care plan for R4 documented in part, "The resident has a venous/stasis ulcer of the Right inner Lateral leg r/t (related to) PVD (peripheral vascular disease). Created on: 08/26/2021. Revision on: 04/20/2023." On 5/29/25 at 11:30 a.m., an observation was made of CNA (certified nursing assistant) #6 providing ADL care to R4. CNA #6 was observed providing incontinence care, changing a soiled brief, dressing R4 and changing soiled bed linens. CNA #6 was observed to wear gloves but failed to wear a gown during the care provided. After performing ADL care, LPN (licensed practical nurse) #7 assisted CNA #6 to transfer R4 from the bed to the wheelchair. Neither staff member wore a gown during the care provided. On 5/29/25 at 11:43 a.m., an interview was conducted with LPN (licensed practical nurse) #8, infection preventionist. LPN #8 stated that the criteria for residents to be on enhanced barrier	F 880	when and how to use EBP, proper PPE usage, the correct placement of EBP signage, and the location of PPE. The Director of Nursing (DON) or designee will conduct weekly audits for four weeks, followed by monthly audits for two months, to ensure proper use of PPE for residents identified under EBP. 4. All findings will be addressed and corrected as needed. Results will be reported to the Quality Assurance (QA) Committee, and the action plan will be revised accordingly. The findings will also be presented to the QAPI Committee for review and further recommendations. Once the committee confirms that the issue has been resolved and sustained, future reviews will be conducted on a random basis 5. Date of compliance: 6/24/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495297	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN HEALTH & REHABILITATION CENTER	120 ANDERSON AVENUE BOWLING GREEN, VA 22427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17	F 880		

precautions (EBP) was for chronic wounds with drainage, PICC (peripherally inserted central catheters) or anything that could cause an infection were an indication for EBP. She stated that the criteria was basically driven from the facility policy. LPN #8 stated that when on EBP, the staff wore gown and gloves when providing care such as wound care, bed baths, and ADL care.

On 5/29/25 at 1:21 p.m., an interview was conducted with CNA #8 who stated that when a resident was on EBP there was a sign on the door and a bin outside of the room that held the gowns and gloves for them. She stated that they wore the gowns and gloves when they were providing care such as baths and incontinence care.

The facility policy "Enhanced Barrier Precautions (EBPs)" effective 3/26/24, documented in part, "Employees providing high-contact patient care activities will follow Enhanced Barrier Precautions (EBPs) for patients who meet the criteria... EBPs require the use of gown and gloves by staff during high-contact patient care activities as defined below: a. Dressing, b. Bathing/showering, c. Transferring, d. Changing linens, e. Providing hygiene, f. Changing briefs or assisting with toileting..."

On 5/29/25 at 2:51 p.m., ASM (administrative staff member) #1, the administrator and ASM #5, regional director of clinical services were made aware of the concern.

No further information was provided prior to exit.