STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495093	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrisonburg Hlth & Rehab Cntr	1225 Reservoir Street Harrisonburg, VA 22801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and clinical record review, the facility staff failed to develop a care plan for one of eleven residents in a survey sample.Resident #4 (R4) did not have a care plan for bowel incontinence.The findings included: Resident #4 (R4) diagnoses include diabetes, congestive heart failure, respiratory failure, and peripheral vascular disease. The most recent MDS was a quarterly assessment dated [DATE]. R4 was assessed with a cognitive score of 15 indicating cognitively intact. Section H of R4's MDS indicated R4 is incontinent of bowel. On 9/22/25 at 2:30 p.m. R4 was interviewed. R4 verbalized being incontinent of bowel explaining numbness from the waist down and could not tell if a bowel movement had occurred and needed to be checked on frequently. Review of R4's care plan did not indicate that R4 had a care plan in place for bowel incontinence. On 9/22/25 3:15 p.m. certified nursing assistant CNA #1 was interviewed. CNA #1 verbalized taking care of R4 on a regular basis and will check R4 for bowel incontinence about every two hours, saying that R4 has no feeling from the waist down. On 9/23/25 at 9:50 a.m. registered nurse (RN #1, MDS coordinator) was interviewed regarding R4 being incontinent of bowel. MDS reviewed the care plan and agreed that a bowel incontinence care plan should have been put in place but was missed. On 9/23/25 at 3:30 p.m. the above finding was presented to the administrator and director of nursing.No other information was provided prior to the exit conference on 9/23/25.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide timely incontinence care for two of eleven residents in the survey sample (Residents #2 and #5).The findings include:1. Resident #2 did not have timely incontinence care during the early morning on 6/7/25. Resident #2 (R2) was admitted to the facility with diagnoses that included quadriplegia, spinal cord compression, insomnia, gastroesophageal reflux disease and hypertension. The minimum data set (MDS) dated [DATE] assessed R2 as cognitively intact and frequently incontinent of bowel/bladder.On 9/23/25 at 8:30 a.m., Resident #2 was interviewed about a report by staff on 6/7/25 that the resident did not get timely incontinence care. R2 stated he remembered that night and that the CNA (certified nurse's aide) caring for him that early morning was new. R2 stated he slept most of the night, recalled the CNA bringing in water but did not recall when or if incontinence care was provided. R2 stated the facility interviewed him about the CNA's care on 6/7/25 and took care of it. R2 stated he had experienced no further concerns with timely brief changes.On 9/23/25 at 9:20 a.m., the licensed practical nurse (LPN #5) caring for R2 on the 6/7/25 day shift was interviewed. LPN #5 stated around 8:00 a.m. on 6/7/25, CNA #6 reported to her that R2 was soaked and had obviously not been changed prior to the end of the previous shift. LPN #5 stated it was not like R2 to be soaked, as R2 usually called when he needed changing. LPN #5 stated when R2 was found soaked on the morning of 6/7/25, the resident reported he slept most of the night and had not rung the bell. LPN #5 stated R2 was apparently not checked prior to the start of day shift that day. On 9/23/25 at 1:35 p.m., the director of nursing (DON) was interviewed about R2's incontinence care during the early morning shift on 6/7/25. The DON stated CNA #6 reported to LPN #5 that R2 was found soaked at the start of day shift on 6/7/25. The DON stated CNA #7 that cared for R2 on the prior shift was immediately suspended and a report sent to the state agency. The DON stated their investigation supported evidence that CNA #7 had not provided timely incontinence care for R2 during the early morning on 6/7/25, as R2 was found soaked and in need of a brief change at the start of the day shift on 6/7/25. The DON stated a skin assessment following the reported lack of incontinence care indicated no skin issues.R2's plan of care (revised 8/15/25) documented the resident was incontinence of bowel/bladder due to quadriplegia. Interventions to keep the resident clean/dry included one-person assistance with toileting/incontinence care, check and change briefs frequently as needed and provide toileting hygiene with brief changes.The facility's investigation of the reported lack of incontinence care included documented statements dated 6/7/25 from CNA #6 and LPN #5 that stated R2 was found at the start of the day shift with a soaked brief, indicating lack of brief change.This finding was reviewed with the administrator, DON and regional nurse consultant during a meeting on 9/23/25 at 3:30 p.m. with no further information presented prior to the end of the survey. 2. Resident #5 did not have timely incontinence care during the early morning on 6/7/25.Resident #5 (R5) was admitted to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease), diabetes, benign prostatic hyperplasia (BPH), congestive heart failure, dementia, depression, restless leg syndrome and cardiomegaly. The minimum data set (MDS) dated [DATE] assessed R5 as cognitively intact, frequently incontinent of bladder and occasionally incontinent of bowel.On 9/23/25 at 9:35 a.m., licensed practical nurse (LPN #5) was interviewed about a report on 6/7/25 that R5 did not receive timely incontinence care. LPN #5 stated she cared for R5 during the day shift on 6/7/25. LPN #5 stated around 8:00 a.m. on 6/7/25, CNA #6 reported to her that R5 asked for a brief change and was found soaked. LPN #5 stated R5's roommate (Resident #8) reported that CNA #7 had not checked/changed the resident like usual prior to the end of the night shift. On 9/23/25 at 1:35 p.m., the director of nursing (DON) was interviewed about R5's incontinence care during the early morning shift on 6/7/25. The DON stated CNA #6 reported to LPN #5 that R5 was found with a heavily soiled brief around 8:00 a.m. on 6/7/25. The DON stated CNA #7 that cared for R5 on the prior shift was immediately suspended and a report sent to the state agency. The DON stated their investigation supported evidence that CNA #7 had not provided timely incontinence care for R5 prior to shift change on the early morning of 6/7/25. The DON stated R5's roommate (Resident #8) reported that CNA #7 came to the room but did not provide a brief change for R5 prior to the end of the shift. The DON stated a skin assessment for R5 following the reported lack of incontinence care indicated no skin issues.R5's plan of care (revised 6/23/25) documented the resident was incontinent of bowel/bladder due to weakness and BPH. Interventions to keep the resident clean/dry included one-person assistance with toileting, checking and changing briefs frequently as needed

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to follow physician orders for two of eleven residents in the survey sample (Residents #1 and #7).The findings include:1. Facility staff failed to order and administer an eye medication for over 30 days, as recommended by an eye physician for treatment of Resident #1's glaucoma. Resident #1 (R1) was admitted to the facility with diagnoses that included glaucoma, diverticulosis, bipolar disorder, autism, diabetes, obesity, anxiety, personality disorder, sleep apnea, chronic respiratory failure, Crohn's disease and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed R1 as cognitively intact. On 9/22/25 at 12:45 p.m., R1 was interviewed about quality of life/care in the facility. R1 stated during this interview that he was evaluated by an eye doctor in the facility about a month ago and had not received a new eye drop recommended by the provider for treatment of glaucoma. R1's clinical record was reviewed from 7/1/25 through 9/21/25. R1's clinical record documented an ongoing physician's order dated 9/26/24 for Latanoprost ophthalmic solution 0.005% that was administered at each bedtime as ordered for treatment of glaucoma. The record included no newly prescribed eye medications for glaucoma. On 9/23/25 at 9:20 a.m., the licensed practical nurse unit manager (LPN #2) was interviewed about any orders for additional eye drops for R1. LPN #2 reviewed the clinical record and stated she did not find a recent eye consultation or order for new eye drops. LPN #2 stated that an eye doctor came to the facility routinely and assessed residents, but she was not sure when R1 was last seen by the eye physician. On 9/23/25 at 10:45 a.m., the social services director (other staff #5) was interviewed about R1's report of recommended eye drops during a recent eye doctor visit. The social services director stated that an eye physician was contracted to assess/treat residents in the facility. The social services director reviewed R1's record and stated she was not sure when R1 was last seen by the eye doctor. The social services director stated she was not aware of a recommendation for additional eye drops and did not see documentation of an eye consultation for R1. On 9/23/25 at 1:35 p.m., the director of nursing (DON) was interviewed about any recent eye consultation and recommended eye drop order for R1. The DON stated she was not aware of a new order but would research the concern. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/23/25 at 3:25 p.m., the administrator and DON were interviewed about R1's eye drops. The DON stated R1 was seen at the facility by the contracted eye physician on 8/12/25 with a recommendation made for an additional eye medication for treatment of glaucoma. The DON presented R1's eye exam/report dated 8/12/25. The eye physician documented a recommendation to start Dorzolamide-Timolol with instructions for one drop in both eyes twice per day for management of glaucoma. The eye physician's note documented the Dorzolamide-Timolol drops were needed in addition to the Latanoprost already in use. The DON stated the facility had not received the eye physician's consultation report because the report was sent to a former social services/discharge planner's email address. The administrator stated the report system had not been updated with the current social service director's email address. The administrator stated the social services director was responsible for updating contact information for consultants/providers. The DON stated the eye medication recommendation should have been reviewed by R1's primary physician and orders entered for the drops as recommended. The facility's policy titled Report of Consultation (effective 1/29/24) documented, The provider may order a consultation with another physician or health care provider .Review the Report of Consultation or consulting Physician Progress Notes .report findings to center provider .Implement new orders, if indicated .Report of Consultation will be uploaded into the patient's electronic medical record . This finding was reviewed with the administrator, DON and regional nurse consultant on 9/23/25 at 3:30 p.m. with no further information presented prior to the end of the survey. 2. The facility staff failed to administer an antibiotic for Resident #7 (R7) for three doses per physician orders. R7 could not be interviewed as she had been discharged from the facility and was no longer a resident at the time of the observation. On 9-23-25, the Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) were interviewed regarding R7's medications. R7 was admitted to the facility on [DATE] at 7:00 p.m. with physician's orders for Keflex (to be given four times daily). Documentation revealed the antibiotic was not initiated until 7-14-24 at 12:00 p.m. As a result, R7 missed three scheduled doses: the 7-13-24 evening dose, the midnight dose, and the 6:00 a.m. dose on 7-14=24. During the interview, the DON stated the delay occurred because the medications were not entered into the electronic system until approximately 10:00 p.m. on 7-13-24 and were not verified until 2:42 a.m. on 7-14-24. The DON reported this was the reason the first doses were not administered. When interviewed, the RDCS was unable to clarify why the midnight and 6:00 a.m. doses on 7-14-24 were not given, because the orders were entered in the electronic system on 7-13-24 at approximately 10:00 p.m. On 9-23-25, the facility policy titled, General Guidelines for Medication Administration. was reviewed. Under section II. Administration, items 2: 1. Medications are administered only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications. 2. Medications are administered in accordance with the written orders of the prescriber. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9-23-25, a review of Resident #7's (R7) clinical record was conducted. Hospital discharge orders dated 7-13-24 directed that antibiotic be administered four times daily. R7 was admitted to the facility on [DATE] at 7:00 p.m. Scheduled antibiotic doses included 7-13-24 at 6:00 p.m., 7-14-24 at 12:00 a.m., and 7-14-24 at 6:00 a.m. These doses were not administered. Documentation showed the medication was available in the facility's backup supply. The Medication Administration Record (MAR) reflected that the antibiotic was not initiated until 7-14-24 at 12:00 p.m. admission orders, including the antibiotic, were entered into the electronic system at approximately 10:00 p.m. on 7-13-24, though R7 had arrived at 7:00 p.m. This resulted in a delay in the initiation of antibiotic therapy. On 9/23/25 at 3:45 p.m., an end-of-day meeting was held with the Director of Nursing (DON), the Administrator, and the Regional Director of Clinical Services. They were made aware of the above concerns. No additional information was provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident interview, staff interview, and facility documentation the facility staff failed to serve a palatable meal to two residents, Resident #7 (R7) and Resident #10 (R10) out of a survey sample of eleven residents.The findings included:On 9/23/25 at 12:00 p.m., an observation was conducted during the lunchtime meal service in the main dining room. During this observation, it was noted that several residents was not eating their meal. One resident complained about the temperature of the food. She stated that the food was not served hot and that is how she likes her food.On 9/23/25 at 12:11 p.m., a test tray was conducted. The tray served included: baked ham, mixed vegetables, scalloped potatoes, a roll, and a brownie. Food temperatures were taken with the following results:Baked ham: 121.6 FScalloped potatoes: 138.4 FMixed vegetables: 129.7 FRoll and brownie: served at room temperatureFor comparison, temperatures obtained in the kitchen prior to service were:Baked ham: 180 FScalloped potatoes: 190 FMixed vegetables: 183 FThe test tray food items were noted as lukewarm. The ham, potatoes, and vegetables were not served at an appetizing temperature. The vegetables were also reported to be very soft, bland, and lacking seasoning. The potatoes were bland and needed seasoning.The dietary manager was present during the test tray tasting and commented: Ham: good, Potatoes: delightful, and Mixed vegetables: it's veggies.An interview was not conducted with R7 because she was no longer a resident at the facility.On 9/23/25 at 11:45 a.m., an interview was conducted with R10. She stated that her meals were never served hot. She stated that she liked her meals served hot and not lukewarm or cold.On 9/23/25 at 2:05 p.m., an interview with the dietary manager was conducted. He stated: Everything we serve needs to be less than 150 degrees, so no one is scalded. The temperature dropped significantly due to hot plates sitting and waiting to be served out there on the cart.On 9/23/25 the Facility documentation was reviewed. The facility document titled, Quality and Palatability, read in part, It is the center policy that, food is prepared by methods that conserve nutritive value, flavor and appearance. Food is palatable, attractive and served at a safe and appetizing temperature.On 9/23/25 at 3:45 p.m., an end-of-day meeting was held with the Director of Nursing (DON), the Administrator, and the Regional Director of Clinical Services. They were made aware of the above concerns.No additional information was provided.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, resident interview, staff interview and facility documentation the facility staff failed to provide the residents preference with the meals for three residents, Resident #9 (R9), Resident #10 (R10), and Resident #11 (R11) out of a survey sample of eleven residents. The findings included: On 9/23/25 at 12:00 p.m., an observation was conducted during the lunchtime meal service in the main dining room. During this observation, it was noted that three residents did not receive their stated meal preferences as listed on their meal tickets. Specifically, two residents, R10 and R11, had preferences for baked potato with meals and milk, and one resident, R9 preferred dessert and milk. These preferences were not honored during the lunch service. On 9-23-25 at 12:00 p.m., during the lunchtime meal service, resident interviews were conducted.R9 stated, she never receives her dessert without having to ask for it and reported that she does not receive her milk with meals.R10 stated, she does not receive her milk with meals and that condiments are not provided on her tray.R11stated, she likes milk but seldom receives it with her meals. She also reported she seldom receives her baked potato as ordered.On 9/23/25 at 12:00 p.m., during an interview in the dining room, the Certified Nursing Assistant, CNA#1 (CNA1) reviewed a meal ticket and stated he was unsure why the baked potato was not served, but he would check on it and provide one if available.On 9/23/25 a review of facility documentation was conducted. The document reviewed was titled, Menu. The policy states menus are planned in advance to meet the nutritional needs of residents/patients and are developed utilizing established national guidelines. It further states menus are to be served as written unless changes are made in response to resident preference, unavailability of an item, or for a special meal.On 9/23/25 at approximately 3:45 p.m., an end-of-day meeting was held with the Regional Director of Clinical Services, the Director of Nursing, and the Administrator. The above concerns were discussed. No additional information was provided.