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	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrisonburg Hlth & Rehab Cntr	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, and facility document review, the facility staff failed to maintain a clean, comfortable, homelike environment for 3 of 3 nursing units, public congregate spaces, and the building as a whole.The findings included:From the time of initial tour on 4-13-26, through the course of survey concluding on 4-15-26, the physical plant was observed and inspected. Those observations continue below. Initial tour of the facility revealed Residents #101, #103, #107, and #114's rooms on 3 different units to be crowded (hoarded) with boxes, food items, personal items, and plastic storage containers in front of, and on top of the air conditioning/heating units restricting air flow. Also observed were articles of clothing balled up in beds with soiled linens, soiled clothing articles scattered around the rooms. Large opened (16 to 18 ounce) containers of food sauces (Texas [NAME] sauce and others), and food spices spilled on and over the overbed tables, and bedside cabinet surfaces. Privacy curtains between beds in the semi private rooms had stains and brown colored smears on them which caused them to stick to them selves in places. Found were partially eaten corn bread squares which were spoiled with obvious blue mold on them. Different food items and drink items in cups and plastic glasses appearing to be mixed and were unidentifiable. No food or drink items were refrigerated, and the rooms had a sour spoiled food smell comingled with a strong odor of urine. Resident #101 was laying on a soiled bed encrusted with spilled food. The Resident's black sweatshirt was encrusted in a 6-inch by 6-inch stain on the front with dried, spilled foods and liquids, and the resident stated when asked I don't know what it is. Resident #101 was naked from the waist down covered partially by a soiled sheet. The Resident's roommate was not in the room, however, his side of the semi-private room looked very similar to Resident #101's side of the room. There were several rooms with hoarding habitation noted during tour, and an interview with the Administrator revealed that he knew of the hoarding, however, did not want to upset the Residents and so had not cleaned certain areas of those rooms. It was noted by all 5 surveyors that during the rest of the survey that shower rooms revealed a black substance along corners and caulking areas. Broken tiles were noted in the shower rooms, used soap and hair were found in the drain covers. The hallway floors had holes in them which were trip hazards. Base boards were found to be knocked down in places, and the main hallways and resident room floors were covered in black track marks and a sticky substance. Rooms had food crumbs, paper and plastic wrappers scattered about, and in the corners of rooms a built-up crust of dirt and black grime [which could be scratched off easily] was found in most areas. On 4-14-26 at 12:00 P.M., an interview was conducted with a housekeeping staff member cleaning the hallway on one of the units. She was asked what her workload was like daily, and she replied, I am the only one here today, and I can't do it all. The facility consisted of 180 beds on 3 units, shower rooms on each unit, activity rooms, courtyards, dining rooms, and various other offices and gathering spaces. The statement made by the lone housekeeper was confirmed by the Environmental Services Director who was the only laundry attendant for the day also, by her own admission. The laundry room was found with soiled clothing and linens stacked in a large mound over 5 feet tall. When she left the facility for the day, all of the dryers were full, and the washing machines (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were full of wet clothes and linens to wait overnight to mildew before someone would return the following morning to pick up where she left off.Clean linen carts in the hallways of each unit were observed and surveyors found approximately the following on each cart; 3-4 sheets, 5 pillowcases, 4-5 bath towels, 6 wash cloths, and 3 hospital gowns per unit for a 180 bed facility. This was clearly insufficient for evening hygiene and bathing needs as residents prepared for bed.The Administrator was again interviewed at approximately 5:00 P.M. and he said we have had a lot of call outs, and we have terminated some staff.The tables and floor in the main dining room were spattered with paint, chipped in places, encrusted and smeared with a slippery/greasy black substance on the floors. The dining tables were smeared and dirty, and stained chairs were piled and stacked against the wall in the front corner of the room. Dirty linen rooms held large bins of soiled clothing, and linens, which were draped over the bins flowing onto the floor. Sharps/needle containers with blood in them, and biohazardous materials in red 55-gallon bins were found in one unlocked [taped open] room, and chemicals were found in another unlocked room. Both rooms were open to anyone who wished to enter. The 2 rooms were next to each other on a side hallway not visible from the nursing station, where several residents were sitting in wheelchairs and found to be cognitively impaired. There were other ambulatory residents walking in the hallway with rolling walkers as well. On 4-14-26, and 4-15-26 at the end of day debriefing, the Administrator, DON and Regional [NAME] President of Operations were notified of the concerns of hoarding, unsafe, and unclean areas. They stated on 4-15-26 prior to exit that cleaning had been completed in those areas mentioned, and surveyors did see improvements. They stated at that time they had no further information to provide. 2. The facility staff failed to provide a safe, clean, comfortable, and homelike environment by failing to ensure adequate linen supply and routine housekeeping services, including daily cleaning of resident rooms, across all three units.Observations conducted from 4/13/26 - 4/15/26 on all three units revealed linen carts contained minimal supplies, including only a few pillowcases and approximately two towels, with no wash clothes or blankets available. Resident rooms were observed without facility-provided bedspreads, with some residents using personal blankets from home in place of appropriate bedding.On 4/13/26 at 2:00 pm, an interview was conducted with Resident #119(R119). He reported ongoing concerns regarding insufficient linen availability, stating there was not enough linen for his bed and that he did not have a bedspread. The resident reported his room had not been cleaned for approximately two weeks.On 4/13/26 at 5:32 pm, an observation of the laundry room was conducted. During the observation, there was excessive accumulation of personal clothing and facility linen. Clothing and linens were observed piled on top of trash cans, and the pile was to the vent on the top part of the wall, personal clothing was piled on top of a tote, and linen was piled on chemical buckets and the pile was halfway up the wall. There was another pile of personal clothes that was on a trash can and was piled high and covering the electrical boxes. The piles were excessive high piles of clothing. Multiple bin containers were overflowing, and excessive amount of bags of wet laundry were noted piled on the floor in front of the laundry room doors as high as half way up the door. The three dyers and three washers were full of linen and personal clothing and were just sitting in the machines.On 4/14/26 at 10:36 am, an interview was conducted with a licensed practical nurse, LPN#2 (LPN2). LPN2 said, it is very true that linen is short on the units. We struggle, do what we can and seems like a third world country here trying to survive. Families bring in linen, not enough staff in laundry to do the laundry and when is sits down there becomes molded and it's thrown away. Observation of R119's room revealed trash under both beds, black scuff marks on the floor, and cobwebs present in the corners of the room.A review of grievances and Resident Council meeting minutes revealed repeated concerns regarding rooms not being cleaned and personal items missing and not returned.A review of the facility policy titled, Daily Resident/Patient Room Cleaning, read in part, housekeepers are responsible for ensuring they are adequately supplied for tasks of the day with appropriate supplies, equipment, tools, and personal protective equipment (PPE). On 4/14/26 at 5:00 pm, an end of day meeting was held with the administrator, director of nursing, regional director of (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clinical services, and vice president of operations and the above concerns were discussed. They stated that they were working on getting more staff for the laundry and housekeeping services. On 4/15/26 at 10:00 am, an exit conference was conducted with the administrator, director of nursing, regional director of clinical services, and vice president of operations. During the exit conference they stated that staff had been in the building late the previous evening cleaning the facility and addressing laundry backlog. There was noticeable difference in the cleanliness of the hallways and dining area. No more new information was provided prior to exit.