

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 02/13/2026
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews and facility document review, the facility staff failed to maintain a safe environment for two of forty-three residents in the survey sample (Resident #108 and Resident #142). One oxygen cylinder was observed free-standing, unsecured constituting the identification of immediate jeopardy (IJ) at Level Four, Isolated scope and severity resulting in substandard quality of care. Upon verification of the removal of the IJ, the scope and severity were lowered to Level Two, Isolated. The facility also failed to ensure an electric space heater was not used as a primary source of heat for one of forty-three residents (Resident #80). The findings include: On 2/10/26 at 1:13 PM, during initial rounds, one oxygen e-tank was observed sitting on the floor, freestanding in an upright position, not contained in a stand or holder in Resident#108 and Resident#142's room. It was observed that the gauge on the green tank read as being full. (An E tank or E cylinder is a common medical oxygen cylinder, typically holding around 680 liters of highly flammable gas.) On 2/10/26 at approximately 1:35 PM, a second observation was made of the free-standing oxygen e-tank with two surveyors. Resident #108 was observed lying in his bed with oxygen being administered by nasal cannula via a concentrator at 3 liters per minute. The cylinder tank was freestanding approximately 2 inches from the wall and approximately 3 feet across from the foot of Resident #108's bed. Resident #108's wheelchair was positioned against the oxygen tank. Resident #142 was observed sitting in his wheelchair between the two beds. On 2/10/26 at 1:40 PM, an interview was conducted with a licensed practical nurse (LPN#9) on how oxygen is to be stored in a resident's room and she replied, we place them on the back of the resident's wheelchair or in the storage area is all I know. On 2/10/26 at 1:45 PM, an interview was conducted with Resident #108 (R108) to ask if he was aware of how long the oxygen tank was stored on the floor, unsecured. According to R108, the tank was not on his wheelchair 2/09/26 as he recalled being in his wheelchair, in his room and the oxygen tubing was attached to his concentrator. He said the tank was on back of his wheelchair the day prior [2/8/26]. On 2/10/26 at 2:05 PM, an interview was conducted with LPN#8 on proper storage of oxygen in resident rooms. According to LPN#8 oxygen tanks can only be in a resident room if in a tank holder or attached to the back of the resident's wheelchair with the sling holder so they don't fall over and explode or propel like a rocket. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview was conducted with the UM (Unit Manager) for the [NAME] Unit regarding her expectations of how oxygen is to be stored in the residents' rooms. According to the UM, oxygen is to be stored in a caddy, never free-standing due risk of possible fire or explosion if the tank is accidentally knocked over. Resident #108 was admitted to the facility 12/09/2020 with diagnoses including but not limited to chronic obstructive pulmonary disease, chronic kidney disease, stage 3A, heart failure, hypertension, chronic respiratory failure, major depressive disorder, diabetes mellitus, type 2, and anxiety. Resident #108 had a physician order for oxygen 3 liters per minute via nasal cannula. Resident #108's most recent MDS (Minimum Data Set) Quarterly Assessment with ARD (Assessment Reference Date) 1/16/26 was coded in Section C. Cognitive Pattern with a score of 14 out of 15 indicating resident is cognitively aware. Section GG. Functional Ability for sit to stand, roll side to side and chair to bed to chair transfer is coded as 03 indicating resident requires supervision or touching assistance and once seated in his wheelchair has the ability to wheel himself at least 50 feet and make two turns. This same MDS coded Resident #108 as having used oxygen. Resident #142 was admitted to the facility 10/3/25 with diagnoses to include but limited to non-Alzheimer's dementia, hypertension, diabetes mellitus, type 2, and mood disorder. Resident#142's most recent MDS (Minimum Data Set) Quarterly Assessment with ARD (Assessment Reference Date) 1/7/26 was coded in Section C. Cognitive Pattern with a score of 4 out of 15 indicating resident was cognitively impaired with impaired safety awareness. Section GG. Functional Ability was coded for chair to bed to chair, sit to stand, roll side to side as requiring substantial to maximum assistance. On 2/10/26 at 2:30PM, the survey team conducted a sweep of the entire facility and there was no other unsecured oxygen tanks found in the facility. An inspection of the facility's oxygen storage area was conducted where all oxygen tanks were observed securely stored in stands and/or racks. On 2/10/26 at 4:55 PM, a meeting was conducted with the Administrator, Director of Nursing and Regional Director of Clinical Services to inform them of Immediate Jeopardy due to the observation of the oxygen cylinder tank stored unsecured in Resident #108 and #142's room on the [NAME] Unit. The risk of these unsecured tanks posed an imminent risk of safety for all residents, all visitors and all staff, which required immediate action by the facility. The potential exists that the oxygen e-tank could fall or be knocked over rupturing the valve which could cause a projectile hazard, fire and/or explosion risk. Unsecured oxygen tank(s) pose high risk for projectile hazards, fire and explosions to not only Resident #108 and Resident #142 but to all nearby residents. The e-tank was observed sitting on the floor, free standing in an upright position, not contained in a stand or holder which makes serious adverse outcome likely. The immediate jeopardy was determined to have started on 2/9/26. A review of the facility's policy #1901 Respiratory Care & Oxygen Equipment dated, 1/29/2024, read in part: paragraph entitled, Safety Guidelines: 3. When not in use, store oxygen cylinders securely, upright, in appropriate carts/holders. On 2/10/26, the Administrator submitted the facility's IJ (Immediate Jeopardy) Removal Plan. The IJ Removal Plan was reviewed by the survey team, sent to the State Agency for review and the IJ Removal Plan was accepted at 6:17 PM. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility's IJ Removal Plan read, Plan Corrective Action for those residents found to be affected by the deficient practice: Resident #108 and Resident #142 had no negative outcomes related to the deficient practice. The oxygen tank was properly secured onto the back of the wheelchair per policy after it was found free-standing. Corrective Actions taken for residents with potential to be affected by deficient practice: A sweep of all residents' rooms to ensure no free-standing oxygen tanks. All areas but not limited to activities room, therapy and dining rooms where residents may have oxygen. Systemic Changes put into place to ensure the deficient practice does not recur: The Interdisciplinary Team (Administrator, Director of Nursing, Assistant Director of Nursing, Director of Social Work, Dietary Manager, Business Office Manager, Director of Housekeeping and Laundry, Human Resources, and Unit Managers) will be educated by the Regional Director of Clinical Services on the facility's policy for proper storage of oxygen tanks being secured, upright and in appropriate carts/holder. All facility staff will be educated by the Director of Nursing or designee on the proper storage of oxygen tanks, to be upright and in appropriate holders. This training will be given to new facility staff prior to starting with the facility. Any member of staff who hasn't completed the education will be educated prior to the start of their next shift. The Administrator to conduct an ADHOC Quality Assurance Performance Improvement Meeting on 2/10/26 including Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Director of Social Work, Dietary Manager, Business Office Manager, Director of Housekeeping and Laundry Services and Unit Managers to review the policy of oxygen tanks. Completion of the removal plan 2/10/26 at 11:30AM. The Administrator made the Medical Director aware of the Immediate Jeopardy via telephone on 2/10/26 at 5:21PM. On 2/11/26, from 8:30AM to 9:35AM, the survey team validated the facility's removal plan to include interviews were conducted with multiple staff across varying departments related to the storage of oxygen. All staff interviewed confirmed they had received education on storage of oxygen tanks and were able to verbalize the proper storage of oxygen tanks to store oxygen tanks, upright and in appropriate carts/holders or racks. In addition to interviewing staff on receiving education on proper oxygen storage, education attendance records were reviewed and verified to confirm all staff working had received education. Rounds were conducted to verify no other oxygen tanks were observed unsecured. The immediate jeopardy (IJ) was determined to be removed effective 2/11/26 at 9:40 AM. The Administrator, Director of Nursing, [NAME] President of Operations and Regional Director of Clinical Services were made aware that the IJ Removal Plan was verified and IJ removed effective 9:40 AM. Following the removal of IJ, the scope and severity was lowered to a level two, isolated. 2. The facility was using a portable space heater as a primary source of heat in Resident #80 (R80) room (room [ROOM NUMBER]). (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R80's diagnoses included neuropathy, respiratory failure, and chronic kidney disease. The most recent MDS (minimum data set) was an annual dated 2/2/26 and indicated R80 was cognitively intact, was able to self-propel in wheelchair and self-transfer. On 2/10/2026 at 2:41 p.m. an interview was conducted with R80. During the interview it was noted that R80 was using a portable electric heater to heat the room. R80 verbalized the permanent heating system had not been working for months. The heater was located near the middle of the room away from combustible materials and directly plugged into an outlet (no extension cords). On 2/11/2026 at 4:37 p.m. the maintenance director was interviewed regarding the heating system in room [ROOM NUMBER] where R80 resided. The maintenance director explained that the facilities heating comes from a boiler system and a coil had busted in R80's room which resulted in water escaping. The heating unit had to be taken off-line and R80 refused to move out of the room, so a portable heater was put in place. The maintenance director verbalized to fix the problem, the heating system throughout the building would have to be shut down and due to the cold weather, it would not be a good time to work in one room that could have an impact on many rooms. The maintenance director verbalized uncertainty as to how long the heater had been down, saying that it probably has been down since October 2025 before the weather had gotten cold. The maintenance director was unable to provide any documentation regarding a work order or a quote for the repair of the heating system. Specification information for the heater was presented and indicated that the heater had an anti-tip over shut off mechanism. On 2/12/2026 at 5:10 p.m. the administrator and director of nursing (DON) was informed of the above finding. On 2/13/2026 at 9:22 a.m. the administrator was interviewed. The administrator verbalized that R80 had been relocated to another room and verbalized unawareness regarding the use of electric space heaters. The administrator went on to say that an HVAC (heating ventilation and air conditioning) company has been contacted for an estimate of repairs. No other information was presented prior to exiting on 2/13/2026.		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure proper fitting of a mattress and bed frame for one of forty-three residents in the survey sample (Resident #130) and failed to conduct regular inspections of all bed frames, mattresses and bed rails for identification of possible entrapment risks as part of the facility's maintenance program. The findings include: 1. Resident #130, with a recently installed mattress, had no prior inspection to identify possible entrapment risks and to ensure proper fit. The mattress was observed in use without appropriate adjustment of the bed frame to maintain proper mattress position. Resident #130 (R130) was admitted to the facility with diagnoses that included polyarthritis, chronic respiratory failure, diabetes, Crohn's disease, anemia, glaucoma, Asperger's syndrome, irritable bowel syndrome, obstructive sleep apnea, bipolar disorder and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed R130 as cognitively intact. On 2/10/26 at 4:14 p.m., R130 was observed in bed. The mattress was not centered on the bed frame and there was an approximately 5-inch gap between the bed frame edge and mattress on the left side (facing foot of bed). There were raised grab rails on both sides of the bed near the headboard. R130 stated he used to have a concave mattress but switched to a standard bariatric mattress about a month ago. R130 stated the current mattress had slipped over a little, was not centered on the bed and that he used the bed rails to move about in bed. On 2/11/26 at 3:30 p.m., the licensed practical nurse (LPN #11) unit manager caring for R130 was interviewed about the mattress/bed frame. The unit manager stated R130's current mattress was installed on 1/21/26. The unit manager stated R130 had a bariatric bed frame with a bariatric mattress. The unit manager stated she was not sure if maintenance had inspected the frame with the current mattress. On 2/11/26 at 4:24 p.m., accompanied by the maintenance director (other staff #7), R130's bed/mattress were observed. The bed frame had been adjusted with the previously observed gap eliminated. The maintenance director stated the bed frame width was adjustable with the frame edge held in place with spring-loaded pins. The maintenance director stated the frame looked as if someone had adjusted the frame width to match the mattress, but he was not sure who adjusted it. The maintenance director stated he had no record of installing or checking R130's current bed frame and mattress. The maintenance director stated if he was notified of the mattress change, he would have conducted an inspection to ensure proper fit and eliminate potential entrapment risks. On 2/12/26 at 2:13 p.m., the maintenance director (other staff #7) was interviewed again about any inspections for R130's newly installed mattress. The maintenance director stated nursing installed R130's mattress, did not inform maintenance prior to the installation and that the bed frame should have been adjusted to match the new mattress to eliminate gaps prior to use. 2. Facility staff failed to conduct regular inspections of all bed frames, mattresses and bed rails for identification of possible entrapment risks as part of the facility's maintenance program. On 2/12/26 at 2:13 p.m., the maintenance director (other staff #7) and administrator were interviewed about a maintenance program in the facility regarding bed frames, mattresses and bed rails to identify/minimize entrapments risks. The maintenance director stated the facility had an audit policy regarding beds, mattresses and rails but he had no evidence the program had been implemented. The administrator stated an outside vendor conducted an inspection of all facility beds on 8/11/25, but this was focused on electrical functioning and bed controls. The administrator stated the vendor inspection did not include inspection of bed frames, mattresses or rails. The administrator stated he had no evidence that the bed frame, mattress and bed rail checks for entrapment risks had been completed, and he did not know when these required inspections were last done. The administrator stated there had been no reported incidents of resident injury or entrapment related to the bed frames, mattresses or rails. The facility's policy titled Bed System Audits (dated 12/2018) (continued on next page)		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	documented, .Maintenance will conduct annually a full bed audit on each bed to identify and mitigate areas of risk for possible entrapment and bed safety. This audit will occur as scheduled in the electronic preventative maintenance electronic record (TELS) .The inspection will include the frame, the deck, the headboard, the footboard, the mattress, and any installed bed rails and/or assistive devices in order to .Assess for correct installation .identify and mitigate areas of risk for possible entrapment and/or bed safety .Identify gaps .Ensure a tight fit of mattress to the bed system .If appropriate, inspect for mattress compressibility [sic] .Annual bed audits will reference the FDA's Seven Zones of Entrapment, the dimensional criteria as established by the HBSW (Hospital Bed Safety Workgroup) guidelines and other areas of potential safety risk within the bed system .Maintenance will conduct an intermittent audit immediately upon notification by nursing of any individual change of a bed frame, assistive device, mattress, or bed rail .Bed will be assessed collaboratively with nursing . The facility's bed audit policies listed that all inspections were to be documented on logs that identified bed frame identification numbers, brand/make of bed/mattress, model numbers, date inspections were completed, pass/fail status of inspection and initials of person completing the inspection. These findings were reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 2/12/26 at 5:10 p.m. with no further information presented prior to the end of the survey.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on information obtained during the Resident Group interview, observations, staff interviews, and Resident Group meeting minutes, the facility staff failed to demonstrate their response, action and/or rationale regarding Resident Group concerns and requests. The findings included: On 02/11/26, at approximately 2:00 p.m., a Resident Group meeting was held with the President, and six Residents who attends the group meeting regularly. It was the consensus of seven out of seven residents, including the President, that they have been provided no feedback, updates, or outcomes regarding concerns or requests that were voiced during past group meetings. The President stated that the Activities Director, the facility designated staff person approved by the resident group, is responsible for aiding and responding to written requests that result from group meetings. The president went on to say that she was told, by the activity's director, that she could not take notes during the meeting and that she, the Activities Director, would take notes and forward the requests and concerns to the Administrator. On 02/11/26, at approximately 3:30 p.m. brief interview was conducted with the Administrator concerning the above. The Administrator stated he did receive meeting minutes, request and concerns from the Resident Council Group meetings from the Activities Director prior to her termination of employment approximately two weeks ago. The Administrator went on to say that he had not communicated or provided written outcomes, results or actions regarding the requests and concerns resulting from the Resident Group meetings to the Resident Council President or group. On 02/11/26, six months of Resident Council meeting minutes form were reviewed and revealed there were no entries/answers under the Administrative Resolutions, or Resolved from last meeting tabs on the form. On 2/12/26, at approximately 5:10 p.m., during the end of day meeting, the above concerns were addressed with the Administrator, Director of Nursing, and the Regional Nurse Consultant. No additional information was provided prior to exit.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on observations, interviews, record review and facility policy review, the facility failed to provide detailed and accurate notification regarding the ending of Medicare covered services for 3 out of 3 residents (Residents 93,155 and 200) reviewed. Findings included:A review of Resident #155's Notice of Medicare Non-Coverage and Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (ABN) dated 9/16/2025 and signed by Resident #155 on 9/12/2025, had the box for Daily Skilled Nursing Care check-marked indicating that service would end. An interview with Resident #155 was conducted on 2/11/2026 at 4:00pm. Resident #155 confirmed the signature on the ABN but could not remember the details. Resident #155 acknowledged that a staff member discussed ABN. However, neither document was fully understood by Resident #155.An interview was completed with the Discharge Planner (other #5) on 2/11/2026 at 4:14pm. The Discharge Planner confirmed Resident #155 was receiving Physical Therapy and Occupational Therapy that was to end however, the ABN was incorrectly check-marked indicating Daily Skilled Nursing Care would be ending. A review of Resident #93's Notice of Medicare Non-Coverage and Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (ABN) dated 12/25/2025 and signed by Resident #93 on 12/23/25, had boxes for Physical Therapy, Occupational Therapy and Daily Skilled Nursing Care all check-marked indicating those services would end. An interview with Resident #93 was conducted on 2/11/2026 at 3:37pm. Resident #93 confirmed the signature on the ABN but did not remember signing it. Resident #93 also acknowledged that a staff member reviewed the ABN. However, neither document was fully understood by Resident #93. An interview with the Discharge Planner (other #5) on 2/11/2026 at 4:14pm revealed that Resident #93 was receiving Speech Therapy prior to receiving the ABN. The Discharge Planner confirmed that the ABN had been marked incorrectly by including check marks in the 3 boxes marked Physical Therapy, Occupational Therapy and Daily Skilled Nursing Care. A review of discharged Resident #200's Notice of Medicare Non-Coverage and Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (ABN) dated 10/6/2025 and issued to resident #200's wife/POA, on 10/3/2025 at 2:30pm, had the box for Daily Skilled Nursing Care check-marked indicating that service would end. On 2/11/2026 at 5:02pm the Discharge Planner (other #5) discussed Resident #200's ABN information and confirmed that this resident had been receiving Physical Therapy prior to receiving the ABN form. The ABN had the Daily Skilled Nursing Care box check-marked, indicating that service would end. The Discharge Planner (other #5) acknowledged the Daily Skilled Nursing Care box was check-marked by mistake. The Discharge Planner (other #5) was interviewed on 2/11/2026 at 4:14pm. The Discharge Planner (other #5) stated that the ABN is reviewed with the residents or resident's responsible party, as well as the appeals process. The ABN lists the services that the resident has been receiving that will end, and a daily cost to continue services is included. The Discharge Planner (other #5) stated that the intent of the ABN is to make the resident aware of what specific services would be stopping so the resident can make an informed decision about their care. The Discharge Planner (other #5) also stated that the ABN had 4 boxes that could be marked, indicating which service would end. The boxes include Physical Therapy, Occupational Therapy, Daily Skilled Nursing Care and Other. The Discharge Planner (other #5) advised that the ABN is discussed in great detail with the resident however, there was no documentation listed on the ABN that included any details or examples of services that would be ending. The Discharge Planner (other #5) agreed that it was difficult to determine which specific services would stop based on what was marked on the ABN. An interview was conducted with the Director of Nursing (DON) at 5:31pm on 2/11/2026. The discussion reviewed the ABN process. The DON advised that she was not familiar with the process and did not know how it was done. On 2/12/2026 at 8:32am an interview with the facility Administrator was performed. The Administrator advised that the facility has a designated staff member that handles them. The Administrator explained the purpose is to notify the residents of Medicare services to end and why and that the resident can appeal. The (continued on next page)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident can choose to stay in the facility and continue to receive services and bill Medicare, the resident can receive services and pay out of pocket, or the resident can choose not to receive services.		

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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, family interview, staff interview, facility document review and clinical record review, the facility staff failed to provide a clean, homelike room environment for two of forty-three residents in the survey sample (Residents #130 and #165), failed to provide protections to prevent loss/theft of personal property for two of forty-three residents in the survey sample (Residents #6 and #69) and failed to process laundry timely for multiple residents on three of three units. The findings include:1. Facility staff failed to consistently provide a properly sized fitted sheet for Resident #130's bed as required in the resident's plan of care. Resident #130 (R130) was admitted to the facility with diagnoses that included polyarthritis, chronic respiratory failure, diabetes, Crohn's disease, anemia, glaucoma, Asperger's syndrome, irritable bowel syndrome, obstructive sleep apnea, bipolar disorder and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed R130 as cognitively intact. On 2/10/26 at 3:30 p.m., R130 was observed in bed. The fitted sheet on the bed did not cover the entire mattress with the left corner of the mattress exposed due to the ill-fitted sheet. R130 was interviewed at this time about the sheet. R130 stated he switched from a concave mattress to a standard bariatric mattress a few weeks ago and that the facility did not always have a properly sized sheet for the current mattress. R130 stated the current sheet was too small for the mattress and if the sheet was stretched to fit, the corner of the mattress would raise up. R130 stated he showered in the evenings and sheets were usually changed when he took a shower. R130 stated the orange trimmed sheets fit the mattress best and that many times these sheets were not available in the linen room. The resident demonstrated there was no orange trim on the current fitted sheet. On 2/11/26 at 3:50 p.m., accompanied by the licensed practical nurse unit manager (LPN #11) caring for R130, the linen supply on R130's unit was inspected. There was a supply of sheets, towels and washcloths in the room. There were two teal trimmed sheets, but no orange trimmed sheets available in the linen supply room. The unit manager stated R130 had expressed concerns to her a couple of times about sheets not available for his new mattress. On 2/11/26 at 4:30 p.m., R130 was in bed with a teal trimmed fitted sheet on the bed. The sheet covered the mattress but was tight and pulled at the corners. R130 stated the teal trimmed sheet did not fit. R130 stated that the orange trimmed sheet fit best and that staff reported that there were not many orange trimmed sheets available. On 2/12/26 at 8:18 a.m., the unit manager (LPN #11) was interviewed again about R130's sheet that did not cover the mattress. The unit manager stated she thought the sheet with the teal trim fitted the mattress and she did not know why a proper fitting sheet was not used on the bed. On 2/12/26 at 8:20 a.m., the certified nurse's aide (CNA #7) that routinely cared for R130 was interviewed. CNA #7 stated R130 was adamant that the fitted sheet got replaced at shower time. CNA #7 stated the teal or orange trimmed sheets fit R130's current mattress and that at times those sheets were not in the supply room. CNA #7 stated staff had access to the laundry area on all the shifts and that additional linen was available in clean laundry if not available in the linen room. CNA #7 stated she thought at times the aides waited until the actual shower time to find a sheet and if the sheets were not in the linen room, that whatever sheet was available was used without attempts to (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	get the correct sheet from laundry. CNA #7 stated she did not know why the correct size sheet was not on R130's bed. On 2/12/26 at 10:45 a.m., accompanied by the laundry supervisor (other staff #1), the clean laundry supply was observed. The laundry supervisor stated that the orange trimmed sheet best fit R130's mattress. The laundry supervisor stated there were approximately ten residents with that type of mattress in the facility and she had a supply of 24 orange trimmed sheets. The laundry supervisor stated that amount of inventory was adequate to ensure sheet availability for R130's bed. The laundry supervisor stated if proper sheets were not in the unit linen rooms, that staff had access around the clock to the clean linen area in laundry. R130's plan of care (revised 1/15/26) documented the resident has behaviors secondary to Asperger's and bipolar disorder that included refusal of care, hoarding items, cluttered room, refusal to have dirty linens changed and will only use bariatric sheets with orange thread. Interventions to minimize stress included assigning staff members that are familiar or preferred by the resident, if possible, assure the resident is safe if distressed and provide emotional support stuffies. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 2/12/26 at 5:10 p.m. with no further information presented prior to the end of the survey. 2. Housekeeping was not provided/maintained in Resident #165's room. Resident #165 (R165) was admitted to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease), mood disorder, chronic pain syndrome, major depressive disorder, anxiety, hypothyroidism and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed R165 with severely impaired cognitive skills. On 2/10/26 at 1:23 p.m., R165's room was observed with the resident in bed. Paint was scraped from the wall to the right of the window. Brown/tan colored drips and spatters were observed on the wall right of the room's window. Multiple paper trash items and candy wrappers were on the floor beside and under R165's bed. The wall behind the bed had multiple deep scrapes in the drywall. There was a missing section of drywall along the left side of the window. The floor in the room was dirty with black/gray color film visible across floor. Drips and footprints were visible on the floor around the bed, near the sink and in the bathroom. Black/brown specks were observed scattered on the wall to the right of the toilet. On 2/11/26 at 8:14 a.m., the floor in R165's room remained dirty with same spatters, footprints and black/gray film observed on the floor. The same splatters on the floor and wall were observed along with the same candy wrappers and paper trash seen on 2/10/26. A used Styrofoam cup was on the floor to the left side of the bed along with the top and a straw. On 2/11/25 at 9:56 a.m., R165's family member (other #8) was interviewed about housekeeping. The family member stated she visited R165 several days ago and picked up trash from the floor. The family member stated, Housekeeping could be better. On 2/11/26 at 4:30 p.m., the maintenance director (other staff #7) was interviewed about the missing drywall and wall damage in R165's room. The maintenance director stated he was not aware of the damaged walls, and no work order had been entered for the repairs. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/12/26 at 8:26 a.m., R165's room was observed again with the empty cup on the floor to the left of the bed. The floor remained dirty to the left of the resident's bed, near the sink and door with footprints visible. On 2/12/26 at 10:39 a.m., the housekeeping supervisor (other staff #1) was interviewed. The housekeeping supervisor stated that resident rooms and bathrooms were supposed to be cleaned each day and that cleaning included sweeping, mopping, cleaning toilets and emptying trash. The housekeeping supervisor stated she currently had adequate staffing to provide needed housekeeping. On 2/12/26 at 10:52 a.m., accompanied by the housekeeping supervisor, R165's room was observed. Regarding the dirty floor, the housekeeping supervisor stated the floor definitely needed cleaning and possible stripping/wax. The housekeeping supervisor observed the spatters around the toilet and in the floor around the resident's bed and stated, Yes. This needs cleaning. On 2/12/26 at 11:08 a.m., the housekeeper (other staff #4) on R165's unit was interviewed. The housekeeper stated resident rooms were supposed to be clean each day and that included sweeping, mopping and emptying trash. The housekeeper stated there recently had been a lot of room changes. The housekeeper stated room changes required a deep clean that was more thorough and time-consuming. The housekeeper stated if she had a lot of room changes, that she did not have time to get to all the rooms each day. The housekeeper stated she got to every room at least every other day. The housekeeper stated staff or residents notified her if extra cleaning was needed for a spill or accident. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 2/12/26 at 5:10 p.m. with no further information provided prior to the end of the survey. 3. Facility staff failed to implement interventions to protect Resident #69's personal property from loss during room changes. Resident #69 (R69) was admitted to the facility with diagnoses that included cerebral infarction, atherosclerotic heart disease, liver cirrhosis, peripheral vascular disease, dementia, anxiety, insomnia, seizures, urine retention and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated [DATE] assessed R65 with moderately impaired cognitive skills. On 2/10/26 at 3:50 p.m., R69 stated he had recently moved rooms, and his pictures and other personal items were lost during the room move. R69 stated he was most concerned about 14 laminated pictures of his kids/pets. R69 stated a grievance was entered about the items but he had never received a response and was not aware if anyone had searched and/or located his personal items. R69's clinical record documented room changes on 10/10/25 and 11/16/25. R69's clinical record documented no personal belongings inventory list upon or since admission. Two grievances were documented in the facility's tracking system for R69. R69 had a grievance concern entered on 12/16/25 regarding missing items following a room change on 11/16/25. This grievance form documented, Patient was moved from [room numbers] .When the patient was moved some of his belongings came up missing through the transfer. The patient is missing glasses, fingernail clippers and several pictures of his family This form documented no investigation, no findings and no actions taken in response to the report as the sections for these were blank. Another (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	grievance was entered on 1/8/26 regarding R69's missing items. This grievance documented, resident reports he is missing 2 hats and a small white fan from his last room move, missing multiple laminated pictures from last room move . This form documented no investigation, no finding and no actions taken regarding the missing items. On 2/11/26 at 8:25 a.m., the licensed practical nurse unit manager (LPN #11) caring for R69 was interviewed about the lost items. The unit manager stated she was aware that a grievance had been entered about the lost pictures, but she was not sure of the status. On 2/12/26 at 9:51 a.m., the administrator was interviewed about R69's missing items. The administrator stated the grievances were entered into the facility's tracking system and were supposed to be assigned to the appropriate department for follow up and/or search for missing items. The administrator stated that no response or actions had been taken regarding R69's missing items. On 2/12/26 at 11:04 a.m., the administrator stated the housekeeping supervisor should have been assigned to investigate and that no action had been taken. The administrator stated, We messed up. The administrator stated no department or staff person was assigned to investigate the two grievances filed by R69. On 2/12/26 at 11:44 a.m., the housekeeping supervisor (other staff #1) was interviewed about R69's reported missing items. The housekeeping supervisor stated when resident items came to the storage area, that items were entered on a log for tracking. The housekeeping supervisor stated there were no personal items entered on the log storage book for R69. The housekeeping supervisor stated R69 had at least one room move due to a pest issue and that personal items remained in the room for cleaning/treating. The housekeeping supervisor stated she did not know what happened to R69's personal items and that she was never assigned to investigate any grievances for this resident. On 2/12/26 at 4:17 p.m., the social services director (other staff #5) was interviewed about R69's missing personal items. The social services director stated R69's most recent room change (11/16/25) was due to a pest issue and personal items remained in the room for cleaning/treating. The social services director stated R69's personal items should have been returned to the resident after cleaning/treatment were completed. The social services director stated for standard room changes when cleaning/treatments are not required, personal items were moved with the resident at the time of the room change. The social services director stated she was not aware R69 was missing any items. The social services director stated, to account for personal items, the facility required completion of an inventory list upon admission and this list was updated if new items were acquired. On 2/12/26 at 4:24 p.m., the unit manager (LPN #11) caring for R69 was interviewed again about the reported missing items. The unit manager reviewed R69's clinical record and stated she found no personal item inventory list completed upon or since admission. The unit manager stated for the standard room move on 10/10/25, R69's personal items should have been moved with the resident. The unit manager stated the room move on 11/16/25 was due to a pest issue and R69's personal items remained in the room for a time for cleaning/treatment. The unit manager stated whoever deep cleaned R69's old room should have accounted for the personal items. The facility's policy titled Admitting a Patient (effective 1/29/24) documented, .Complete Resident Property List after advising the patient to send his/her valuables and money home. Contact the Business Office manager if the patient chooses to keep her/his valuables in the Business Office. Patient or responsible party sign the Resident Property List .Mark clothing and personal belongings with the patient's name . (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy titled Service Concerns/Grievances (effective 3/1/25) documented, .The Administrator is responsible for ensuring that the management staff are trained in appropriately resolving in-house patient/family service concerns and grievances at the point of service as promptly as possible. The management staff .is charged with listening and responding to questions, needs, problems, or concerns brought to their attention by patients and/or families .The Administrator serves as the grievance official of the Center and is responsible for overseeing the grievance process and for receiving and tracking to their conclusion . This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 2/12/26 at 5:10 p.m. with no further information provided prior to the end of the survey. 4. Resident #6 (R6) did not have an accurate or complete personal property invoice. Diagnoses for R6 included Cerebral infarction, congestive heart failure, peripheral vascular disease, and chronic sacral ulcer. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 12/17/2025. R6 was assessed with a cognitive score of 15 indicating cognitively intact. On 2/10/2026 at 1:03 p.m. an interview was conducted with R6. R6 verbalized that he had been missing a mirror that is used to shave with for about six months and it had been reported but nothing had been done. R6's property list was reviewed and did not specifically list a mirror but did list toiletries. The property list did not evidence R6's signature or a responsible party's signature (signature space was not filled in). The property list had no dates or signatures filled out when an item was added or taken off the list. On 2/13/2026 at 8:17 a.m. the director of nursing (DON) was interviewed regarding the above finding. The DON reviewed the list and verbalized that the personal property list should have been completed accurately. A policy titled Admitting a Patient read in part 4. Complete Resident Property List [.] Patient or responsible party sign the Resident Property List [SIC]. No other information was presented prior to exiting the facility on 2/13/26. 5. On 02/11/26, at approximately 2:00 p.m., a Resident Group meeting was held with the President, and six Residents who attends the group meeting regularly. It was the consensus of seven out of seven residents, including the President, that there has been problem with receiving personal clothing back timely from laundry. Residents went on to say that the laundry takes more than two weeks to be returned and is not returned in the order in which it was sent to laundry, stating that they have received clothing/personal items that are not theirs, or items that were just recently sent to laundry but have not received items that were sent two weeks prior. On 02/11/26 at approximately 4:00 p.m., during an evening tour of the laundry department, large amounts (approximately 25 bags) of mixed soiled facility and resident personal laundry were observed located in bags on the floor at the bottom of the laundry chute. There were approximately five rolling bins of soiled laundry waiting to be washed and folded. There were 2 tables piled high of clean facility (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	linen to be folded, and a long hanging rack, running the length of the back wall, of clean resident personal clothing items ready to be returned to the units. There were two of four dryers and two of four washers being used at the time of the tour. On 02/11/26, an interview was conducted with the Environmental Services (EVS) Director during the tour of the laundry department. When asked about the process regarding resident laundry and turnaround times, she stated three of four washers and three of four dyers are operable. She also stated that she has two full time laundry employees, and that as of 02/11/26, she would add one part-time laundry staff to work six hours in the evening, explaining that she has one part time position available. When discussing the residents' concerns regarding the time it takes to get their laundry back and the missing items, she stated that there are times when laundry gets backed up and that it has taken longer to get laundry processed. Also, if items are not labeled, they are added to the lost and found which also delays processing. She stated she takes the lost and found items up to the units once a month for residents to identify any possible missing items. When asked when the last time was, she had done this, she stated about two months ago. The EVS Director stated the goal is to have resident laundry/clothing laundered and returned within three days. On 2/12/26, at approximately 5:10 p.m., during the end of day meeting, the above concerns were addressed with the Administrator, Director of Nursing, and the Regional Nurse Consultant. No additional information was provided prior to exit.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews, facility document review and clinical record review, the facility staff failed to make prompt efforts to resolve grievances for two of forty-three residents in the survey sample (Residents #6 and #69) and make information of how to file a grievance available to seven out of seven residents in the resident council group meeting. The findings include: On 02/11/26, at approximately 2:00 p.m., a Resident Group meeting was held with the President, and six Residents who attends the group meeting regularly. It was the consensus of seven out of seven residents, including the President, that they did not know how to file a grievance or the process. On 02/11/26, at approximately 3:30 p.m. brief interview was conducted with the Administrator concerning the above. The Administrator stated the facility's grievance policy is available to the residents and that the process is explained on admission and often at meetings with the residents. The Administrator went on to say that the staff was trained in conflict resolution and how to assist residents with grievances. On 2/12/26, at approximately 5:10 p.m., during the end of day meeting, the above concerns were addressed with the Administrator, Director of Nursing, and the Regional Nurse Consultant. No additional information was provided prior to exit. 2. A grievance for Resident #6 (R6) missing mirror was not promptly resolved. Diagnoses for R6 included Cerebral infarction, congestive heart failure, peripheral vascular disease, and chronic sacral ulcer. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 12/17/2025. R6 was assessed with a cognitive score of 15 indicating cognitively intact. On 2/10/2026 at 1:03 p.m. an interview was conducted with R6. R6 verbalized that he had been missing a mirror that is used to shave with for about six months and it had been reported but nothing had been done. A grievance summary dated 9/2/2025 was obtained and indicated a missing Brown leather mirror fold up [sic]. The summary did not evidence any documentation under the headings of Resolved Date, Summary of Investigation, Summary of Findings, or Summary of Actions Taken. On 2/12/2026 at 3:20 p.m. the director of nursing (DON) was interviewed regarding missing mirror. The DON verbalized after a report of a missing item, the report is turned into a grievance and is filed. The grievance officer (the administrator) reviews grievance and emails the department that is responsible for investigating and concluding the grievance. The DON reviewed R6's grievance and verbalized it appears the grievance for the mirror was not assigned. On 2/12/2026 at 3:25 p.m. the administrator was interviewed. The administrator reviewed the grievance and verbalized that it wasn't processed. The facilities policy titled Service Concerns/Grievances read in part Center Nursing Staff, Social Work and Discharge Planners or any other team member receiving questions or issues of concern regarding care and/or services are to immediately respond at the point of service in an effort to (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	satisfactorily resolve issues of concerns. No other information was presented prior to exiting the facility on 2/13/26. 1. Facility staff failed to promptly respond to grievances entered by Resident #69 regarding missing personal items following room changes. Resident #69 (R69) was admitted to the facility with diagnoses that included cerebral infarction, atherosclerotic heart disease, liver cirrhosis, peripheral vascular disease, dementia, anxiety, insomnia, seizures, urine retention and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated [DATE] assessed R65 with moderately impaired cognitive skills. On 2/10/26 at 3:50 p.m., R69 stated he had recently moved rooms, and his pictures and other personal items were lost during the room move. R69 stated he was most concerned about 14 laminated pictures of his kids/pets. R69 stated grievances were entered about the items but he had never received a response and was not aware if anyone had searched and/or located his items. R69's clinical record documented room changes on 10/10/25 and 11/16/25. Two grievances were documented in the facility's tracking system for R69. R69 had a grievance entered on 12/16/25 regarding missing items following a room change on 11/16/25. This grievance form documented, Patient was moved from [room numbers] .When the patient was moved some of his belongings came up missing through the transfer. The patient is missing glasses, fingernail clippers and several pictures of his family This form documented no investigation, no findings and no actions taken in response to the report as these sections on the form were blank. Another grievance was entered on 1/8/26 regarding R69's missing items. This grievance documented, resident reports he is missing 2 hats and a small white fan from his last room move, missing multiple laminated pictures from last room move . This form documented no investigation, no findings and no actions taken regarding the grievance. On 2/11/26 at 8:25 a.m., the licensed practical nurse unit manager (LPN #11) caring for R69 was interviewed about the grievances entered. The unit manager stated she was aware that a grievance had been entered about the lost pictures, but she was not sure of the status. On 2/12/26 at 9:51 a.m., the administrator was interviewed about R69's missing items. The administrator stated the grievances were entered into the facility's tracking system and were supposed to be assigned to the appropriate department for investigation and follow up. The administrator stated that no response or actions had been taken regarding R69's grievances entered on 12/16/25 and 1/8/26. On 2/12/26 at 11:04 a.m., the administrator stated the housekeeping supervisor should have been assigned to investigate and that no action had been taken. The administrator stated, We messed up. The administrator stated no department or staff person had been assigned to investigate the two grievances filed by R69. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/12/26 at 11:44 a.m., the housekeeping supervisor (other staff #1) was interviewed about R69's reported missing items. The housekeeping supervisor stated she did not know what happened to R69's personal items and that she was never assigned to investigate any grievances for this resident. On 2/12/26 at 4:17 p.m., the social services director (other staff #5) was interviewed about R69's grievances about missing items. The social services director stated she was not aware R69 was missing any items or that grievances were filed for this resident. The facility's policy titled Service Concerns/Grievances (effective 3/1/25) documented, .The Administrator is responsible for ensuring that the management staff are trained in appropriately resolving in-house patient/family service concerns and grievances at the point of service as promptly as possible. The management staff .is charged with listening and responding to questions, needs, problems, or concerns brought to their attention by patients and/or families .The patient has the right to voice/file grievances/complaints (orally, in writing or anonymously) without fear of discrimination or reprisal. The Administrator serves as the grievance official of the Center and is responsible for overseeing the grievance process and for receiving and tracking to their conclusion .Center Nursing Staff, Social Work and Discharge Planners or any other team member receiving questions or issues of concern regarding care and/or services are to immediately respond at the point of service in an effort to satisfactorily resolve issues of concern .If an issue of concern cannot be immediately and satisfactorily resolved at the point of service, the management staff member will notify the patient/family member that the concern is being submitted to the appropriate department manager and that follow up for resolution will be provided as quickly as possible. The company Grievance form is to be promptly submitted by the staff member through the electronic system .The Administrator will follow up as needed with the patient/family regarding satisfactory resolution and will verify the final outcome in the electronic system under the resolution section of the grievance form . This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 2/12/26 at 5:10 p.m. with no further information provided prior to the end of the survey.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on staff interview and clinical record review, the facility staff failed to ensure dialysis communication logs were completed for one of 43 residents in a survey sample. The Findings Include: Resident #198 (R198) did not have dialysis communication logs completed over a ten-week period. R198 diagnoses include osteomyelitis, renal dialysis related to end stage renal failure, polyneuropathy, and dementia. The most recent MDS (minimum data set) was a discharge date d 11/17/25 and indicated R198 was cognitively intact. Review of R198's clinical record indicated dialysis was being provided three times a week (Tuesday, Thursday, and Saturday). Review of R198's dialysis communication logs indicated the log was last completed on 11/25/25 consecutively. After 11/25/25 there were two other communication entries dated 12/1/25 and 12/27/25. On 2/12/2026 at 840 a.m. the medical records director (MR director) was interviewed. The MR director verbalized that a dialysis packet is sent with the resident which includes a communication form which is to be filled out and returned to the facility and then scanned into the electronic record. On 2/12/2026 at 9:09 p.m. the MR director returned and verbalized medical records for R198 had been reviewed and found two other communication forms that had not been scanned into the medical record. The MR director indicated the missing communication logs were not found. On 2/12/2026 at 5:10 p.m. the above information was presented to the administrator and director of nursing (DON). On 2/13/2026 at 8:12 a.m. the DON was interviewed. The DON verbalized that the communication logs were reviewed and had not been completed and should have been. No other information was presented prior to exit conference on 2/13/2026.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interviews and facility document review, the facility staff failed to ensure medications used in the facility were labeled in accordance with currently accepted professional principles to include prescription labels and used within expiration dates for 2 of 3 medication storage rooms (West and South Units) and 4 of 9 medication carts (West, East and South Units). Findings included: On 2/12/26, medication storage rooms and medication carts were inspected, which revealed the following: Medication Storage Room [NAME] Unit Over the counter medications: 3 bottles of vitamin D3 - expiration dates 12/2025, 1/2025, 8/2025; 3 bottles Vitamin C - expiration date 12/2025; 1 bottle Calcium with Vitamin D3 - expiration date 11/2024; 2 bottles multivitamin - expiration date 8/2025[2 bottles Magnesium - expired 11/2025; 2 bottles Zinc - expired dates 8/25, one expired for 1/26 Lab collection tubes - seven purple top expiration date 12/31/25, ten blue top tubes expiration date 4/30/25 and six red top tubes expiration date 9/30/25 Under sink - caution tape, 1 bottle of neutral floor cleaner, a battery for mechanical lift, one gray bath basin and two glass flower vases Medication Storage Room South Unit Over-the-counter medications on shelf: one bottle of Tylenol expiration date 12/2025 Lab collection tubes - three purple top tubes with expiration date of 12/2025 A vial of injectable Haldol was observed on the shelf with over-the-counter medications - no name, no prescription (a high-potency medication used in the treatment of schizophrenia, Tourette's disorder and acute agitation which requires a prescription) Medication Refrigerator: one bottle of Aplisol opened 11/24/25 (a sterile diagnostic solution administered under the skin and used in detecting tuberculosis); two bags of intravenous Vancomycin (an antibiotic) with a used by date of 9/25/25 Medication Cart [NAME] Unit Middle Cart: Over-the-counter medications: one bottle of Vitamin C expired 12/25 One insulin (Lantus pen) opened 1/10/26, open date reveals insulin has been opened and unrefrigerated for thirty-three days after opening (Lantus has a special expiration date of 28 days after opening) Medication Cart [NAME] Unit Long Cart: One insulin pen (Lantus) dated 12/23/25, 51 days past special expiration date of 28 days after opening Medication Cart [NAME] Unit Cart for Room of 60's: Over-the-counter medications: CoQ10 expired 12/23 (an over-the-counter nutrient that acts like a vitamin to improve heart health, combat fatigue, reduce migraine frequency and help to reduce muscle aches caused by medications used to treat high cholesterol). Medication Cart East Unit Middle Cart: Over-the-counter medications: one bottle Geri-dryl expiration date 12/25 (an over-the-counter antihistamine used to temporarily relieve allergy symptoms), one package Mucus relief tablets (over-the-counter medication used to thin and loosen mucus in the airways) expiration date 12/25; one bottle magnesium oxide expiration date 7/25. Insulins: one pen Humulin open date 12/1/2025, one Lantus open date 11/1/2025, one Humulin R pen open date 10/1/2025. Observed a syringe with needle exposed on top of medication cart, interview with LPN#8 conducted and when asked what the exposed syringe was on top of cart she replied, Oh, yes, that is not acceptable, I left that there while I was putting other medications away, I need to discard this one and start over. Small drawer top right of medication cart revealed a variety of routes of medications stored without separation of route, without resident identifier or prescription label, expired medications and completed courses of antibiotics: eye drops dispensed 11/6/2025 and 10/20/2025 with directions to be administered in both eyes at bedtime; one vial of Erythromycin eye drops for seven days (per Unit Manager the resident had completed the antibiotic course), two vials of powdered prednisone expired 10/14//2025 and 5/2025 - no resident name; two vials of liquid Lidocaine - no name no date - one vial open and one not; Midodrine 10mg tablets (prescription medication used to treat symptomatic low blood pressure) in blistered packs (according to the Unit Manager, the nurse cuts medication blisters from the bingo card dispensed from pharmacy and sends with the resident to dialysis, tablets were without resident name or prescription label; 2 tablets in blistered packs no name, no prescription (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	label. On 2/12/2025 at 2:40PM, an interview was conducted with the DON (Director of Nursing) on her expectations on medication storage. According to the DON, she expects nurses to adhere to basic principles of medication storage to ensure medication rooms and carts are kept clean and multiple dose vials or bottles of medications are dated upon opening and administered within expiration dates and to discard any medications once the resident has completed course, or when the medication is either discontinued or expired. A review of the facility policy, Storage of Medications Policy #4. Read in part: Procedures: General Guidelines: I. 3. All medications dispensed by the pharmacy are stored in the pharmacy container with the pharmacy label. 4. Orally administered medications are stored separately from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, etc. Eye medications are stored separately according to the facility policy. 8. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medications disposal, and reordered from the pharmacy if a current order exists. General Guidelines: III. 3. Certain medications or package types, such as IV (fluids through the veins), multiple dose injectable vials, ophthalmic, nitroglycerin tablets, and blood sugar testing solutions and strips require an expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency. 6. The nurse will check the expiration date of each medication before administering it. 7. No expired medication will be administered to a resident. 8. All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining. On 2/12/2026, during the end of the day meeting with the Administrator, Director of Nursing Services, Regional Director of Clinical Services and Regional [NAME] President of Operations, an opportunity was offered to the facility staff to present additional information. No further information was provided regarding the above findings.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and facility document review, it was determined that the facility staff failed to maintain the main kitchen and one of the three unit pantries (West Unit) in a sanitary manner. The findings include: On 2/10/26 at 11:35AM, during the initial tour of the kitchen, a package of sliced ham was observed on top shelf, open and exposed to air/elements without an open date. The Assistant Dietary Manager who accompanied the surveyor on kitchen tour stated, They know better than that. The Dietary Manager arrived at 11:40AM and accompanied the surveyor on the rest of the kitchen tour. During inspection of the dishwasher area, two trays were observed with missing pieces of the corked surface and two trays noted with chipped edges. According to the Dietary Manager, I had not seen these before, I was not aware that this could be an issue. On 2/10/26, the Director of Nursing, [NAME] President of Operations and Regional Director of Clinical Service were informed of the above concerns. A review of the facility's Food Storage-Cold policy revealed, The Dining Services Director or designee ensures that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination. On 2/11/26 an inspection was completed of the facility's three-unit pantries. In the pantry refrigerator on the [NAME] Unit, a bag of frozen meatballs was observed in the freezer section open and exposed to air/elements without an open date or name. According to the Unit Manager (West Unit) she stated they would need to be discarded due to no open date or name. On 2/11/26, the Director of Nursing, [NAME] President of Operations and Regional Director of Clinical Service were informed of the findings in the unit pantries. A review of the facility's policy entitled Outside Food which revealed, Procedure: 2. The items must be labeled and dated with the patient's name, room number, and the use-by-date. 3. Food that is sealed in original manufacturer's packaging may be kept until manufacturer's expiration date. On 2/12/26, during the end of the day meeting with the Administrator, Director of Nursing Services, Regional Director of Clinical Services and Regional [NAME] President of Operations, an opportunity was offered to the facility staff to present additional information. They had no further comments regarding the above findings.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to maintain a performance improvement program that corrected previously identified concern regarding a clean, comfortable, homelike environment and ensure the availability of linen sufficient to provide daily care of residents. The facility's quality assurance and performance improvement program failed to ensure thd implementation of actions to improve and sustain regulatory compliance, which affected residents on three of three units. The findings included:On 4/13/26, upon surveyor entry to the facility, observations were conducted on each of the three resident units. The facility was found to be unclear, floors severely soiled, rooms overcrowded, and there was a lack of adequate linen. On 4/13/26, observations of Residents #101, #103, #107, and #114's rooms on 3 different units were noted to be 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. 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.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 themselves 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 appeared 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.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. 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.On 4/13/26 at 1:15 PM, an interview was conducted with a housekeeper. The housekeeper reported she was the only housekeeper for the entire facility working that day, as two others had not reported for their assigned shift. The housekeeper went on to report that her manager was having to work in the laundry department. When asked about the cleaning of resident rooms, the housekeeper reported every resident room was to be cleaned daily. When asked if that happens, the housekeeper said, No. Since I've been put over here, I've been trying to get these rooms cleaned, sometimes I don't even get to the rooms on the long hall. The housekeeper went on to report that the rooms are actually cleaned every three to four days or once a week. On 4/13/26, in the afternoon, a resident's family member was observed sweeping the room. The resident in the hallway reported that was his roommate's family member and reported he had been a resident of the facility for seven weeks and had not seen any housekeeping staff clean his room since his arrival.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. Bags of soiled clothing were noted in a corner where the laundry chute was (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and the bags were piled to the bottom of the chute which was halfway up the wall. Resident's personal clothing was observed piled on top of several 55-gallon trash cans and large capacity bins that were piled within inches of the ceiling. Soiled linens were piled on top of 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. Multiple bin containers were overflowing, and excessive numbers of bags of wet laundry were noted piled on the floor in front of the laundry room doors as high as halfway 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 it sits down there becomes molded and it's thrown away. On 4/14/26 in the early afternoon, an interview was conducted with Resident #119, who reported he had clothes he had sent to laundry over a month ago that hasn't been returned. He further reported that he had just received notification that they [the facility] was going to reimburse him for some missing clothing items and pointed to a form lying on his over bed table. Resident #119 went to say, I just want my clothes. 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, 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 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. The surveyor's shoe stuck to the floor in places to the point that as she stepped her foot came out of the shoe and the shoe remained stuck to the floor. During a prior survey conducted by the state survey agency from 2/10/26-2/13/26, similar concerns were identified. The facility alleged in their plan of correction for the citation that . DON [director of nursing] or designee will educate staff to ensure residents' rooms are clean, free of trash on the floors, and liners in trash cans. DON or designee will audit new admissions 5x a week for 8 weeks to ensure the resident property list has been completed in its entirety. DON or designee will audit residents with bariatric fitted sheets 2x a week for 8 weeks to ensure correct fitting sheets in place. DON or designee will audit 10 rooms a week for 8 weeks to ensure room cleanliness. The facility alleged they had corrected the issues and would be in compliance with the regulatory requirement as of 3/19/26. The facility's Quality Assurance and Performance Improvement Plan dated January 1, 2026, was received and reviewed. The document read in part, . iii. QAPI efforts. Effective performance improvement efforts will focus on the development, maintenance and periodic improvement of systems that influence organizational outcomes. Systems will be designed and modified to achieve reliable and efficient outcomes. Feedback systems may include but are not limited to the following: . resident (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	council meetings,. regulatory surveys, grievance/service concern logs. e. PIP [performance improvement program] Team Reporting Process. 1. The PIP team will meet daily, weekly, and quarterly as needed. IV. Systematic Analysis and Systemic Action: The facility leadership will be responsible for assessing the outcome and impact of changes implemented. Leadership should ask questions such as 'Have the revisions or changes had a positive impact on resident outcomes?' or 'Have the revisions or changes improved the residents' quality of life?'. On 4/14/26 at 4:23 PM, an interview was conducted with the facility's administrator. The administrator was asked to explain the purpose and role of the quality assurance program and performance improvement (QAPI). The administrator said, quality assurance and performance improvement, we look at metrics in each department and how to improve things. With QAPI, we also go over survey tags [instances of cited deficient practice], what plan of correction we are going to be going over and metrics for that. The administrator was asked specifically about things such as cleanliness, laundry, linens, personal laundry, and the general living environment within the facility which are all quality of life items for residents. The administrator went on to state, Those are things we have been working on and tackling. We are making sure we are staffing appropriately, we have been actively hiring and posting, it [housekeeping and laundry] are an outsourced entity, they are trying to hire but because this is a rural area we are working on retaining people. When asked, the administrator confirmed they have used agency staffing to support their laundry and housekeeping departments but are currently not utilizing those services. The administrator was asked when the last time he visited the laundry department was. The administrator reported he has been to the laundry department last Friday [4/10/26]. When asked if he had concerns, the administrator said, no, not any big concerns. We had an evening laundry person because we identified that our laundry was not to capacity. He went on to say, we have been down there, and our team stays down there and hits it and gets it knocked out. When asked if he had laundry staff working over the weekend of 4/11/26-4/12/26, the administrator said, I don't know, I will have to look at the schedule. During the above interview with the facility administrator, the observations of the laundry department on the afternoon/evening of 4/13/26 were discussed. The mounds of laundry that was stacked within inches of the ceiling was discussed along with resident complaints. The observations within the facility regarding the lack of cleaning, the rooms being filthy, hallways with black marks throughout and the dining room were all reviewed. The administrator stated that in the past when they had linen issues, they ordered more linen. When the discussion about only have one housekeeper on 4/13/26 and the housekeeping/laundry supervisor being the only employee working in laundry on 4/13/26 was shared, the administrator stated that there is more money in the budget and if needed, we will use overtime or use agency to come in and get the work done. We aren't pulling housekeepers to get the laundry done, we get someone in. It was explained that those things are not happening because there is a lack of cleanliness observed throughout the entire facility, residents are complaining about the lack of linen and personal clothes not being returned and the survey team has confirmed those allegations. The administrator said, I am doing my best to get involved with the residents and talk to them daily. On 4/15/26, at 4:44 PM an end of day debriefing was conducted with the administrator, director of nursing, regional director of clinical services and regional vice president of operations were notified of the concerns of hoarding, unsafe, and unclean areas, as well as the mounds of resident personal laundry and linen in the laundry department waiting to be laundered. The RVPO confirmed that the contracted agency for housekeeping and laundry, was having their contract terminated. The survey team shared the concern about the lack of an effective QAPI program with sustainable outcomes. No further information was provided.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interviews, and staff interviews, the facility failed to ensure a heater was functioning for one of forty-three residents and failed to maintain essential equipment for one of four washers and one of four dryers in the laundry area. The findings included: 1. Resident #80 (R80) did not have a proper standard functioning heating system and relied on a portable heater. On 2/10/2026 at 2:41 p.m. an interview was conducted with R80. During the interview it was noted that R80 was using a portable electric heater to heat the room. R80 verbalized the permanent heating system had not been working for months. On 2/11/2026 at 4:37 p.m. the maintenance director was interviewed regarding the heating system in room [ROOM NUMBER] where R80 resided. The maintenance director explained that the facilities heating comes from a boiler system and a coil had busted in R80's room which resulted in water escaping. The heating unit had to be taken off-line and R80 refused to move out of the room, so a portable heater was put in place. The maintenance director verbalized to fix the problem, the heating system throughout the building would have to be shut down and due to the cold weather, it would not be a good time to work on one room that could have an impact on many rooms. The maintenance director verbalized uncertainty as to how long the heater had been down, saying that it probably has been down since October 2025 before the weather had gotten cold. The maintenance director was unable to provide any documentation regarding a work order or a quote for the repair of the heating system. On 2/12/2026 at 5:10 p.m. the administrator and director of nursing (DON) was informed of the above finding. On 2/13/2026 at 9:22 a.m. the administrator was interviewed. The administrator verbalized that R80 had been relocated to another room, and an HVAC company has been contacted for an estimate of repairs. No other information was presented prior to exiting on 2/13/2026. On 02/11/26 at approximately 4:00 p.m., during an evening tour of the laundry department, large amounts (approximately 25 bags) of mixed soiled facility and resident personal laundry were observed located in bags on the floor at the bottom of the laundry chute. There were approximately five rolling bins of soiled laundry waiting to be washed and folded. There were 2 tables piled high of clean facility linen to be folded, and a long hanging rack, running the length of the back wall, of clean resident personal clothing items ready to be returned to the units. There were two of four dryers going and two of four washers. On 02/11/26, an interview was conducted with the Environmental Services (EVS) Director during the tour of the laundry department. When asked about the process regarding resident laundry and turn around times, she stated three of four washing machines and three of four dryers are operable stating that the washer was recently repaired but recently broke again. (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 2/12/26, at approximately 5:10 p.m., during the end of day meeting, the above concerns were addressed with the Administrator, Director of Nursing, and the Regional Nurse Consultant. No additional information was provided prior to exit. On 2/12/26, at approximately 11:30 a.m. The maintenance director verbalized that the one broken washer in the laundry area had been repaired but it needs a part that they have not been able to obtain and that they are in the process of looking for a replacement part. When asked about the malfunctioning dryer. The maintenance director states that the dryer works, it just takes longer than the other three to heat taking longer to dry items, so it is utilized last. The maintenance director was unable to provide any documentation regarding a work order regarding the washer. On 2/12/2026 at 5:10 p.m. the administrator and director of nursing (DON) was informed of the above finding. No other information was presented prior to exit.		

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

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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 02/13/2026
NAME OF PROVIDER OR SUPPLIER Harrisonburg Hlth & Rehab Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 1225 Reservoir Street Harrisonburg, VA 22801	
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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. Based on observation, and staff interview, the facility staff failed to maintain a clean and sanitary environment for nine of 89 resident rooms (rooms #86, #26, #19, #12, #6, #5, #3, #41, and #34), six of 89 resident room bathrooms (resident room bathrooms #84, #27, #8, #5, and #35, and #34), and two of three units (the South unit and East unit). The findings include: On 7/15/26 at 8:55 a.m., an observation of the facility was conducted. Layers of sticky dirt and dust were observed in the vents of the heating/air conditioning units in rooms #86, #26, #19, #12, #6, #5, #3, #41, and #34, in the ceiling air vents in the resident room bathrooms #84, #27, #8, #5, and #35, and #34, and in the ceiling air vents at the South unit nurse's station, and on the East unit short hall and the East unit long hall. On 7/15/26 at approximately 3:35 p.m., an interview was conducted with the Director of Maintenance. The Director of Maintenance stated the maintenance staff typically clean the vents of the heating/air conditioning units in the resident rooms and the ceiling air vents in the resident bathrooms once a month and clean the ceiling air vents on the halls every three months. The Director of MaintBased on observation, and staff interview, the facility staff failed to maintain a clean and sanitary environment for nine of 89 resident rooms (rooms #86, #26, #19, #12, #6, #5, #3, #41, and #34), six of 89 resident room bathrooms (resident room bathrooms #84, #27, #8, #5, and #35, and #34), and two of three units (the South unit and East unit). The findings include: On 7/15/26 at 8:55 a.m., an observation of the facility was conducted. Layers of sticky dirt and dust were observed in the vents of the heating/air conditioning units in rooms #86, #26, #19, #12, #6, #5, #3, #41, and #34, in the ceiling air vents in the resident room bathrooms #84, #27, #8, #5, and #35, and #34, and in the ceiling air vents at the South unit nurse's station, and on the East unit short hall and the East unit long hall. On 7/15/26 at approximately 3:35 p.m., an interview was conducted with the Director of Maintenance. The Director of Maintenance stated the maintenance staff typically clean the vents of the heating/air conditioning units in the resident rooms and the ceiling air vents in the resident bathrooms once a month and clean the ceiling air vents on the halls every three months. The Director of Maintenance stated the staff had got behind on cleaning the vents due to other environmental projects. The Director of Maintenance stated that due to those other environmental projects, there has been a lot of sanding in the facility lately and this clogs up the vents so the maintenance staff would probably have to increase their cleaning schedules. On 7/15/26 at 4:58 p.m., the Administrator and Director of Nursing were made aware of the above concern. The facility did not provide a policy regarding a clean and sanitary environment. No further information was provided prior to exit. enance stated the staff had got behind on cleaning the vents due to other environmental projects. The Director of Maintenance stated that due to those other environmental projects, there has been a lot of sanding in the facility lately and this clogs up the vents so the maintenance staff would probably have to increase their cleaning schedules. On 7/15/26 at 4:58 p.m., the Administrator and Director of Nursing were made aware of the above concern. The facility did not provide a policy regarding a clean and sanitary environment. No further information was provided prior to exit.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **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 assess one of forty-three residents for safe self-administration of medication (Resident #44). The findings include: Resident #44, with a self-managed insulin pump, had no assessment for self-administration of medication. Resident #44 (R44) was admitted to the facility with diagnoses that included hip fracture, diabetes, anemia, osteoporosis, hypothyroidism, cerebral infarction, major depressive disorder and asthma. The minimum data set (MDS) dated [DATE] assessed R44 as cognitively intact. On 2/10/26 at 1:49 p.m., R44 was interviewed about medication administration, including insulin. R44 stated she had an insulin pump for management of diabetes that provided insulin and monitoring of blood sugar levels. R44 stated she had the insulin pump prior to admission to the facility, had managed the pump/insulin without difficulty for years and that her family member provided supplies as needed. R44's clinical record documented a physician order dated 12/30/25 for a Lispro insulin pump with instructions stating, Resident manages pump. The record included a physician's order dated 12/30/25 for Dexcom to be changed every 10 days with instructions stating, Family will provide. R44's plan of care (revised 1/14/26) included no problems, goals and/or interventions regarding self-administration of medications. R44's medication administration record for January 2026 documented the Dexcom was changed every 10 days and blood sugar readings before meals and at bedtime but made no mention of administration of Lispro insulin via the insulin pump. On 2/11/26 at 3:26 p.m., the licensed practical nurse unit manager (LPN #11) caring for R44 was interviewed. The unit manager stated R44 had orders for the insulin pump, but she was not sure that an assessment for self-administration had been done. On 2/12/26 at 8:16 a.m., the unit manager stated she reviewed R44's clinical record and found no record of an assessment for self-administration of the insulin and/or insulin pump. The facility's policy titled Self-Administration of Medication at Bedside (effective 1/29/24) documented, A licensed nurse will assess patient's ability to self-administer medication. Complete Medication Self-Administration Safety Screen assessment. The Interdisciplinary Team will review the assessment and together, use clinical judgement to determine if the patient is eligible. If eligible, medications that are ordered by a provider to be self-administered will be identified in the medical record. A licensed nurse will monitor and chart self-administered medications and will monitor for proper storage on each medication pass. The Medication Self-Administration Safety Screen assessment will be reviewed quarterly by the Interdisciplinary Team. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 2/12/26 at 5:10 p.m. with no further information provided prior to the end of the survey.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **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 protect the resident's right to be free from verbal abuse by a staff member for one of forty-three residents in the survey sample (Resident #44).The findings include:In response to a request for assistance with the bedpan, a certified nurse's aide (CNA #8) yelled at Resident #44, told R44 to change her own brief and provided rushed assistance with bedpan placement. Resident #44 (R44) was admitted to the facility with diagnoses that included hip fracture, diabetes, anemia, osteoporosis, hypothyroidism, cerebral infarction, major depressive disorder and asthma. The minimum data set (MDS) dated [DATE] assessed R44 as cognitively intact.On 2/10/26 at 1:36 p.m., R44 was interviewed about quality of life/care in the facility. When asked about any concerns with abuse, R44 stated she recently reported an issue with a CNA and that the facility had addressed the incident. R44 stated late one evening after asking for assistance, an aide pointed her finger and said, We're not doing this tonight. R44 stated voices raised high and the conversation got heated. R44 stated she did not remember what all was said but that she talked with the head nurse about the incident. R44 stated when she asked for help with the bedpan, this CNA threw a clean brief toward her that landed on her legs and the CNA told her to do it yourself. R44 stated when this aide assisted with the bedpan, she felt rushed when getting off the pan. R44 stated she had pain in her hip when she moved a certain way, and this CNA did not allow her to get off the bedpan at her own pace. R44 stated she thought the aide was agency, that nursing backed her about the incident and she had not seen the CNA since the incident. R44 stated she was upset by the way the CNA treated her, felt the facility responded and she was ok following the incident. R44 stated she had never reported anyone before but was glad that she reported the incident. R44 stated she had experienced no problems with any other staff members and had no prior incidents with this CNA. R44 stated she did not remember the date but that she talked with the head nurse about the incident the next morning after it happened.A report was sent to the state agency on 1/27/26 documented that R44 reported verbal abuse during incontinence care that occurred on 1/26/26 by a staff member identified as CNA #8. This report documented that CNA #8 was suspended pending investigation and that notifications of the incident were made to the physician, responsible party, adult protective services, department of health professions and law enforcement. The facility's investigation documented an interview with R44 by the director of nursing (DON) on 1/27/26. This interview documented R44's report of the incident as, I am having issues with my leg. I had to go to the bathroom, she put me on the bedpan, and did not let me help. She put her finger in my face and said, 'we are not having this tonight.' She [CNA #8] rolled me back over, threw the brief, and stated, 'you can do it yourself.' She [CNA #8] yelled at me because I was upset that she would not let me assist in turning myself. The facility's investigation included an interview with R44's roommate (Resident #28) dated 1/27/26. This interview documented that the roommate (R28) saw CNA #8 throw the incontinence brief toward R44 and heard CNA #8 yell at the resident to change the brief herself. The roommate's interview documented that R28 described CNA #8 as not professional and acting with an attitude. A written statement by CNA #8 about the incident documented that the resident was lying and documented refusal to provide any other statements about the incident. Statements obtained from other residents cared for by CNA #8 documented no issues or concerns with improper treatment by any staff members. The facility assessed the roommate (R28) on 1/8/26 as cognitively intact.A skin assessment for R44 was documented on 1/27/26 listing the resident's skin was warm and dry with no impairments noted other than a left hip surgical incision. This assessment documented the resident had no pain, no signs of infection with no identified concerns with the condition of the incision or skin in general.The nurse practitioner (NP) assessed R44 on 1/27/26, 1/29/26, 1/30/26, (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/4/26 and 2/9/26 with no concerns documented resulting from the reported mistreatment by CNA #8. R44 was assessed by psychiatry on 2/4/26 with the resident reporting no concerns about abuse/neglect. Psychiatry documented the resident was oriented with appropriate/cooperative attitude and no signs of psychological distress. The psychiatrist ordered the resident's dose of the antidepressant medication Wellbutrin decreased from 300 mg (milligrams) per day to 150 mg per day. A social services note dated 2/9/26 documented follow up with R44 about the reported incident with CNA #8. This note documented the resident stated she was doing okay, that she had talked with her sister about the incident and that she had shared her experience with some staff members. The social services director documented the resident requested no additional support services and that further support was available if needed. On 2/11/26 at 3:22 p.m., the licensed practical nurse unit manager (LPN #11) caring for R44 was interviewed about the reported verbal abuse by CNA #8. The unit manager stated the incident was reported on 1/27/26, that CNA #8 was suspended and had since been terminated. The unit manager stated R44 reported that she asked for assistance with the bedpan, that CNA #8 got upset and words were exchanged. The unit manager stated she had talked with R44 following the incident, explained the investigation/protocol and that R44 stated she was pleased with the outcome/response. The unit manager stated there had been no prior reports of concerns with CNA #8. On 2/11/26 at 4:47 p.m., the administrator was interviewed about the abuse incident with R44 and CNA #8. The administrator stated, We substantiated verbal abuse. The administrator stated CNA #8 was suspended at the time the incident was reported. The administrator stated the abuse was substantiated based on the investigation that included R44's statement and statements from R44's roommate (R28). The administrator stated R28 (R44's roommate) witnessed CNA #8 throw the incontinence brief at the resident and tell the resident to change the brief herself. The administrator stated R44 was assessed following the incident, had follow up by social services and had voiced no further concerns. The administrator stated a plan of correction was initiated in response to the incident and monitoring was ongoing. On 2/11/26 at 5:13 p.m., R44 was interviewed again about the abuse incident with CNA #8. R44 stated she was fine following the incident. R44 stated she did not like getting treated like that but was glad the facility took care of it. R44 stated she had experienced no issues with staff prior to or since this incident and that she knew she could report any concerns to nursing. R44 stated she had seen psychiatry since the incident and said, They have cut my antidepressant in half and that so far, she was doing well with that adjustment. On 2/11/26 at 5:13 p.m., the DON was interviewed about R44's incident of reported verbal abuse. The DON stated R44 reported on 1/27/26 that the CNA on the evening of 1/26/26 told her to change her own incontinence brief, that the CNA would not let her do the bedpan as she liked. The DON stated that R44 usually assisted with getting on/off the bedpan and reported that the CNA wanted to do it. The DON stated R44 stated that she got frustrated with the CNA and that the CNA hollered back, shook her finger at her, threw a brief on the bed and told the resident to change the brief herself. The DON stated CNA #8 was identified as the aide involved in the incident. The DON stated that CNA #8 was immediately suspended, the incident was reported to the state agency and other required agencies and an investigation was started. The DON stated the resident's roommate (R28) witnessed CNA #8 get loud with the resident and saw CNA #8 shake her finger and tell R44 to change her own brief. The DON stated CNA #8 was terminated and reported to the department of health professions. The DON stated a plan of correction was initiated regarding the identified verbal abuse. The DON stated CNA #8 was an agency staff member and there had been no prior complaints from residents or staff about CNA #8. The DON stated CNA #8 had received the required education about abuse prevention and a criminal background check prior to working in the facility. Required abuse education and criminal background checks for CNA #8 were requested and reviewed. In-serviced education was documented for CNA #8 on 10/26/25 that included abuse prevention/policies, neglect, timely call bell response, timely incontinence care, psychosocial well-being and resident rights. The objectives of this training were documented as, The facility staff will ensure that all residents are free from abuse/neglect. Call (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bells will be answered timely and incontinence care provided timely. Resident's psychosocial wellbeing and resident rights will be upheld. The facility's abuse prevention policies were included in this training with CNA #8 listed as passing a post-test regarding abuse prevention/policies. Criminal background checks for CNA #8 were completed on 10/27/25 and documented no findings from checks conducted through the state police website and a national sex offender registry. The facility's policy titled Abuse/Neglect/Misappropriation/Crime (effective 10/17/23) documented, .There is a zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center .Patients of the Center have the legal right to be free from verbal, sexual, mental, and physical abuse, corporal punishment, involuntary seclusion including abuse facilitated or enabled through the use of technology . This policy defined verbal abuse as, .Threats of harm, saying things to intentionally frighten a patient. Statements made to a patient which result in ridicule or humiliation of the patient .Any use of oral, written, or gestured language that includes cursing, disparaging and derogatory terms to other patients or visitors within hearing range, to describe patients, regardless of their age, ability to comprehend or disability .The facility presented the following plan of correction for abuse initiated on 2/3/26 in response to this incident.1. The facility reported an allegation of abuse on 1/27/26 between a resident (R44) and a CNA (CNA #8). The CNA's license was reported to DHP (department of health professions), and the employee was suspended pending investigation. On 2/3/26, the facility substantiated the allegation of abuse and the CNA was terminated. 2. All residents with BIMS (brief interview for mental status) of 13 or higher were interviewed to ensure no forms of abuse had taken place. All residents with a BIMS of 12 or below had skin assessments completed to ensure no injuries of unknown origin.3.The DON or designee will educate staff on the abuse policy, to include verbal abuse, and professionalism in the workplace.4.The DON or designee will audit 5 residents daily five times per week for 4 weeks, then 3 residents three times a week for 4 weeks to ensure residents are free from abuse and professionalism in the workplace is being maintained. The DON or designee will audit 5 resident skin assessments five times a week for 4 weeks, then 3 resident skin assessments three times a week for 4 weeks to ensure no injuries of unknown origin.5. Date of compliance: 2/12/26.The surveyor verified that the abuse incident involving CNA #8 was reported to the state agency, department of health professions, adult protective services in addition to the physician and responsible party. Interviews with residents with BIMS of 13 or higher were documented and included responses to questions: Has a staff member mistreated you since you have been a resident here .Have you seen or heard any resident here being abuses or mistreated .If yes, did you tell anyone what happened; what was their response .Do you feel the staff acted professionally when providing care? Interviews were documented as completed on 2/5/26 and 2/9/25 and indicated no abuse and positive results for professionalism. Education for all staff was documented on 2/3/26 regarding the facility's abuse prevention policies. Multiple staff members on each unit were interviewed on 2/13/26 regarding the education. All staff members interviewed verified education had been completed and were able to voice abuse prevention/reporting protocols. Skin audits were documented as completed by 2/11/26 on a checklist for residents with BIMS scores of 12 or below with no injuries of unknown origin identified. The DON conducted five resident interviews on 2/13/26 regarding abuse/professionalism as part of the monitoring plan with no indications of abuse or lack of professionalism noted. The survey team deemed the plan of correction implemented as listed with monitoring ongoing.Resident interviews, family interviews, a resident council interview, staff interviews and record reviews conducted during the current standard survey revealed no further allegations/incidents of abuse since R44's incident or prior to the survey exit on 2/13/26. This deficiency was cited as past non-compliance with correction date of 2/12/26.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident/staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide an accurate MDS (minimum data set) assessment for one of 37 residents in the survey sample, Resident #233. The findings include: The facility staff failed to complete an accurate MDS (minimum data set), an annual assessment for Resident #233. Resident #233 (R233) was admitted to the facility on [DATE] with diagnosis that included but were not limited to idiopathic neuropathy, left toe amputation and depression. The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 3/11/26, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is oriented to person, place and time and has unimpaired immediate recall. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring supervision for locomotion/transfer/dressing/toileting, hygiene and eating. Section J-health conditions: J1300. Current Tobacco Use-coded as no. A review of the comprehensive care plan dated 4/14/25 revealed, FOCUS: Resident prefers to smoke cigarettes. INTERVENTIONS: Educate on facility smoking policy. OT (occupational therapy) referral as needed. Smoking assessment as needed. A review of the smoking safety screen for R233 dated 1/29/26 revealed, Does the resident smoke? Coded R233 ?yes'. Observations on 6/8/26 at approximately 11:40 AM and 6/9/26 at 10:00 AM revealed, R233 smoking outside off facility property. An interview was conducted on 6/9/26 at 10:05 AM with R233. Asked how frequently he smokes, R233 stated, probably eight to ten times a day. Asked has he smoked since admission, R233 stated, oh yes, have been smoking for over thirty years. On 6/10/26 at 10:25 AM with the MDS coordinator. Asked to review R233's 3/11/26 annual assessment, Section J1300, the MDS coordinator stated, this is coded incorrectly by an agency person that was working here. The MDS will be revised today. On 6/10/26 at 1:55 PM, the Administrator, Director of Nursing, Regional Director of Clinical Services and the Regional Director of Operations were made aware of the findings. According to the RAI (resident assessment instrument) MDS Section J1300: Current Tobacco Use. Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period. No further information was provided prior to exit.		

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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 resident interview, staff interview, facility document review and clinical record review, the facility staff to develop a comprehensive care plan for two of forty-three residents in the survey sample (Residents #44 and #198). The findings include:1. Resident #44 had no plan of care developed regarding self-administration of insulin and self-management of an insulin pump. Resident #44 (R44) was admitted to the facility with diagnoses that included hip fracture, diabetes, anemia, osteoporosis, hypothyroidism, cerebral infarction, major depressive disorder and asthma. The minimum data set (MDS) dated [DATE] assessed R44 as cognitively intact. On 2/10/26 at 1:49 p.m., R44 was interviewed about medication administration, including insulin. R44 stated she had an insulin pump for management of diabetes that provided insulin and monitoring of blood sugar levels. R44 stated she had the insulin pump prior to admission to the facility, had managed the pump/insulin without difficulty for years and that a family member provided supplies as needed. R44's clinical record documented a physician order dated 12/30/25 for a Lispro insulin pump with instructions stating, Resident manages pump. The record included a physician's order dated 12/30/25 for Dexcom to be changed every 10 days with instructions stating, Family will provide. R44's plan of care (revised 1/14/26) included no problems, goals and/or interventions regarding self-administration of insulin or management of an insulin pump. The care plan documented that the resident was at risk of complications and blood sugar fluctuations related to diabetes. Interventions to prevent complications included insulin as ordered by the physician. The care plan made included no interventions referencing use of the insulin pump or management of the Dexcom monitoring device. On 2/11/26 at 3:26 p.m., the licensed practical nurse unit manager (LPN #11) caring for R44 was interviewed. The unit manager stated R44's pump was self-adjusting and that the blood sugar readings were monitored on the resident's cell phone. The unit manager stated she thought the insulin pump and management of the pump should be included in the resident's care plan. On 2/12/26 at 8:49 a.m., the licensed practical nurse (LPN #12) responsible for MDS assessments and care planning was interviewed. The MDS coordinator reviewed R44's plan of care and stated all that was listed was to administer insulin as ordered. The MDS coordinator stated R44's last care plan meeting was held on 1/13/26 and that the unit managers attended the care plan meeting with no requests to add the insulin pump. The facility's policy titled Care Planning (effective 11/1/19) documented, .A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient . This finding was reviewed with the administrator and director of nursing during a meeting on 2/12/26 at 5:10 p.m. with no further information provided prior to the end of the survey. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #198 (R198) did not have a complete care plan related to dialysis interventions. R198 diagnoses include osteomyelitis, renal dialysis related to end stage renal failure, polyneuropathy, and dementia. The most recent MDS (minimum data set) was a discharge date d 11/17/25 and indicated R198 was cognitively intact. Review of R198's clinical record indicated care plan interventions for dialysis were not specific to dialysis days, the dialysis center, what type of vascular access R198 had and location of the vascular device. On 2/12/2026 at 5:10 p.m. the above information was presented to the administrator and director of nursing. On 2/13/2026 at 8:12 a.m. the DON was interviewed. The DON verbalized reviewing the care plan and indicated R198 had been readmitted to the facility from the hospital. Upon admission a dialysis care plan was generated which includes a template for interventions; however, the template was not properly filled out. No other information was presented prior to exit conference on 2/13/2026.		

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NAME OF PROVIDER OR SUPPLIER Harrisonburg Hlth & Rehab Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 1225 Reservoir Street Harrisonburg, VA 22801	
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to revise the comprehensive care plan for one of 37 residents in the survey sample, Resident #215. The findings include: For Resident #215 (R215), the facility staff failed to revise the comprehensive care plan regarding smoking status. On the most recent annual minimum data set (MDS) with an assessment reference date (ARD) of 2/2/2026, the resident was assessed as being a current tobacco user. The comprehensive care plan for R215 documented in part, The resident prefers to smoke cigarettes. Created on: 07/12/2024. Revision on: 12/28/2025. Under Interventions it documented in part, .May smoke independently. Created on: 08/14/2024 . Supervise with smoking. Created on: 03/12/2026. On the most recent smoking safety screen dated 3/13/2026, R215 was assessed as scoring a five indicating they required supervision with smoking. The section of the assessment titled Care Plan documented in part, Intervention: May smoke independently .Intervention: supervise with smoking. On 6/10/2026 at 10:24 AM, an interview was conducted with the MDS coordinator who stated that the care plan was developed to correspond with the MDS assessment and was revised as needed with anything that needed to be updated daily. She stated that they reviewed the orders daily and updated the care plan as needed. The MDS coordinator stated that the purpose of the care plan was to show an overall picture of the resident and to show what was going on with them. She reviewed R215's care plan and the smoking assessment and stated that both independent and supervised were checked, and it should have been revised because it was not clear which status was current. The facility policy Care Planning effective 11/1/2019 documented in part, . Care plans will be updated on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment . 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.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to meet professional standards for two of 37, Resident #205 and Resident #216. The findings include: 1. The facility staff failed to meet professional standards by entering an order May go out on LOA (leave of absence) independently for Resident #205. Resident #205 (R205) was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident), COPD (chronic obstructive pulmonary disease) and DM (diabetes mellitus). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/16/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is oriented to person, place and time and has unimpaired immediate recall. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximum assist for hygiene/bathing; supervision for bed mobility, transfer, dressing and eating. No annual assessment has been completed. A review of the comprehensive care plan dated 12/18/25 revealed, FOCUS: Resident requires assistance with their activities of daily living due to chronic conditions. INTERVENTIONS: Wheelchair for ambulation and transfers. PT/OT (physical therapy/occupational therapy) evaluate and treat as needed. A review of the Nursing to PT (physical therapy) Referral Form dated 3/7/26 revealed, Physical Care/Mobility Skills: Functional Mobility coded for: Difficulty getting in/out of bed and Difficulty getting in/out of wheelchair. Therapy: Pt recently evaluated slide board transfers, and she was alert, able to follow directions and demonstrated good safety with slide board transfers. Patient's medical status tends to fluctuate, or if she is demonstrating increased fatigue, it is appropriate to use a Hoyer lift for transfers. A review of the 4/14/26 OT (occupational therapy) Evaluation & Plan of Treatment form revealed, Cognitive/Communication Assessment: Decision Making Ability-modified independence and Other Cognitive Function-safety awareness impaired. A review of the Physician's Order Audit Report dated 6/9/26 at 7:51 AM revealed, May go out on LOA (leave of absence) independently, communication method identified as verbal. Order was created by the Regional Director of Clinical Services. On 6/8/26 at approximately 11:40 AM, R205 was observed in the grassy area, next to the sidewalk and road smoking with a second resident (R233) who was smoking. R205 identified this area as off facility property on 6/8/26 at approximately 2:50 PM. An interview was conducted on 6/9/26 at 10:10 AM with R205, outside of the facility, off property on the grassy area reachable by scaling a four-inch curb. Asked if she was able to maneuver around the parking lot and scale the four-inch curb, R205 stated, oh no, buddy here (R233) pushes the wheelchair and gets the wheelchair up on the grass. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 6/9/26 at 3:20 PM with the Attending Physician. Asked if he had given the orders for R205 May go out on LOA independently, he stated, the facility creates 50-60 new orders every day. Do not remember being called about this order. Asked would he have given the order as R205 had an OT evaluation revealing Decision Making Ability-modified independence and Other Cognitive Function-safety awareness impaired, the Attending Physician stated, if there is a safety issue, that order would not have been given or approved. I am in the car driving back from Northern Virginia and when I get home, will check the computer and call you. The Attending Physician did not call back. An interview was conducted on 6/10/26 at 11:55 AM with the Director of Rehab Services. Asked to describe the Nursing to PT referral process and purpose for R205, the Director of Rehab Services stated, nursing does an electronic or verbal referral to evaluate the resident. If there is an urgent need and the residents go out frequently, therapy prioritizes those evaluations. Evaluation in gym and outside either PT or OT, are they wheelchair bound. Evaluations are objective assessments, observe them making decisions, crossing threshold, uneven surfaces, going out the front door as this was the main entrance and transit bus pickup area. The front entrance has an uneven surface, yesterday, they started to replace the slab and ramp so it will now be easier for residents to go in and out as there will be no uneven surfaces. R205 was identified to need supervision because of the uneven surfaces. Asked if R205 had a new evaluation on 6/8/26 or 6/9/26, the Director of Rehab Services stated, no new evaluation has been completed yet on R205. You will have to check with nursing, but I believe that order was put in yesterday based on the ramp at the front of the building being fixed, believe the front ramp is open now 6/10/26. An interview was conducted on 6/10/26 at 12:05 PM with the Regional Director of Clinical Services. Asked the process to assess residents for safety off the premises, the Regional Director stated, there is a nursing referral to therapy, who screens them, then orders are placed for the doctors to review and approve, nursing looked at screening. Nursing made the list yesterday evening of who was approved to be supervised and unsupervised when off property. This was done as the IJ (Immediate Jeopardy) plan was being developed. Asked to describe the order process, the Regional Director stated, it is an electronic delivery system, as soon as the order is created, it is sent to the physician for review. Orders may not be signed at that time. Asked how the physician would know if a resident had been evaluated by therapy as Safety Awareness Impaired, the Regional Director stated, the physician would have to call us if there was any discrepancy. Asked the facility's standard of professional practice, the Regional Director stated, there are policies and procedures as well as [NAME] & [NAME] that are followed. An interview was conducted on 6/10/26 at 12:19 PM with LPN (licensed practical nurse) #6. Asked to define order of May go out on LOA (leave of absence) independently, LPN #6 stated, independent LOA indicates the resident has been assessed by therapy and is independent, the resident's BIMS is above 13, the resident would have to sign out and a progress note is written when the resident goes out and returns. On 6/10/26 at 1:55 PM, the Administrator, Director of Nursing, Regional Director of Clinical Services and the Regional Director of Operations were made aware of the findings. According to Clinical Nursing Skills & Techniques [NAME], [NAME], Ostendorf; 8th Edition page 481, Guidelines for Verbal/Telephone Orders: Clearly identify the patient's name, room number and diagnosis. 'Read Back' all orders from the health care provider. Use clarification questions to avoid misunderstandings. Write TO or VO including date and time, patient's name and complete order; sign (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the name of the health care provider and nurse. Physician or licensed health care provider cosigns their order within the time frame required by the agency. No further information was provided prior to exit. 2. For Resident #216 (R216), the facility staff failed to follow professional standards of practice when obtaining verbal orders. On the most recent minimum data set (MDS), an annual assessment with an ARD (assessment reference date) of 3/13/2026, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was oriented to person, place and time and had unimpaired immediate recall. The assessment documented current tobacco use. On 6/8/2026 at 1:30 PM, an interview was conducted with R216 who stated that previously he could go out to the courtyard and smoke anytime he wanted but it was changed to scheduled smoke times about six months ago and now he had to sign out and go off the property when he wanted to smoke outside of the scheduled times. R216 stated that he went out the front door and down the sidewalk off the property and the facility rules forced him to go onto the sidewalks which were not safe and not cleared during inclement weather. R216 stated that in the past he had fallen while stepping over snow on the sidewalk and suffered a cut on his arm. An order audit report for R216 dated 6/9/2026 documented a verbal order entered for May go out on LOA (leave of absence) independently. The order documented a created date of 6/9/2026 at 7:50 AM. Review of the OT (occupational therapy) evaluation and plan of treatment for R216 dated 2/23/2026 provided by the facility administrative team regarding R216's ability to leave the facility independently documented in part, Certification period: 2/23/2026-2/23/2026 . Clinical Impressions/Reason for Skilled [NAME]: Patient ambulates w/ and w/o (with and without) a SPC (single point cane) throughout the facility safely. Patient able to access smoking courtyard w/ I (independent) and safe navigation of the ramp and doorways. Patient owns a phone and is able to call emergency services as needed. Patient would be safe to travel I (independently) outside of the facility IF using public transit. Patient would NOT be safe using sidewalks directly surrounding facility d/t (due to) uneven terrain, steep grades, railroad tracks, and broken concrete. OT recommends patient use public transport whenever leaving the facility to improve safety and decrease fall risk associated w/ surrounding sidewalks . On 6/9/2026 at 3:20 PM, an interview was conducted with the Attending Physician. The physician stated that the facility created 50-60 new orders every day and he did not recall being called about the independent LOA order for R216. The physician stated that if there was a safety issue regarding a resident leaving the facility independently he would not have given the order or approved it. On 6/10/2026 at 11:55 AM, an interview was conducted with the Director of Rehab Services who stated that prior to a resident going off facility property independently nursing sent a referral to them either electronically or verbally to perform an evaluation. She stated that they evaluated the resident in the gym or outside with either physical therapy or occupational therapy. The director stated that the objective of the evaluation was to observe the resident and make decisions regarding their ability to cross thresholds, uneven surfaces, make decisions and enter and exit the facility. She stated that R216 was a resident that they planned to reevaluate since the concrete work had started on 6/9/2026 and completed on 6/10/2026. When asked about the LOA order for R216 placed on 6/9/2026 she (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that she thought the order was placed based on the front of the building being fixed but the re-evaluation had not been completed yet. On 6/10/2026 at 12:05 PM, an interview was conducted with the Regional Director of Clinical Services (RDCS) who stated that she had placed the LOA orders for R216 on 6/9/2026. She stated that any resident that had been screened by therapy for independent LOA had orders placed to be able to go out independently and R216 was able to go out by transit independently. The RDCS stated that the orders were placed electronically and were sent to the physician who reviewed them and called if there were any concerns. She stated that the order was placed prior to the LOA resident list and plan put into place that afternoon. When asked how the physician would know if a resident had been evaluated by therapy as a safety risk, the Regional Director stated that the physician would have to call if there was any discrepancy. On 6/10/2026 at 12:19 PM, an interview was conducted with licensed practical nurse (LPN) #6 who stated that when there was an order that stated the resident could go out on LOA independently it meant that the resident would have to sign out, their BIMS had to be above 13, they would have to write a note when the resident went out and returned. She stated that independent LOA indicated the resident had been assessed by therapy and so the order was for independence. 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.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and clinical record review, the facility staff failed to ensure enteral nutritional feeding was administered according to physician's order for one of forty-three residents in survey sample (Resident #2). Findings include: Resident #2 was admitted to the facility on [DATE] with diagnoses to include but not limited to pulmonary embolism, tracheostomy, cerebral palsy, generalized epilepsy, neuromuscular dysfunction of the bladder, chronic respiratory failure, severe intellectual disabilities, bipolar depression, and dysphagia. Resident #2's most recent MDS (Minimum Data Set Assessment with ARD (Assessment Reference Date) of 11/20/25 coded her Section C. Cognitive Status as 99 unable to complete interview and Section K. Nutritional Approaches coded Yes for tube feeding. On 2/11/26 at 11:00AM, Resident #2's enteral pump was observed with Osmolite 1.5 (a specialized, high-protein, and low-residue enteral nutrition formula designed for tube feedings, a feeding through an opening in the stomach) running at 60 ml (milliliter, a metric unit of volume) per hour. The enteral feed bottle was dated 2/10/26 hang time 6:16PM. A review of the physician's orders revealed an order dated 2/10/26 at 9:18PM for Osmolite 1.5 at 75 ml per hour for twelve hours a day between 6:00PM to 6:00AM for a total volume of 900 ml/hour. An interview was conducted with LPN#7 regarding Resident #2's enteral pump running at 60ml/hour and order revealing 75ml/hour with a stop time for 6:00AM. According to LPN#7, she stated she had not worked this hall much and wasn't very familiar with the residents and the enteral feeding was not due to come down yet on her shift, so she had not checked it. Review of the MAR (Medication Administration Record) revealed that LPN#7 had administered 9:00AM medications to Resident #2. Review of the MAR showed that the new order for Osmolite at 75ml/hour for 12 hours a day at 6:00PM to 6:00AM was initiated by LPN#6 on the night shift of 2/10/25. An interview was conducted with the Unit Manager regarding Resident #2's enteral pump running at 60ml/hour at 11:00AM and order was for 75 ml/hour to run from 6:00PM to 6:00AM. The Unit Manager reviewed the MAR (Medication Administration Record) and conducted an observation of Resident #2's enteral pump rate and MAR with LPN#7 and the enteral feed was stopped. On 2/11/26 at 5:20PM, an interview was conducted with the DON (Director of Nursing) regarding Resident #2's enteral feeding. According to the DON, the Unit Manager had informed her of Resident #2's incorrect enteral feed flow rate and failure to follow order to stop the feed at 6:00AM. According to the DON, the RD (Registered Dietician) was working remotely and had changed the order, entered the order into the Electronic Medical Record, confirmed the order herself, therefore leaving the nurse out of the new order process. She stated the process is for the RD to enter the order only, allowing it to appear in the queue for the nurse to see and complete the transaction. On 2/12/26 at 9:30AM, rounds were made to verify Resident #2's enteral feeding. The pump was on, running at 75ml/hour. A review of the order on the MAR revealing order for Osmolite 1.5 at 75 ml per hour for twelve hours a day between 6:00PM to 6:00AM for a total volume of 900 ml/hour. An interview was conducted with RN#3 regarding Resident #2's pump running at 9:30AM when order was to run from 6:00PM to 6:00AM. According to RN#3, she stated the (MAR) Medication Administration Record shows that Resident #2's feeding was to start at 9:00AM and that is when she started the pump. A review of the MAR with RN #3 did not show an order to hang/or start feeding at 9:00AM. An interview with the Unit Manager was conducted to review Resident #2's enteral feed orders on the Medication Administration Record and the following orders were revealed: Enteral Feed Order - every morning and night shift Osmolite 1.5 @ 75 ml/hour for twelve hours a day 6:00PM to 6:00AM (900 ml total volume). Order date 2/10/26 at 9:18PM Hang tube feeding one time a day at 1400 (2:00PM) Take down feeding one time a day at 1200 (12 NOON) According to the Unit Manager, the 2:00PM hang time and the 12:00NOON take down orders should have been discontinued on 2/10/26 when the 60ml/hour order to run for twenty-two hours was discontinued. She stated she does not know where RN#3 got the start (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time of 9:00AM, I see that she signed off the order enteral feed order - four times a day flush feeding with 170 cc of water QID (four times a day) at 9:00AM this morning, but I do not see any order to start the feeding at 9:00AM. On 2/12/26 at 9:45AM, an interview was conducted with the Regional Director of Clinical Services and Assistant Director of Nursing Services regarding observing the tube feeding running at 9:30AM when the order is to run for 12 hours from 6:00PM to 6:00AM, this being the second day of failing to follow enteral feed order for Resident #2. According to the Regional Director of Clinical Services, her expectation is for nurses to follow physician's order for tube feeding and monitor the pump settings. A copy of the facility's policy on Enteral Feed Management and Following Physician Orders was requested. A review of the facility's policy #1008, entitled, Enteral Feeding Tubes, Policy reads: It is the policy of the center to provide care and services for patients with enteral feeding tubes according to current standards of nursing practice. On 2/12/26, during the end of the day meeting with the Administrator, Director of Nursing, Regional Director of Clinical Services and [NAME] President of Operations, an opportunity was offered to the facility staff to present additional information. They had no further information to provide.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and staff interview, it was determined that the facility staff failed to dispose of refuse properly. The facility staff failed to maintain a clean dumpster area during the facility task-kitchen observation on 2/10/26 at 11:40AM. Findings include: On 2/10/26 at 11:50AM, an observation was conducted in the dumpster area outside of the kitchen, with the Dietary Manager. One dumpster was observed with top flaps pushed all the way back resting on the edge of the loading dock overflowing with bags of trash. The other dumpster was positioned in front of the open overflowing dumpster with the side door open. On the ground, on both sides of the dumpsters, the snow-covered area was littered with gloves, paper towels, candy wrappers, straws, and plastic cup lids., forks and spoons. The loading dock was observed with pieces of trash, two wheelchairs and two mattresses. An interview was conducted with the Dietary Manager on 2/10/26 at the time the dumpster area was inspected. When asked about the findings, the Dietary Manager stated, the waste disposal company comes twice a week, usually on Mondays and Thursdays, but with the snow and icy conditions there has been some delay. When asked about the dumpster not being covered, the Dietary Manager stated, I guess my staff just kept throwing the bags in the dumpster since it was open and they are frequently bringing bags of trash out here so just didn't think shutting the top was necessary and it was easier to just toss them. I am sure the freezing temperatures and snow and ice affected their thinking. A request for the facility's policy on disposal of garbage and refuse was requested but according to the Director of Nursing she was informed that the facility did not have a policy to cover disposal of trash. On 2/12/26, during the end of the day meeting with the Administrator, Director of Nursing, Regional Director of Clinical Services and [NAME] President of Operations, an opportunity was offered to the facility staff to present additional information. They had no further information to provide.		

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on staff interview, facility document review and employee record review, the facility staff failed to provide required training in communication for one of ten employee records reviewed, RN (Registered nurse) #1. The findings include: On 2/11/2026 at approximately 12:20 p.m., a request was made for the employee training records for RN #1. The review of the employee training records revealed that RN #1 did not have the required training in communication. On 2/12/2026 12:36 PM, the Regional Director of Clinical Services, stated that the RN did not have the training in communication, QAPI and Ethics and compliance. For some reason, it wasn't triggered in their electronic education program for her to take these. The facility policy, Continuing training documented in part, All nursing staff will participate at a minimum in the following mandatory, annual in-services .bb. Effective Communication. The Administrator and [NAME] President of Operations were made aware of the above findings on 2/12/2026 at 12:45 p.m.		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on staff interview, facility document review and employee record review, the facility staff failed to provide required training in quality assurance performance improvement (QAPI) for one of ten employee records reviewed, RN (Registered nurse) #1. The findings include: On 2/11/2026 at approximately 12:20 p.m., a request was made for the employee training records for RN #1. The review of the employee training records revealed that RN #1 did not have the required training in quality assurance performance improvement. On 2/12/2026 12:36 PM, the Regional Director of Clinical Services, stated that the RN did not have the training in communication, QAPI and Ethics and compliance. For some reason, it wasn't triggered in their electronic education program for her to take these. The facility policy, Continuing training documented in part, All nursing staff will participate at a minimum in the following mandatory, annual in-services .y. Quality Assurance Performance Improvement. The Administrator and [NAME] President of Operations were made aware of the above findings on 2/12/2026 at 12:45 p.m.		

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

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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 02/13/2026
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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on staff interview, facility document review and employee record review, the facility staff failed to provide required training in ethics and corporate compliance for one of ten employee records reviewed, RN (Registered nurse) #1. the findings include: On 2/11/2026 at approximately 12:20 p.m., a request was made for the employee training records for RN #1. The review of the employee training records revealed that RN #1 did not have the required training in communication. On 2/12/2026 12:36 PM, the Regional Director of Clinical Services, stated that the RN did not have the training in communication, QAPI and Ethics and compliance. For some reason, it wasn't triggered in their electronic education program for her to take these. The facility policy, Continuing training documented in part, All nursing staff will participate at a minimum in the following mandatory, annual in-services .bb. Effective Communication. The Administrator and [NAME] President of Operations were made aware of the above findings on 2/12/2026 at 12:45 p.m.		