STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 4/29/25 through 5/1/25. Corrections are required for compliance with the Virginia Regulations for the Licensure of Nursing Facilities. Seven complaints were investigated during the survey. The census in this 120 bed facility was 114 at the time of the survey. The survey sample consisted of twenty three current resident reviews and seven closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This STANDARD is not met as evidenced by: 12VAC5-371-220 (F). cross reference to F558 12VAC5-371-150 (B). cross reference to F580 12VAC5-371-140 (A)- cross reference to F607, F609 12VAC5-371-250 (A). cross reference to F655. 12VAC5-371-250 (C). cross reference to F657. 12 VAC 5-371-220-(A, B) - cross reference to F658 12VAC5-371-220 (A) & (D). cross reference to F677. 12VAC5-371-280 (A). cross reference to F679.	F 001	558 Reasonable Accommodations SS=D 1)Resident # 111 was discharged on 11/18/2024. 2)Residents who reside at Summit Health and Rehabilitation Center and are having showers per preference have the potential to be affected by this practice. A 100% audit of current residents was accomplished to ensure twice weekly showers were accomplished per resident preference. 3) Resident shower completion & refusals will be reviewed as part of the Morning Clinical Meeting process. The	6/13/25

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

Electronically Signed | 05/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 1 12VAC5-371-280 (1 & 5). cross reference to F680. 12VAC5-371-220 (B). cross reference to F684. 12VAC5-371-220 (A). cross reference to F685. 12VAC5-371-220 (C.1) cross reference to F686. 12VAC5-371-220 (A) cross reference to F689. 12VAC5-371-180 (A). cross reference to F880.	F 001	DON/Designee will conduct a re-education for the C N A and LPN/RN Staff on honoring resident preferences for showers twice per week, and documentation in the POC to support care provided. 4)The DON/Designee will complete an audit of 20 current resident showers for completion per resident preference weekly x 4 weeks then monthly x 2 months to ensure ongoing compliance with this process. Audits will be submitted by the Administrator/Designee to the QAPI Committee monthly for review and recommendation. 5)Compliance Date: 06/13/2025 F580 Notify of Changes SS=D 1)Resident #109 Resident/Family/Physician notification occurred on 10/11/2024. Corrective action cannot retroactively occur. Resident #110 Peg Tube was replaced on 6/28/2024. Resident was discharged on 10/09/2024. 2)Residents who reside at Summit Health and Rehabilitation Center who have a change in condition and require resident/responsible party/physician notification have the potential to be affected by this practice. A 24-hour report Audit was conducted for the last 30 days by the DON/Designee validating that Resident/Family/Physician notification occurred with change of condition.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 2	F 001	3)Resident changes in condition documentation will be reviewed daily in the Morning Clinical Meeting. Supportive documentation/Progress notes will be reviewed for notification to the resident/responsible party/physician. The DON/Designee will provide re-education to LPN/RN staff on informing physician/responsible party / resident of changes in condition. 4)The DON/Designee will complete an audit of 20 of the current residents, weekly x 4 weeks and then monthly x 2 months, to ensure Resident / responsible party / physicians are notified of any changes in condition. Audits will be submitted by the Administrator/Designee to the QAPI Committee monthly for review and recommendation. 5)Date of Compliance: 06/13/2025 F607 Develop/Implement Abuse/Neglect Policies SS=D 1)Resident #111 was discharged on 4/19/2024. APS unsubstantiated 1/2/2024. Initial FRI identified during survey as not submitted per policy was submitted on 5/28/2025 to OLC, APS, and DHP. 2)Residents who currently reside at Summit Health and Rehabilitation Center have the potential to be affected by this practice. A 24-hour report Audit was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 3	F 001	conducted for the last 30 days by the DON/Designee to review any potential injury of unknown origin. Any findings of injury of unknown origin will be reported as required. 3)As part of the Clinical Morning Meeting process / utilizing the 24-hour report, the IDT members will review any documentation/progress notes of injury of unknown origin. The Administrator/Designee will complete re-education for the IDT members and LPN/RN and C N A staff on following abuse prevention policies for reporting an injury of unknown origin. 4)The Administrator/Designee will complete a weekly audit of 24-hour report progress notes for any potential injury of unknown origin weekly x 4 weeks then monthly x 2 months to ensure ongoing compliance with this process. Audits will be submitted by the Administrator/Designee to the QAPI Committee monthly for review and recommendation. 5)Compliance Date: 06/13/2025 F609 Reporting of Alleged Violations SS=D 1)Resident #111 was discharged on 4/19/2024. APS unsubstantiated 1/2/2024. Initial FRI identified during survey as not submitted per policy was submitted on 05/28/2025 to OLC, APS, and DHP.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 4	F 001	2)Residents who currently reside at Summit Health and Rehabilitation Center have the potential to be affected by this practice. The DON/Designee conducted an audit of the 24-hour report to review any potential injury of unknown origin, and timeliness of reporting such events. The Administrator/Designee conducted an audit of Facility Reported events completed over the last 30 days regarding abuse, were reviewed for timeliness of reporting. 3)As part of the Clinical Morning Meeting process / utilizing the 24-hour report, the IDT members will review any documentation/progress notes of injury of unknown origin, and timeliness of reporting. The Administrator/Designee completed a re-education for IDT members, LPN/RN and C N A staff, on immediately reporting to the state agency and adult protective services (APS), an injury of unknown origin suspected of abuse. 4)The Administrator/Designee will complete a weekly audit of 24-hour report progress notes for any potential injury of unknown origin and timeliness of reporting such events weekly x 4 weeks then monthly x 2 months to ensure ongoing compliance with this process. Audits will be submitted by the Administrator/Designee to the QAPI Committee monthly for review and recommendation. 5)Compliance Date: 06/13/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 5	F 001	F655 Baseline Care plan SS=D 1. Resident # 37 was discharged from Summit Health and Rehabilitation Center on 5/3/2025. 2. Residents who were admitted to Summit Health and Rehabilitation Center with baseline care plan development on admission, have the potential to be affected by this practice. The DON/Designee completed an audit of the last 30 days of admissions to ensure the resident and/or resident representative was provided with a baseline care plan summary. 3. As part of the IDT Stand Up Morning meeting, new admissions will be reviewed by the Administrator/Designee for provision of the baseline care plan summary to the resident and/or resident representative and documentation to support this process in the EMAR. The DON/Designee will complete re-education with the LPN/RN, and IDT members assure the resident and/or resident representative were provided with a baseline care plan summary. 4. The DON/Designee will complete an audit weekly x 4 weeks and then monthly x 2 months, of all new admissions to ensure the resident and/or resident representative are provided with a baseline care plan summary. Audits will be submitted by the Administrator/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 6	F 001	to the QAPI Committee monthly for review and recommendation. 5. Compliance Date: 06/06/2025 F657 Care Plan Timing and Revision SS=D 1)Resident #91 The Care Plan was updated to include preference for female care givers. 2)Residents who were admitted to the Summit Health and Rehabilitation Center with preferences for care providers have the potential to be affected by this practice. An audit was conducted by the DON/Designee with the current residents for any preference for provision of care takers. Changes in resident preference for care takers were updated in the resident plan of care. 3)As part of the admission comprehensive care plan process, residents preferences will be discussed and interventions added to their care plan. The DON/Designee will complete re-education for the IDT team members, and CNA/RN/LPN staff on reviewing and revising the comprehensive care plan to meet the resident preferences. 4)The DON/Designee will complete an audit of 10 residents weekly x 4 weeks and then monthly x2 months on their preferences for femail or male provision of care. Updates will be made to the resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 7	F 001	plan of care as indicated. Audits will be submitted by the Administrator/Designee to the QAPI Committee monthly for review and recommendation. 5)Compliance Date: 06/13/2025 F658 Services Provided Meet Professional Standards SSS=E 1)Resident # 11, Resident #70, Resident # 76 RN #9 & C N A #10 were given disciplinary actions according to the facility policy. RN # 9 resigned from her position on 4/26/2025. C N A #10 was terminated on 4/29/2025. DON and Administrator notified residents, family members, and providers, of the RN allowing CNA to administer medications and obtain blood sugar testing. DHP, OLC, and APS were notified on 04/21/2025. Resident # 84 Discharged 5/2/2025. Resident #169 Discharged 4/29/2025. 2) Residents who were admitted to the Summit Health and Rehabilitation Center and received medications have the potential to be affected by this practice. An audit was conducted by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 8	F 001	DON/Designee of current resident and staff members to assess awareness of any similar practice and/or awareness of nursing services that do not meet the professional standards of quality. An audit was conducted by the DON/Designee of current resident medication on hand to ensure adequate medication availability. 3) As part of the orientation process for nursing staff and annual skills review, delegation of duties, and the process of medication administration and process for medication availability will be reviewed to ensure awareness of nursing services that meet professional standards of quality. The DON/Designee will conduct re-education to LPN/RN/CNA on nursing services to meet the professional standards of quality / delegation of duties / medication administration / medication availability. 4) The DON/Designee will conduct walking rounds and interview 5 staff members weekly x 4 weeks, then monthly x 2 months during medication pass times, to monitor nursing services that may not meet professional standards of quality. Audits will be submitted by the Administrator/Designee to the QAPI Committee monthly for review and recommendation. 5) Compliance Date: 06/13/2025 F677 ADL Care Provided for the Residents SS=D	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 9	F 001	1)Resident 36 ,41 was provided with incontinence care and skin assessment was completed. C N A #1 was provided with re- education regarding incontinence care for the dependent resident in a timely manner. 2)Residents who were admitted to the Summit Health and Rehabilitation Center and are dependent for incontinence care have the potential to be affected by this practice. An audit was conducted of those residents who are dependent on incontinence care, to ensure incontinent care was provided in a timely manner. 3)The DON/Designee will provide re-education for the C N A and LPN/RN nursing staff on the provision of incontinence for the dependent resident in a timely manner / at least every two hours and what that care entails. 4)The DON/Designee will complete an audit of 10 dependent residents weekly x 4 weeks and then monthly x 2 months, observing the care, and incontinence checks in a timely manner. Audits will be submitted by the Administrator/Designee to the QAPI Committee monthly for review and recommendation. 5)Compliance Date: 06/13/2025 F680 Qualifications of Activities Personnel SS=D 1)The Activity Director submitted notice of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 10	F 001	resignation on 05/05/2025 at Summit Health and Rehabilitation. a. Summit Health and Reehabilitation is utilizing a certified Activity direcotr from Fairmont Crossings to provide oversight to the activites department until we can hire a certified director. 2)Residents who were admitted to the Summit Health and Rehabilitation Center and attend daily activities have the potential to be affected by this practice. 3)Re-education was provided by the Regional Director of Human Resources for the HR/Administrator on the hiring requirements for the Activities Director position. 4) The Human Resources Director will complete a qualification check on hire, and a yearly audit to ensure that the Activity Director has the credentials/certification approved by the state. Audits will be submitted by the Administrator/Designee to the QAPI Committee monthly for review and recommendation. 5)Compliance Date: 06/13/2025 F684 Quality of Care SS=D 1)Resident # 19 wound dressing was changed by RN #6 on 4/29/2025 at the time she was made aware it was open to air.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 11	F 001	2)Residents admitted to the Summit Health and Rehabilitation Center and have wound dressing needs have the potential to be affected by this practice. The DON/Designee completed an audit of the residents who require wound dressing changes for placement per order. 3)The DON/Designee will provide re-education to the RN/LPN & C N A staff on notification if dressing has come loss/fallen off, ensuring a wound dressing was intact, and redressing of the wound timely. 4)The DON/Designee will conduct a weekly audit of 5 wound dressings for being in place per week x 4 weeks then monthly x 2 months, to ensure ongoing compliance with this practice. Audits will be submitted by the Administrator/Designee to the QAPI Committee monthly for review and recommendation. 5)Compliance Date: 06/13/2025 F686 Treatment Services/Prevent/Heal Pressure Ulcers SS=D 1)Resident # 36 was provided repositioning, and a skin assessment was accomplished to ensure intact skin. 2)Residents admitted to the Summit Health and Rehabilitation Center and are dependent on turning and repositioning have the potential to be affected by this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 12	F 001	practice. The DON/Designee completed a 100% audit of resident head to toe skin assessments and complete audit/interviews with those residents with a BIMS of 13 or greater to ensure turning and repositioning is accruing at least Q2hrs to prevent pressure ulcer development. 3)The DON/Designee will complete re-education for C N A, RN/LPN staff in process for the dependent resident being repositioned at least every two hours to prevent pressure ulcer development. The Unit Manager/Designee will monitor 5 residents who require assistance with turning and repositioning weekly x 4 weeks to ensure positional changes occur at least every two hours. 4)The DON/Designee will complete an audit of 5 residents who are dependent on turning and repositioning, weekly x 4 weeks and monthly x 2 months for turning and repositioning at least every two hours to ensure ongoing compliance with this practice. The Unit Manager/Designee will monitor 5 residents who require assistance with turning and repositioning weekly x 4 weeks to ensure positional changes occur at least every two hours. Audits will be submitted by the Administrator/Designee to the QAPI Committee monthly for review and recommendation. 5)Compliance Date: 06/13/2025 F689 Free of Accidents/Hazards/Supervision/Devices	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 13	F 001	SS=D 1)Resident 88 the water temperature was adjusted to be below 120 degrees on 4/29/2025. Resident # 36 Re-education provided to C N A # 1 and C N A # 2 on the Kardex, use of transfer devices, and following transfer techniques to reduce the risk of resident injury. Resident # 69 An order for the Wander Gard usage and Elopement Risk Assessment was completed. 2)Residents admitted to the Summit Health and Rehabilitation Center and require transfer devices, Wander Gard secure system usage, or utilize the Bathroom utilities have the potential to be affected by this practice. The Maintenance Director/Designee will complete a 100% audit of bathroom faucets and/or water access temperatures to ensure they are not greater than 120 degrees. The DON/Designee will complete an audit of residents who require transfer devices to ensure staff are utilizing devices per Care Plan / Kardex intervention. The DON/Designee will complete and audit of residents utilizing wander gard system for assessments and orders to support usage. 3)The DON/Designee will re-educate RN/LPN staff on Wander Gard system / band usage and the requirement for Assessment, and physician order. The DON/Designee will re-educate C N A, RN/LPN staff on utilization, supervision, and need to use transfer devices as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 14	F 001	indicated on Care Plan, and Kardex. The Regional Director of Maintenance/Designee will re-educate the Maintenance Director of water temperature testing and the requirements of water temperature under 120 degrees. 4)The DON/Designee will complete and audit weekly x 4 weeks and then monthly x 2 months of all residents who utilize the Wander Gard system for completion of assessment, and physician order for usage. The DON/Designee will complete an audit weekly x 4 weeks, then monthly x 2 months on 10 residents for utilization, supervision and transfer device usage as indicated to ensure ongoing compliance with this practice. The Maintenance Director will complete a weekly audit x 4 weeks then a monthly audit x 2 months of 10 resident rooms for water temperatures within guidelines / from 110 degrees to less than 120 degrees. Audits will be submitted by the Administrator/Designee to the QAPI Committee monthly for review and recommendation. 5)Compliance Date: 06/13/2025 F880 Infection Prevention & Control SS=E 1)Resident # 86 / # 63 - EBP during high contact care / LPN #3 was provided with re- education on utilization of PPE for EBP residents during high contact care / foley catheter care. C N A #3 was provided re-education on utilization of PPE for EBP during high contact care / incontinence	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 15	F 001	care. Resident # 63 / EBP signage was updated to reflect current practice and resident population. Resident # 63 / RN # 1 was provided with re-education on utilization of PPE with EBP residents during High contact care / Tube Feeding. Resident #7 / PPE supplies were adequately stocked for use with ESBL resident. Resident # 36 / C N A #1 was re-educated on the use of PPE for the EBP residents while doing incontinence care. Residents 66,22,51,70,35,23, and 36. The C N A # 1 was re-educated on the process of meal pass and hand hygiene between each tray pass. Signage was placed outside resident rooms to alert staff to EBP and PPE bins were placed in centralized locations throughout each unit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 16	F 001	2)Residents admitted to the Summit Health and Rehabilitation Center and require EBP / Contact Infection Control practices have the potential to be affected by this practice. The DON/Designee completed an audit of those residents on EBP to ensure signage, access to PPE on the units, and use of PPE per guidelines is utilized. The DON/Designee completed an audit of the handling of linen by staff members while moving through the unit, and Hand Hygiene during the meal pass. 3)The DON/Designee completed a re-education to the IDT, RN/LPN, CNA, therapy, and house keeping on the guidelines for EBP signage, contact Precautions, the proper PPE usage with high contact care, Hand Hygiene during meal pass, hand hygiene during incontinent care, and hand hygiene moving from dirty area to clean area. EBP precautions will be reviewed daily as part of the Clinical Morning Meeting process. 4)The DON/Designee will complete an audit of 15 EBP rooms weekly x 4 weeks, then Monthly x 2 months for signage per guidelines, and 5 Staff (C N A, RN/LPN, IDT members, Housekeeping, Laundry, and Therapy) following PPE usage during High Contact Care with EBP resident / Enteral. The DON/Designee will complete an audit of 5 staff (C N A RN/LPN) providing incontinent care weekly x 4 weeks and then monthly x 2 months High Contact Care / EBP / PPE Usage. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0382	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH AND REHAB CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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) COMPLETE DATE
F 001	Continued From page 17	F 001	DON/Designee will complete a walking round audit of 5 staff (CNA, RN/LPN, housekeeping, laundry, therapy, IDT members) weekly x 4 weeks and then monthly x 2 months of staff (CNA RN/LPN, Housekeeping, Therapy) handling of linen per protocol to decrease risk of the spread of infection. The DON/Designee will complete 1 audit weekly x 4 weeks and then monthly x 2 months for adequate stocking of PPE for those residents on precautions. The DON/Designee will complete 1 audit weekly x 4 weeks and then monthly x 2 months of 10 staff members for proper hand hygiene during the meal pass time service. 5)Compliance Date: 06/13/2025	