STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495381	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Health and Rehab Center	1300 Enterprise Drive Lynchburg, VA 24502

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to notify the physician/provider of an assessed pressure injury requiring care orders for one of five residents in the survey sample (Resident #1).The findings include:Resident #1 was admitted to the facility with diagnoses that included congestive heart failure, atrial fibrillation, diabetes, pressure ulcer, obesity, anemia, depression, cognitive communication deficit, aortic valve stenosis, insomnia and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed Resident #1 as cognitively intact.Review of Resident #1's clinical record revealed an admission nursing assessment dated [DATE] listing the resident was assessed with an unstageable pressure ulcer on the right hip. A note on this assessment documented, right hip unstageable wound. Daily skilled notes documented the presence of a pressure ulcer but included no documented treatments or dressing changes for the wound. A skin assessment dated [DATE] documented an unstageable pressure ulcer on the right hip but included no descriptive assessment of the wound's status and made no mention of any treatments in place. Nurse practitioners assessed Resident #1 on 5/17/25, 5/18/25, 5/19/25, 5/20/25 and 5/21/25 with no mention of the right hip pressure ulcer.Review of Resident #1's clinical record revealed no notification to the physician and/or provider regarding the pressure ulcer identified on 5/16/25. No treatment orders were initiated for Resident #1's right hip pressure ulcer until 5/22/25 when the consultant wound nurse practitioner (NP) assessed the wound. The wound NP documented on 5/22/25 that Resident #1 had an unstageable pressure ulcer on the right hip measuring 10.0 x 3.5 (length by width in centimeters). The wound NP documented the wound was present upon admission, was 100% covered with slough, had serous drainage, pain with contact and erythema of the skin surrounding the wound. The wound NP entered a treatment order for the pressure ulcer on 5/22/25 that included cleansing the wound with Dakin's solution, application of Santyl ointment, calcium alginate and a foam dressing daily and as needed. On 12/9/25 at 9:45 a.m., the licensed practical nurse unit manager (LPN #1) caring for Resident #1 was interviewed about notification to a provider regarding care/treatment orders for Resident #4's pressure ulcer. LPN #1 stated upon admission, nurses usually entered care orders as provided by the hospital. LPN #1 stated if orders were not provided by the hospital, then nurses were expected to contact the physician/provider or the consultant wound NP to obtain orders for wound care.On 12/9/25 at 12:10 p.m., LPN #1 stated she reviewed Resident #1's clinical record and found no orders for care/treatment of the pressure ulcer prior to 5/22/25 when the ulcer was assessed by the wound NP. LPN #1 stated the hospital discharge orders/summary included no orders for care/treatment of the wound. LPN #1 stated the unstageable ulcer was noted on the admission assessment and in daily skilled notes. LPN #1 stated she found no notification to the physician and/or provider regarding treatment orders for the pressure ulcer prior to the wound NP's assessment/orders on 5/22/25. LPN #1 stated when the pressure ulcer was assessed (5/16/25), nursing should have (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
	495381	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Health and Rehab Center	1300 Enterprise Drive Lynchburg, VA 24502

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contacted the in-house provider, on-call provider or the consultant wound NP for treatment orders. On 12/9/25 at 11:30 a.m., LPN #2 that had cared for Resident #1 several days prior to the wound NP's assessment was interviewed. LPN #2 stated the in-house or on-call provider should have been notified for treatment orders.On 12/9/25 at 1:42 p.m., the wound NP (other staff #1) was interviewed about treatment/care of Resident #1's pressure ulcer. The wound NP stated the in-house provider should have been notified and treatment orders obtained upon when the ulcer was identified. The wound NP stated she was also available for any concerns with wounds. The wound NP stated she performed a thorough assessment and entered treatment orders for the ulcer on 5/22/25. On 12/9/25 at 12:50 p.m., the director of nursing (DON) was interviewed about lack of physician notification regarding Resident #1's pressure ulcer. The DON stated there were no treatments or dressing changes documented for Resident #1's pressure ulcer until 5/22/25 when the wound NP assessed the wound. The DON stated she reviewed the clinical record, and nothing was included in the hospital discharge summary about the ulcer. The DON stated that when the pressure ulcer was assessed during the admission process, nursing should have contacted the in-house or on-call provider for treatment orders. The facility's policy titled Change in a Resident's Condition (dated 10/1/21) documented, .The facility will promptly notify the resident, his or her physician/practitioner, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) .The nurse will notify the resident's Attending Physician/practitioner or physician on call when there has been a .need to alter the resident's medical treatment significantly .specific instruction to notify the physician/practitioner of changes in the resident's condition .The facility's policy titled Pressure Injury Prevention and Management (revised 10/19/22) documented, .Staff will be encouraged to promptly report any observation of a change in the resident's skin integrity .Weekly skin observations will be conducted by a licensed nurse and findings will be documented in the resident's medical record .Observations of new pressure ulcer/injury will be .Reported to the physician/practitioner for further evaluation and treatment . These findings were reviewed with the administrator and DON on 12/9/25 at 12:50 p.m. with no further information provided prior to the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495381	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Health and Rehab Center	1300 Enterprise Drive Lynchburg, VA 24502

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to thoroughly assess and implement timely interventions for care of a pressure ulcer for one of five residents in the survey sample (Resident #1).The findings include:Resident #1 was admitted to the facility with diagnoses that included congestive heart failure, atrial fibrillation, diabetes, pressure ulcer, obesity, anemia, depression, cognitive communication deficit, aortic valve stenosis, insomnia and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed Resident #1 as cognitively intact.Review of Resident #1's clinical record revealed an admission assessment dated [DATE] listing the resident was assessed with an unstageable pressure ulcer on the right hip. A note on this assessment documented, right hip unstageable wound. This assessment included no description of the wound indicating the size, appearance, condition of surrounding skin, or presence of drainage, odor and/or pain. Daily skilled notes documented resident assessments including vital signs, bowel sounds and pain. These notes documented the presence of a pressure ulcer but included no mention of treatments or dressing changes to the wound. A skin assessment dated [DATE] documented an unstageable pressure ulcer on the right hip but included no descriptive assessment of the wound's status and made no mention of any treatments in place. Nurse practitioners assessed Resident #1 on 5/17/25, 5/18/25, 5/19/25, 5/20/25 and 5/21/25 with no mention of the right hip pressure ulcer.No treatment orders were initiated for Resident #1's right hip pressure ulcer until 5/22/25 when the consultant wound nurse practitioner (NP) assessed the wound. The wound NP documented on 5/22/25 that Resident #1 had an unstageable pressure ulcer on the right hip measuring 10.0 x 3.5 (length by width in centimeters). The wound NP documented the wound was present on admission, was 100% covered with slough, had serous drainage, pain with contact and erythema of the skin surrounding the wound. The wound NP documented, [Resident #1] Endorses that the ulcer to . right hip was present while hospitalized .No signs and symptoms of infection noted . The wound NP performed a debridement of the ulcer to remove devitalized tissue. The wound NP entered a treatment order for the pressure ulcer on 5/22/25 that included cleansing the wound with Dakin's solution, application of Santyl ointment, calcium alginate and a foam dressing daily and as needed. Treatment administration records documented the treatments were implemented as ordered starting on 5/22/25. The wound NP documented weekly assessments and monitoring of the wound after 5/22/25 that included measurements, descriptive appearance of the wound and presence of pain, drainage and/or odor with treatment orders entered as needed based upon assessments.There were no comprehensive assessments, treatment orders and/or dressing changes implemented for Resident #1's pressure ulcer until 5/22/25 when the wound NP assessed and entered orders for the wound.Resident #1's care plan (dated 5/19/25) documented the resident had a pressure ulcer on the right hip and was at risk of pressure ulcer development due to immobility and impaired healing due to diabetes. Interventions to heal and prevent pressure ulcers included keeping skin clean and dry, pressure reducing mattress, pressure reducing chair device and treatments as ordered by the physician.On 12/9/25 at 9:45 a.m., the licensed practical nurse unit manager (LPN #1) caring for Resident #1 was interviewed about care/treatment of the right hip pressure ulcer in the days prior to the wound NP's orders on 5/22/25. LPN #1 stated upon admission, nurses usually entered care orders as provided by the hospital. LPN #1 stated if orders were not provided by the hospital, then nurses were expected to contact the physician/provider or the consultant wound NP to obtain orders for wound care.On 12/9/25 at 12:10 p.m., LPN #1 stated she reviewed Resident #1's clinical record and found no orders for care/treatment of the pressure ulcer prior to 5/22/25, when the wound NP assessed the ulcer. LPN #1 stated the hospital discharge (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495381	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Health and Rehab Center	1300 Enterprise Drive Lynchburg, VA 24502

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders/summary included no orders for care/treatment of the wound. LPN #1 stated the unstageable ulcer was noted on the admission assessment and in daily skilled notes. LPN #1 stated she found no comprehensive assessment of the ulcer and no documented treatments and/or dressing changes to the wound prior to 5/22/25. LPN #1 stated she could not explain why the orders were not obtained when the wound was identified. LPN #1 stated when the pressure ulcer was identified, nursing should have contacted the in-house provider, on-call provider or the consultant wound NP for treatment orders. LPN #1 stated thorough assessment of the pressure ulcer should have included the size, appearance, presence of pain, drainage or odor and any signs of infection.On 12/9/25 at 11:30 a.m., LPN #2 that cared for Resident #1 several days prior to the wound NP's assessment was interviewed. LPN #2 stated the in-house or on-call provider should have been contacted for treatment orders since orders were not provided by the hospital.On 12/9/25 at 1:42 p.m., the wound NP (other staff #1) was interviewed about treatment/care of Resident #1's pressure ulcer. The wound NP stated the wound treatment orders should have been provided by the hospital along with the other care orders. The wound NP stated the in-house provider should have been notified and treatment orders obtained upon when the ulcer was identified. The wound NP stated she performed a thorough assessment and entered treatment orders for the ulcer on 5/22/25. The wound NP stated the initial assessment included no signs of infection such as purulent drainage, odor, warmth or induration and treatments were done following the assessment as ordered. The wound NP stated Resident #1's pressure ulcer was already advanced when he was admitted to the facility.On 12/9/25 at 12:50 p.m., the director of nursing (DON) was interviewed about lack of assessment and treatment of Resident #1's pressure ulcer during the five days after admission. The DON stated there were no treatments or dressing changes documented for Resident #1's pressure ulcer until 5/22/25 when the wound NP assessed the wound. The DON stated she reviewed the clinical record, and nothing was included in the hospital discharge summary or orders about the ulcer. The DON stated when the pressure ulcer was identified during the admission process, nursing should have contacted the in-house or on-call provider for treatment orders.The facility's policy titled Pressure Injury Prevention and Management (revised 10/19/22) documented, .Staff will be encouraged to promptly report any observation of a change in the resident's skin integrity .Weekly skin observations will be conducted by a licensed nurse and findings will be documented in the resident's medical record .Observations of new pressure ulcer/injury will be .Reported to the physician/practitioner for further evaluation and treatment .Documentation of the evaluations/assessment of the pressure ulcer/injury will [be] maintained in the resident's medical record. Documentation may include .Location of ulcer/injury .Date that the ulcer/injury was acquired .Description of the ulcer/injury to include stage, measurements [length, width, depth], presence/absence of any tunneling or undermining, type of tissue [epithelial, granulation, slough, necrosis, etc.], presence/absence and type of drainage, surrounding tissue description, and presence/absence of pain with the ulcer/injury .Treatment and interventions to promote healing .Treatments will be ordered by the physician/practitioner .orders for pressure ulcer/injury treatment will be specific for each resident .Treatments, including preventive interventions, will be documented in the resident's medical record . This policy described an unstageable pressure ulcer/injury as, .Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed .These findings were reviewed with the administrator and DON on 12/9/25 at 12:50 p.m. with no further information provided prior to the end of the survey.