STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER: Harrisonburg Hlth & Rehab Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE: 1225 Reservoir Street, Harrisonburg, VA 22801	

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 47067 Based on observation, resident interviews, and staff interviews, the facility staff failed to provide appetizing food with palatable temperatures and appearance to residents on one of three units (West unit). The findings include: On 7/1/24 at 11:25 AM, Resident #4 (R4), who resides on the [NAME] unit, was briefly interviewed concerning meals at the facility. R4 said, We get only what is delivered and it's usually cold and tastes nasty. On 7/1/24 at 11:30 AM, an observation was made of the tray line and the steam table in the kitchen. Temperatures of the food on the steam table were taken at this time and were as follows: Chicken breast 163 degrees Farheinheit, broccoli 162, mashed potatoes 178, peas 174, buttered noodles 162, fish nuggets 152, puree chicken 159, puree peas 159. The meal cart was loaded and sent to the [NAME] unit at 11:33 AM and arrived at 11:35 AM. At 11:35 AM, observations of staff (4 to 5 staff members) conducted, as they began delivering the trays to the residents on [NAME] Unit, upon arrival. A staff member was observed delivering a tray to a resident that needed supervision, with assist to eat, and began to assist the resident, reducing the amount of staff members to deliver the remaining meal trays. R4's tray was observed being delivered at 12:15 PM. When interviewed at this time, R4 said that the food is lukewarm at best and didn't taste very good, adding, It is always like this. R4's roommate overheard the conversation and remarked how bad the food tastes .day after day, using profanity to describe the food. On 7/1/24 at 12:30 PM, another resident (identified as R5) residing on [NAME] Unit was interviewed about the food. R5 explained that she was a vegetarian, So choices are limited. R5 described the food as unappealing and cold, pulling the lid off the food tray, R5 said, Look at this broccoli. It looks awful and I won't be eating that. Resident Council Meeting Minutes were requested for April through June 2024. April's meeting described the food as being cold. May's meeting described the food as being cold and bland, while June's meeting described the food as being dry and bland. It was noted up to 15 residents were documented as attending the meetings. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/24 at 3:50 PM the activities director (other staff, OS #7) was interviewed regarding concerns with the food from residents. OS #7 verbalized that it is the consensus of the resident council that the food isn't good and is usually cold. OS #7 stated that this information is given to the administrator to see what can be done but that the very next meeting the residents continue to complain about the food. On 7/2/24 at 8:40 AM the dietary manager (OS #5) was interviewed. OS #5 verbalized having awareness of food being cold and that he makes sure it goes out hot (appropriate temperature), but feels sometime the food is not being served fast enough. When asked about choices and alternatives, OS #5 said that the resident's can get an alternative and explained that the food is plated according to the diet a resident is on, when the food gets to the resident and they don't want what is served, then the aides will call for an alternative. On 7/2/24 at 10:30 AM the above finding was presented to the administrator and director of nursing (DON). The administrator verbalized that the facility has redone the steam table and is aware of the residents complaining about the food. No other information was presented prior to exit conference on 7/2/24.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 49456 Based on observations, staff interviews, resident interviews, and facility documents, the facility staff failed to ensure a sanitary, clean, and comfortable environment for 3 of 3 nursing units in the facility and in the dining room. The findings included: 1. The facility staff failed to maintain a clean. sanitary and comfortable environment for the residents in their rooms, shower rooms, halls, and common areas. On 7/1/24 at 11:30 a.m. a tour of the facility on all three units was conducted. Observations of the [NAME] unit spa noted feces on the floor in the shower room, the tiles in the shower stall had black mold-like coloring around the tiles, black marks were observed on the floor in the shower room, that appeared to be feces upon closer inspection, the orange shower stall mat appeared heavily soiled and stained gray, and rust colored stain was on the floors under the air conditioner unit. room [ROOM NUMBER] was observed to have tiles missing under the sink, bathroom walls had blackened areas marks on the walls, brown colored stain on the floor, and brown stains around the base of the commode. The walls in the bathroom and around the sink had various black colored stains, while there were unfinished, white patches where the walls had been repaired. room [ROOM NUMBER] had copious amounts of debris on top of the air unit, discolored tile under the air conditioner, and the flooring under the sink had black stains, with loose debris in the corners. room [ROOM NUMBER] had significant dirt build-up and stains were on the floor under the sink and in the bathroom. On 7/1/24 at 11:37 a.m., room [ROOM NUMBER] was observed. The bathroom was noted to be in extremely poor repair, with paint peeling and missing, the wall appeared to be crumbling in large areas on three sides of the toilet, with a large gaping black area directly behind the toilet, the baseboard was loosely attached and hanging off the wall, and black mold-like substances were observed on the wall and floor. Dirt and grime was built-up on the floor, especially in the corners, with the bathroom appearing extremely dirty and unsanitary. On 7/1/24 at 11:50 a.m. a tour of the main dining room was conducted. The dining room was observed with trash and cobwebs in all the corners of the dining area. Sitting tilted on two wheels, a severly soiled IV pole was observed at the entrance of the dining room, with a heavily dirt and rust encrusted base, which was missing a wheel, while the other was suspended in the air. Under the pole, loose debris, trash, and cobwebs were observed. All around the dining room baseboards were food remnants, bugs, and dirt, as well as a coffee cup sitting on the floor. The floors in the dining room were also observed to have black colored streaks in several different areas. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/24 at 12:02 p.m. an interview was conducted with Resident #6 (R6). R6 stated that their room was cleaned weekly, and that housekeeping would sweep and mop mostly in the center of the room. R6 stated that the housekeeping staff does not move any items to clean and that the overbed table does not get wiped down. When questioned further, R6 stated that it was a lack of housekeeping staff and mostly staying on the cell phones were the reasons that the rooms were not cleaned daily like they should be. R6 stated that she had been in her room for several years and had never seen it get a deep clean. On 7/1/24/at 12:14 p.m. an interview was conducted with Resident #5 (R5). R5's bathroom had been observed to have holes in the wall. R5 stated that the holes in the bathroom wall had been there for a long time. R5 stated that the grab bars were pulled out of the wall, and that no one had filled the holes or painted the walls. R5 stated that the housekeepers do a good job with cleaning the rooms and that their room was cleaned every four to five days. On 7/1/24 at 12:30 p.m. observations were conducted on the South unit. It was found that the south unit hallways had black marks on the floor, the doorway to the rooms had black marks and stains on the floor, and a significant build-up of grime around the door facings. The nurse's station had black marks and stains on the floor, while the baseboards had dark brown stains. room [ROOM NUMBER] had brown stains at the base of the commode, brown substance staining the walls, and black marks on the floor. On 7/1/24 at 12:40 p.m. an interview was conducted with the housekeeping manager (OS1). OS1 stated that housekeeping was short staffed and that there was only four housekeepers on Monday and Friday. OS1 said that we need six housekeeping aides but there were only five housekeeping aides employed. OS1 stated there was a deep cleaning schedule but that deep cleaning had not been completed for a length of time. OS1 stated that the expectation of the housekeeping staff was to clean the sinks, commodes, high touch areas, wipe off the over bed tables, sweep the floors, and mop the floors daily. OS1 said that housekeeping staff had been asked to clean around the lights and window seals weekly. OS1 said, When we only had three housekeepers, rooms do get missed. When quesztioned further, OS1 reported that the dining room was cleaned on Monday, Thursday, and Friday's and that all the tablecloths were changed, all the tables were wiped down, and the floor tech cleans the floors. OS1 said that there was a deep cleaning room schedule and a daily room cleaning schedule, which the housekeeper aides follow and check off when completed. On 7/1/24 at 12:49 p.m., an interview was conducted with the housekeeping aide (OS14). OS14 said that she was the main housekeeper on the East unit. OS14 said that the trash is emptied first, then the bathroom is cleaned, then wipes down the sink and overbed table, then sweeps the floor, and then mops the floor. OS14 said, We have a check off sheet with the room numbers, and it goes from Sunday to Saturday, and we turn the sheets in to the supervisor monthly. OS14 said that some days all rooms were cleaned but some days rooms are missed due to being short staff. OS14 said, Employees will not stay here and work. OS14 stated that deep cleaning had not been completed for a long time. OS14 said that buffing the floors should be done daily but, on most days, there was no floor technician so the floors was not cleaned. When asked about the unsightly black marks on the floor, OS14 said that the black scuff marks seen all over the floors was from the stripping and waxing of the floors. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/24, a facility document review was conducted. The facility policy titled, Method of cleaning, read, .top down: always start cleaning surfaces, ledges, shelves, etc., at the top and work your way down. Clean the face of areas as well. Move furniture around, clean behind not commonly moved furnishings. Restrooms-address the same as a room, paying careful attention to the sink and commode. Infection control is critical here. Always clean the sink first then the toilet. Remove all debris from floors, counters, and edges. Remove all trash and replace liners. On 7/1/24, a review of the housekeeping check-off lists from 6/21/23 - 8/30/23, that the housekeeping manager had, was reviewed. During this period, the documentation revealed that the rooms and common areas were cleaned one day a week. On 7/1/24, multiple interviews were conducted with various residents and facility staff, which included but were not limited to, Resident #1, Resident #2, Resident #3, LPN #1, and CNA #1. Each of them reported that the housekeeping department is short staffed, rooms are not cleaned daily, and that concerns had been reported about the cleanliness and sanitation of the facility. On 7/1/24, a review of the past three months of resident council minutes was conducted. According to meetings held on April 18, 2024, May 16, 2024, and June 20, 2024, the council minutes documented that residents reported their rooms were not being cleaned and that bathrooms were dirty. Each of these facility documents had been signed by the administrator. On 7/2/24 at 9:23 a.m., observations were again conducted of the dining room again, as it reportedly had been cleaned the day prior. Near the dining room entrance, the same soiled IV pole that was missing a wheel, and was heavily encrusted with rust and dirt remained unmoved in the dining room. The floor throughout had copious amounts of loose debris and dirt, with an intact tater tot noted to be sitting on the base molding, fully visible. The build up of dirt and grime around the walls and in all the corners throughout the dining room remained unchanged. On 7/2/24 at 10:20 a.m., these findings were reviewed with the administrator, director of nursing, and regional consultants. No further information was provided prior to the end of the survey. 21875 2. Resident and facility equipment/supplies were stored in alcoves/hallways on each of the three living units. The South unit had a broken floor tile in the hallway used by residents, staff, and visitors. On 7/1/24 at 4:00 p.m., the hallways in the facility were inspected. A broken floor tile was observed on the South unit adjacent to a stainless-steel plate positioned across the width of the hall. This broken area and plate were located between rooms [ROOM NUMBERS]. The broken area was approximately six inches in length and one inch wide creating a gap in the floor next to the stainless plate. Two mattresses were observed leaning against the wall in the alcove beside the MDS office. In this same alcove, a wheelchair was observed, positioned near the exit door, while a rolling walker stored next to the wall. An empty bed was observed in the alcove near the exit doors on the East unit, across from the nursing station. A mechanical lift and rolling cart were observed in the alcove near the exit doors on the [NAME] unit. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/2/24 at 7:45 a.m., a pallet with boxed furniture was observed in the hallway across from the kitchen entrance. There were two broken bedside tables, a floor buffer, and a ceiling light lens also observed in this area next to the wall. On 7/2/24 at 7:50 a.m., when shown the above items/areas, the maintenance director (other staff #4) was interviewed about equipment/supply storage. Regarding the bed stored in the alcove on the East unit, the maintenance director stated, That's my fault. The maintenance director stated that he was not sure who placed the mattresses in the alcove near the MDS office, but that maintenance was responsible for mattress placement/storage. The maintenance director stated that beds/mattresses were supposed to be stored in the basement. The maintenance director stated that the wheelchair and walkers were placed in the alcoves by therapy and/or nursing. Regarding the broken tile in the South unit hall, the maintenance directors stated that the broken tile/gap had been repaired in the past but broke again because the tile rests against the stainless steel plate in the floor. The maintenance director stated that he was aware of the broken tile but had not repaired the gap. The maintenance director stated the pallet near the kitchen entrance and facility exit was new furniture for the facility. The maintenance director stated, That's my fault. I told them to put that [pallet] there. The maintenance director stated that the floor buffer belonged to housekeeping and he did not know why the broken furniture and light lens were stored in the hallway. On 7/2/24 at 9:05 a.m., the therapy department manager (other staff #3) was interviewed about empty wheelchairs and walkers stored in the alcove throughout the facility. The therapy manager stated all resident equipment used by therapists was stored in the rehab gym. The therapy manager stated that there was additional storage in the basement for equipment not in use. The therapy manager stated, Everybody in the facility places resident equipment in the halls and alcoves, adding that the equipment should be stored out of resident use areas. These findings was reviewed with the administrator, director of nursing and regional consultants during a meeting on 7/2/24 at 10:20 a.m. with no further information presented prior to the end of the survey.