

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/10/2026
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 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 observation, resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to maintain a clean and homelike environment for three of 37 residents, Residents #227, #228 and #237; in one of six shower rooms; and in four of 89 resident rooms, room [ROOM NUMBER], #42, #45, and #5. The findings include: 1. The facility staff failed to maintain a homelike environment for Resident #227 (R227). R227's wall in their room contained a large black scuff mark and multiple areas with discolored yellowish colored painted areas on the wall. On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 5/11/2026, the resident scored 12 out of 15 on the BIMS (brief interview for mental status) assessment, indicating moderate cognitive impairment. On 6/8/2026 at 2:35 PM, an observation of R227's room was conducted and interview with R227 was conducted. Observation of R227's room revealed a black scuff mark on the wall along the doorway to the room approximately 24 inches long and six inches wide. R227 stated that he had reported the scuff to staff many times and they kept saying they were going to paint but had not gotten to it. R227 pointed to an area above the black scuff which contained a yellowish colored area on the beige wall and stated that it had been there for a long time and needed painting. R227 pointed to another area on the wall in front of his bed which contained a large yellowish colored area on the beige wall and stated that it had been there for a long time as well. R227 stated that he did not like the patchy colors on his walls and the scuff on the wall and had complained multiple times but had not had any follow up from anyone about when it was going to get painted. Additional observations of R227's room as described above were made on 6/8/2026 at 4:48 PM, 6/9/2026 8:43 AM, and 3:10 PM. On 6/9/2026 at 3:19 PM, an interview was conducted with the Director of maintenance who stated that he was made aware of repairs needed in the facility by the staff entering work orders in the computer system. He stated that he prioritized any safety needs first and then cosmetic repairs were last. He stated that he had just hired an additional staff member and anticipated being able to take on more of the cosmetic repairs needed in the building soon and had a plan to paint all the walls and repair the drywall. The director reviewed the active work orders and stated that there were none for R227's room. At 3:35 PM, the director observed R227's room and stated that he was not sure what the yellowish color was on the walls but there was a plan to paint all the rooms and that would cover up the black scuff on the wall as well. He stated that he was without any help for a long time and for a time nothing was done in the rooms and they had suffered but recently they had completed a lot of (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	Observation of the bathroom in room [ROOM NUMBER] on 6/8/2026 at 12:07 PM revealed two areas on the floor in front of the toilet approximately two inches and four inches with dried brown material, a trash can against the wall in front of the toilet with brown material on the wall approximately 1/2 inch wide and a toilet riser sitting on top of the toilet with visible brown splatter on the inside of the toilet bowl and inside of the toilet riser. Additional observations of the bathroom in room [ROOM NUMBER] were made on 6/8/2026 4:38 PM and 6/9/2026 at 8:55 AM. The observations were the same as described above. On 6/9/2026 at 3:02 PM, an interview was conducted with the Director of housekeeping and laundry who stated that resident rooms were cleaned daily including the bathrooms which were cleaned from top to bottom. She stated that she had three housekeepers on each unit each day from 7:00 AM to 3:00 PM and 12:00 PM to 8:00 PM. At approximately 3:06 PM, the director observed room [ROOM NUMBER]'s bathroom, the toilet riser had been cleaned however the brown material remained on the floor. On 6/10/2026 at 2:21 PM, the Administrator and the Director of Nursing were made aware of the concern. No further information was provided prior to exit. 6. In room [ROOM NUMBER], the facility staff failed to maintain a clean and home-like environment. room [ROOM NUMBER]'s bathroom was observed with brown material in the toilet, smeared on the toilet rim and above the trash can. Observation of the bathroom in room [ROOM NUMBER] on 6/8/2026 at 3:08 PM revealed brown material in the toilet, smeared on the toilet rim and above the trash can against the wall in front of the toilet. Additional observations of the bathroom in room [ROOM NUMBER] were made on 6/8/2026 at 4:44 PM and 6/9/2026 at 9:19 AM. The observations were the same as described above. On 6/9/2026 at 3:02 PM, an interview was conducted with the Director of housekeeping and laundry who stated that resident rooms were cleaned daily including the bathrooms which were cleaned from top to bottom. She stated that she had three housekeepers on each unit each day from 7:00 AM to 3:00 PM and 12:00 PM to 8:00 PM. At approximately 3:06 PM, the director observed room [ROOM NUMBER]'s bathroom and stated that it needed to be cleaned. On 6/10/2026 at 2:21 PM, the Administrator and the Director of Nursing were made aware of the concern. No further information was provided prior to exit. 7. The facility staff failed to maintain a comfortable home-like environment by failing to maintain an accurate clock for two of 89 rooms (room [ROOM NUMBER] and room [ROOM NUMBER]). a. Observation during initial tour on 06/08/2026 at 12:16 p.m. revealed that the time on the clock in room [ROOM NUMBER] was 11:14. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional observation on 06/10/2026 at 12:45 p.m. revealed that the time on the clock in room [ROOM NUMBER] was 11:43. During an interview with the administrator, we observed the clock in room [ROOM NUMBER] on 06/10/2026 at 1:30pm, he stated the clock was an hour behind and they must have missed it. The administrator declined to answer a question regarding the homelike nature of a clock not on the accurate time. b. Observation during initial tour on 06/08/2026 at 12:33 p.m. revealed that the time on the clock in room [ROOM NUMBER] was 11:38. Additional observation on 06/10/2026 at 12:46 p.m. revealed that the time on the clock in room [ROOM NUMBER] was 6:20. During an interview with the administrator, we observed the clock in room [ROOM NUMBER] on 06/10/2026 at 1:35 p.m., he stated the time on the clock was not accurate to the current time. The administrator did not respond when asked regarding the homelike nature of a clock not on the accurate time. No further information was provided prior to exit.		