STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Rehabilitation and Nursing Center	940 East Lee Highway Chilhowie, VA 24319

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and facility document review the facility staff failed to provide a safe, clean, comfortable environment for 1 of 3 units in the facilty. The findings included: During the initial tour of the facility on 12/9/25 several residents on the second floor complained of cold showers, which were fairly consistent for approximately two months. On 12/9/25 at 1:20 PM this surveyor interviewed resident #5. Resident #5 stated, Showers are sometimes cold and sometimes the water fluctuates, it'll be hot and then all of the sudden it goes really cold then it might get hot again. When asked if this was a recent or new issue they stated, No, it's been going on for a long time, a couple months probably. We just have to deal with it; we have to bathe.On 12/9/25 at 1:35 PM this surveyor interviewed resident #79. They stated, I enjoy showers but lately I've been getting bed baths because the water is too cold in the shower, I can't hardly stand that, and they give me good bed baths.On 12/19/25 at 1:45 PM this surveyor interviewed resident #3. They stated, It's hard to get a decent shower sometimes, the water temperature is cold, or I guess you'd call it tepid. I don't know how long it's been going on, a while I guess. They say they've worked on it, and I guess they have but it still isn't hot like it should be.On 12/9/25 at 2:18 PM this surveyor asked staff to unlock the shower room on the second floor Summit unit. This surveyor turned on the water in the shower stall. After 5 minutes the water was still cold on my hand. Licensed Practical Nurse (LPN) #4 stated, Let me see if they left the knob turned in the housekeeping closet. If they did, that is why it won't get hot. They returned and stated that it was the issue, I turned the knob back so if you wait and come back in 20 minutes or so the water should be warm then.On 12/9/25 at 3:30 PM this surveyor returned to the shower room and tried the water again. It was still not hot.At 3:37PM this surveyor interviewed Certified Nursing Assistant (CNA) #5. When asked to come in the shower room and show this surveyor how to get hot water to work they stated, That's about as warm as it gets to be honest. The water was less than lukewarm. When this surveyor asked CNA #5 if they would be comfortable bathing in water of that temperature they stated, I wouldn't take a shower in water that cold. I know that maintenance knows and has been working on it. It's a little warmer in the mornings usually. CNA #5 called maintenance to come to the shower room.At 3:45 PM other staff members #2 and #3 arrived at the shower room and stated they were the maintenance assistants. This surveyor asked if they were aware of low water temperatures and residents complained of cold showers. Other Staff Member #2 stated, We have had an ongoing problem, and we've been working on it through the process of elimination. To be honest, we thought it was fixed I haven't heard a word this week, so I thought we had it figured out. This surveyor asked them to get a water temperature in the shower stall. After approximately 8 minutes the water temperature never got above 84 degrees, it fluctuated between 80 and 84. The water temperature in the sink which was right beside the shower stall was 107 degrees right away with less than a minute of the faucet running. Other Staff Member #2 stated, It's an old building and the water has to travel a good distance through the pipes to get here so if the solenoid on the water heater is bad that could be the problem or there are spindles in there that may need to be replaced. We could turn up the mixing valve but with that we run the risk of the water getting too hot (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in other places like this sink. When asked if the company had considered calling in a contractor or professional plumber they stated, I will say that they are aware of the problem, that's all I know to say about that and like I said we have been going through and replacing parts kind of going through the process of elimination to find the problem and there are more spindles and a solenoid on order now.On 12/10/25 at 1:07 this surveyor asked the maintenance assistants to tour all of the facility shower rooms. The first floor Bathing room [ROOM NUMBER] water temperature was 90.1 degrees and felt comfortable for a shower. In bathing room [ROOM NUMBER] the water temperature read 92 degrees and felt comfortable. Other Staff Member #2 stated he had tried to calibrate the thermometer and is concerned it isn't accurate, he put it in ice, and stated the temperature only got down to 34 degrees. On the second floor in bathing room [ROOM NUMBER], the same one with the issues on 12/9/25, the water only got up to 78.1 and did not feel comfortable for bathing. In bathing room [ROOM NUMBER], the water temperature was 75 degrees, not comfortable for bathing. The maintenance assistant stated that this shower room is not used much. The sink water was hot in each area of these two bathing rooms. Other Staff Member #2 mentioned several times that they were unsure of the accuracy of the thermometer they were using. I asked how they would ensure the water is not too hot if the thermometer is not reading accurately. He stated they do routinely check water temps and adjust mixing valve as needed. On 12/10/25 at 1:40 PM this surveyor met with the administrator and informed them of the concern with cold showers and the concern of potential inaccurate thermometer readings per maintenance. The Administrator stated, We will get a new one today. The Administrator also provided a document called a Maintenance REQ that showed parts ordered on 10/22/25 for the shower room. On 12/11/25 8:15 AM this surveyor met with the Administrator and the Regional Director of Clinical [NAME] (RDCS). The Administrator stated that maintenance worked until 10:00 PM the night before on the water in the shower rooms and stated, It's better than it was, but not where it needs to be. The Administrator provided temperature logs and stated, We started these in October when we were first made aware of the issue. We have been working on it. On 12/11/25 at 9:00 AM this surveyor went on a tour with the two maintenance assistants to the 2nd floor bathing room [ROOM NUMBER]. They had a new temperature gun. After 7 minutes the temperature in the shower got up to 90 degrees. Other #2 stated they cleaned the spindles and checked the solenoid and earlier this morning it the temperature got up to 97 degrees. On 12/11/25 at 3:50 PM the Administrator came to surveyor and stated they have a corporate master plumber coming Monday 12/15/25 they stated, We recognize we still have issues, and the water is not where it needs to be. They stated they are showering residents on the first floor as needed until the issue is resolved. Administrator provided copy of email correspondence with their corporate office regarding the master plumber scheduled to come to the facility Monday 12/15/25. On 12/12/25 at 12:30 PM the survey team met with the Administrator Director of Nursing and the RDCS. This concern was discussed during this meeting. No further information was provided to the survey team prior to the exit conference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, and clinical record review the facility staff failed to ensure an accurate minimum data set assessment for 4 of 35 residents, Resident #18, Resident #2, Resident #61, and Resident #69. The findings included:1. For Resident #18 the facility staff incorrectly coded high-risk medications on the minimum data set. Resident #18's clinical record included diagnoses which included but not limited to Alzheimer's disease, dementia, anxiety, and depression. Resident #18's most recent quarterly minimum data set (MDS) with an assessment reference date of 09/12/25 coded the resident as having both long- and short-term memory loss with severely impaired skills for daily decision making, in Section C, cognitive pattern. Section N, subsection N0415, High-Risk Drug Classes: Use and Indication, coded the resident as receiving hypnotic, anticoagulant, antibiotic, diuretic, opioid, antiplatelet, hypoglycemic, and anticonvulsant medications without indications for use. Resident #18's physician's order summary for September 2025 through December 2025 was reviewed and contained an order for Ceftriaxone Sodium Solution Reconstituted 1 GM (gram). Inject 1 gram intramuscularly every 24 hours for pharyngitis for 5 days. This antibiotic medication was ordered on 09/01/25 and discontinued on 09/06/25. Surveyor could not locate any medications in the other classifications indicated on the MDS. Surveyor spoke with MDS coordinator on12/09/25 at 4:05 pm regarding Resident #18's medications and coding the current MDS. MDS coordinator stated the medications were coded in error, and she would do a correction. The concern of incorrectly coding high-risk medications on Resident #18's MDS was discussed with the administrator, director of nursing, and regional director of clinical services on 12/10/25 at 3:30 pm. No further information was provided prior to exit. 2. For Resident #2 the facility staff inaccurately coded the resident as receiving discontinued antianxiety medication on a significant change MDS (minimum data set) assessment dated [DATE]. Resident #2's diagnosis list indicated diagnoses that included, but were not limited to, type 2 diabetes mellitus with diabetic polyneuropathy, dementia, depression, and anxiety disorder. The most recent significant change MDS with an assessment reference date (ARD) of 9/30/25 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities indicating the resident was severely impaired in cognition. Section N (Medications) was coded to indicate Resident #2 received antianxiety medication during the 7-day look-back period. A review of a medical provider orders included an order dated 8/7/25, that read in part, .Clonazepam.give 0.5 tablet by mouth in the afternoon for anxiety.D/C (discontinue) date 9/3/25. A review of the September 2025 MAR (medication administration record) revealed Resident #2 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received the medication from 9/1/25 through 9/3/25 on the discontinued date. On 12/11/25 at 11:19 AM, this surveyor spoke with registered nurse #1 (RN#1) and she agreed Resident #2's antianxiety medication should not have been coded on the MDS, as it was discontinued on 9/3/25. RN#1 stated she would do a modification of the 9/30/25 MDS. This concern was discussed at the end of day meeting on 12/11/25 at 3:30 PM with the administrator, director of nursing, and regional director of clinical services. A review of Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.1 October 2024, read in part, .(p. N-1).Section N: Medications.Intent: The intent of the items in this section is to record the number of days, during the last 7 days.that any type of.medications were received by the resident.(p. N-7).N0415B1. Antianxiety: Check if an anxiolytic medication was taken by the resident at any time during the 7-day look-back period. No further information was provided to the survey team prior to exit on 12/12/25. 3. For Resident #61, the facility staff failed to code the resident's admission minimum data set (MDS) assessment for dialysis. Resident #61 was receiving hemodialysis three times a week. During the entrance conference the team leader asked for a completed matrix for the residents of the facility. This matrix identified Resident #61 as receiving hemodialysis. Resident #61's diagnoses included end stage renal disease and dependence on renal dialysis. Section C (cognitive patterns) of Resident #61's admission MDS assessment with an assessment reference date (ARD) of 11/26/25 included a brief interview for mental status (BIMS) score of 7 out of a possible 15 points. Per the MDS manual a score of 7=severe impairment in cognitive skills for daily decision making. Section O (special treatments/procedures/programs) was not coded to indicate this resident was receiving dialysis. Resident #61's comprehensive care plan included the focus area dialysis, receives dialysis three times a week. Resident #61's current medication summary included provider orders for dialysis every Tuesday/Thursday/Saturday. On 12/10/25, during an interview with Resident #61 this resident stated they had dialysis three days a week. On 12/10/25 at 9:05 a.m., the surveyor interviewed Registered Nurse (RN) #1 regarding the MDS. RN #1 confirmed dialysis was not marked on this resident's MDS assessment and they would be completing a modification. The clinical record included information to indicate RN #1 completed a modification to section O of this MDS on 12/10/25 at 9:15 a.m. Dialysis was now coded yes. On 12/10/25 at 3:30 p.m., during an end of the day meeting with the Administrator, Director of (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing, and Regional Director of Clinical Services the issue with Resident #61's admission MDS not being coded for dialysis was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #69, the facility staff coded the residents Trulicity medication as insulin on a quarterly minimum data set (MDS) assessment. Trulicity belongs to the drug class of Glucagon-Like Peptide-1 (GLP-1) receptor agonists and is a multifaceted hormone. Resident 69's diagnoses included diabetes and dementia. Section C (cognitive patterns) of Resident #69's quarterly MDS assessment with an assessment reference date (ARD) of 10/24/25 included a brief interview for mental status (BIMS) score of 00. Indicating this resident was severely impaired in cognitive skills for daily decision making. Section N (medications) had been coded to indicate Resident #69 received insulin once in the last 7 days. Resident #69's clinical record included a provider order for Trulicity 1.5 mg subcutaneously one time a day every Wednesday for diabetes mellitus. On 12/09/25 at 3:55 p.m. Licensed Practical Nurse (LPN) #1 was asked about the coding of the Trulicity on the quarterly MDS assessment. On 12/09/25 at 4:05 p.m., LPN #1 stated the MDS was coded incorrectly, and she would be completing a modification of this MDS assessment. On 12/10/25 at 3:30 p.m., during an end of the day meeting with the Administrator, Director of Nursing, and Regional Director of Clinical Services the issue with Resident #69's quarterly MDS being miscoded regarding the Trulicity was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review the facility staff failed to develop/implement a person-centered comprehensive care plan for 4 of 35 residents, Resident #2, Resident #15, Resident #75, and Resident #13. The findings included:1. For Resident #2 the facility staff failed to develop and or implement a comprehensive person-centered activity care plan to address the resident's activity preferences, interests, and psychosocial needs. Resident #2's diagnosis list indicated diagnoses that included, but were not limited to, difficulty in walking, dementia, depression, anxiety disorder, macular degeneration-bilateral, and legal blindness. The most recent significant change MDS with an assessment reference date (ARD) of 9/30/25 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities indicating the resident was severely impaired in cognition. A review of an activity admission assessment dated [DATE] disclosed that reading the Bible and true stories, listening to gospel music, watching the news on TV, doing things with groups of people, Bible quizzes, being around dogs, and going outside in nice weather were very important to Resident #2. A review of the most recent activity assessment dated [DATE] disclosed that listening to music (plays radio in room all day) was very important to Resident #2. Being around animals such as pets was coded as somewhat important to the resident. Reading was coded as not very important to the resident and keeping up with the news, doing things with groups of people, doing favorite activities, and being outside in nice weather were coded as no response or non-responsive. A review of the comprehensive person-centered care plan disclosed a focus which read in part, .Resident prefers to pursue independent activities such as music and TV. Encourage resident to participate in group activities. At times enjoys socializing with other residents. The interventions for the focus read in part, .assist resident to group activities as needed.review resident preferences for group activities as needed. On 12/10/25 at 1:31 PM, the facility administrator informed this surveyor she believes the activity staff are doing activities with the resident but are not documenting it properly and agreed there is an issue with activity care plans. This concern was discussed at the end of day meeting on 12/11/25 at 3:30 PM with the administrator, director of nursing, and regional director of clinical services. Surveyor requested and received a facility policy titled, Care Planning with an effective date of 11/1/19, which read in part, .develops and implements an individualized plan of care for each patient in order to provide effective, person-centered care, and the necessary.services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. No further information was provided to the survey team prior to exit on 12/12/25. 2. For Resident #15, the facility staff failed to develop and or implement a comprehensive person-centered activity care plan to address the resident's activity preferences, interests, and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	psychosocial needs. Resident #15's diagnosis list indicated diagnoses that included, but were not limited to, Alzheimer's Disease with early onset, anxiety disorder, depression, bipolar disorder, and tracheostomy. The most recent quarterly MDS with an assessment reference date (ARD) of 10/17/25 assigned the resident a brief interview for mental status (BIMS) summary score of 0 out of 15 for cognitive abilities indicating the resident was severely impaired in cognition. A review of the clinical record disclosed the following: A review of an activities assessment dated [DATE] did not disclose any previous interests of the resident and was coded to reflect Resident #15 wished to participate in activities while in the center and wished for one to one activities and self-directed activities. The assessment also disclosed Resident #15 had mental and physical impairments that limited scope of activity participation, required 1:1 room visits as tolerated, and required assistance with mobility and daily routine. Activities would need to be modified to accommodate for cognitive deficits and assistance should be provided to get the resident to the activities. A review of the comprehensive person-centered plan of care disclosed a focus/goal which read in part, .Resident is most at ease when she can watch TV.encourage resident to participate in individual activities. The interventions read in part, .Activity calendar.Assist to and from activities.Respect choice in regard to limited or no activity participation. On 12/10/25 at 11:13 AM, AD#1 returned to this surveyor and provided with surveyor with the most recent activity assessment dated [DATE] and stated this was a staff assessment of the resident, as the resident could not communicate effectively and it is difficult to get in touch with the resident's family. AD#1 agreed the resident's activity care plan needs to be updated. This concern was discussed at the end of day meeting on 12/11/25 at 3:30 PM with the administrator, director of nursing, and regional director of clinical services. Surveyor requested and received a facility policy titled, Care Planning with an effective date of 11/1/19, which read in part, .develops and implements an individualized plan of care for each patient in order to provide effective, person-centered care, and the necessary.services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. No further information was provided to the survey team prior to exit on 12/12/25. 3. For Resident #75, the facility staff failed to develop and/or implement a comprehensive person-centered activity care plan to address the resident's activity preferences, interests, and psychosocial needs. Resident #75's diagnosis list indicated diagnoses that included, but were not limited to, dementia, chronic pain, anxiety disorder, depression, muscle wasting and atrophy, and difficulty walking. The most recent quarterly MDS with an assessment reference date (ARD) of 10/29/25 coded the resident in Section C (Cognitive Patterns) as being rarely/never understood with short and long-term memory problems. The resident was coded as being severely impaired in cognitive skills for daily (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	decision making and never/rarely made decisions. A review of the clinical record disclosed the following documentation: A review of an activity assessment dated [DATE] disclosed that reading a variety of materials, being around animals (dogs), and keeping up with the news were somewhat important to Resident #75. Listening to country/gospel music and participating in religious services were coded to reflect that these activities were very important to the resident and the resident preferred Presbyterian services. The resident was coded to have wished to participate in activities while at the center and would enjoy self-directed activities. Resident #75 was also coded to have physical and mental impairments. A review of the most recent activity assessment dated [DATE] did not disclose any previous/current interests of the resident. The assessment was coded to reflect the resident wished to participate in self-directed activities without modifications to accommodate cognitive deficits and that assistance should be provided to get the resident to activities. The assessment also disclosed that Resident #75 had physical limitations. A review of the comprehensive person-centered plan of care disclosed a focus and interventions which read in part, .resident prefers to participate in self-directed activities such as watching tv programs in their room.assist the resident to perform self-directed activities as needed.provide materials for self-directed activities per resident request if able.review with resident what their self-directed preferences are. On 12/10/25 at 1:41 PM, this surveyor interviewed the facility administrator, and she agreed Resident #75 did not have a person-centered activity care plan. This concern was discussed at the end of day meeting on 12/11/25 at 3:30 PM with the administrator, director of nursing, and regional director of clinical services. Surveyor requested and received a facility policy titled, Care Planning with an effective date of 11/1/19, which read in part, .develops and implements an individualized plan of care for each patient in order to provide effective, person-centered care, and the necessary.services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. No further information was provided to the survey team prior to exit on 12/12/25. 4. For Resident #13 the facility staff failed to develop and implement an individualized comprehensive care plan (CCP). Resident #13's diagnoses included respiratory failure, altered mental status, hypotension, and muscle weakness. Section C (cognitive patterns) of Resident #13's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/26/25 included a brief interview for mental status (BIMS) score of 3 out of 15 points. Indicating Resident #13 was severely impaired in cognitive skills for daily decision making. Resident #13's CCP included the focus area of impaired vision related to macular degeneration, resident prefers self-directed activities such as watching tv programs in their room, stated she (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	doesn't prefer group activities, she enjoys listening to tv in her room. Interventions included assist the resident to perform self-directed activities, respect choice in regard to limited/no group participation, and review with the resident what their self-directed preferences are. Resident #13's clinical record included an activities assessment completed 11/14/25. Under the questions how important is it to you to listen to music you like, be around animals such as pets, keep up with the news, go outside to get fresh air when the weather is good, and participate in religious services or practices the facility staff had marked Resident #13's response as Very important. On 12/10/25 at 9:55 a.m., Resident #13 was observed in their room, resting on bed, their TV was off. On 12/10/25 at 10:30 a.m., the surveyor requested from the Activities Director a 1:1 activity participation record and/or any evidence of social activities completed with this resident. The Activities Director stated she did not have the requested item(s), and she had not done any with this resident as the resident is usually lethargic. After this interview the surveyor and the Activities Director entered Resident #13's room. Resident #13's TV was again observed to be off. The Activities Director asked the resident if she would like a radio and the resident stated that would be nice. On 12/10/25 at 1:05 p.m., the surveyor again observed Resident #13 in their room, resting on bed. The TV remained off and there was no radio in the room. Under the census tab in Resident #13's clinical record Resident #13's payor source was identified as Medicaid Pace (Program of all-inclusive care for the elderly). The surveyor was unable to locate any reference to this program on this Residents CCP. On 12/11/25 at 11:29 a.m., during an interview with the Administrator, this staff stated this resident has always been PACE and had been admitted on PACE. The Administrator provided the surveyor with evidence to indicate the staff from PACE visited the resident at the facility and she did not attend any off-campus programs with PACE. On 12/11/2025 at 11:30 a.m., Registered Nurse (RN) #1 stated she was not aware the resident was receiving services at the facility from PACE. This surveyor confirmed with the Administrator that the staff from PACE were providing services at the facility for this resident. After hearing this conversation RN #1 stated yes, it should have been on the residents CCP. On 12/11/25 at 3:30 p.m., during and end of the day meeting with the Administrator, Director of Nursing, and Regional Director of Clinical Services the issue with the resident's CCP not being individualized to this resident and the resident's PACE services not being on the CCP was reviewed. The Administrative staff provided the survey team with a copy of their policy titled, Care Planning this policy read in part, .the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care. No further information regarding this issue was provided to the survey team prior to the exit conference.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Rehabilitation and Nursing Center	940 East Lee Highway Chilhowie, VA 24319

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide an ongoing, person-centered activity program to support resident choice, interests and physical, mental, and psychosocial well-being for 4 of 35 sampled residents, Resident #2, Resident #15, Resident #75, and Resident #13. The findings included:1. For Resident #2, the facility staff failed to provide an ongoing, person-centered, activity program to support resident choice, interests, and physical, mental, and psychosocial well-being. Resident #2's diagnosis list indicated diagnoses that included, but were not limited to, difficulty in walking, dementia, depression, anxiety disorder, macular degeneration-bilateral, and legal blindness. The most recent significant change MDS with an assessment reference date (ARD) of 9/30/25 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities indicating the resident was severely impaired in cognition. On 12/9/25 a 2:11 PM, this surveyor observed Resident #2 lying in bed with a radio playing in the room. A review of the clinical record disclosed the following documentation: An activity progress note dated 7/31/25 read in part, .Soothing for the Soul.7/29/25 14:00 (2:00 PM).Location: Activity Room.Resident Attended: Yes. A review of an activity admission assessment dated [DATE] disclosed that reading the Bible and true stories, listening to gospel music, watching the news on TV, doing things with groups of people, Bible quizzes, being around dogs, and going outside in nice weather were very important to Resident #2. A review of the most recent activity assessment dated [DATE] disclosed that listening to music (plays radio in room all day) was very important to Resident #2. Being around animals such as pets was coded as somewhat important to the resident. Reading, was coded as not very important to the resident and keeping up with the news, doing things with groups of people, doing favorite activities, and being outside in nice weather were coded as no response or non-responsive. A review of the comprehensive person-centered care plan disclosed a focus which read in part, .Resident prefers to pursue independent activities such as music and TV. Encourage resident to participate in group activities. At times enjoys socializing with other residents. The interventions for the focus read in part, .assist resident to group activities as needed.review resident preferences for group activities as needed. On 12/10/25 at 10:30 AM, in an interview with the activity director#1 (AD#1), this surveyor requested evidence of Resident #2's activity participation and/or any evidence of social activities completed with the resident. AD#1 informed this surveyor she did not have any evidence of activity engagement for the resident. On 12/10/25 at 1:31 PM, the facility administrator informed this surveyor only the activity assessments could be located for Resident #2 and there was no evidence of activity participation since July 2025. The administrator stated she feels like the activity staff are doing activities with the (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident but are not documenting it properly and agreed there is an issue. This concern was discussed at the end of day meeting on 12/11/25 at 3:30 PM with the administrator, director of nursing, and regional director of clinical services. Surveyor requested and received a facility policy titled, Activities Programming with an effective date of 11/1/23 which read in part, .The recreation department will provide, based on the comprehensive assessment and care plan and the preferences of each patient, an ongoing program to support patients in their choice of activities, both facility sponsored group, individual activities, and independent activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident encouraging both independence and interaction.1.activities must.Reflect the.preferences, goals, choices, and rights of patients.Are person appropriate.Are appropriate for those with cognitive impairments.Are related to the patient's previous work, life roles, life-long interests, culture, spiritual preference.Are inclusive indoors and outdoors.Allow for socializing with other patients, staff, and with people from outside the Center.Are routine on consistent days.Give the patients a sense of purpose or belonging.Encourage.interaction. No further information was provided to the survey team prior to exit on 12/12/25. 2. For Resident #15, the facility staff failed to provide an ongoing, person-centered, activity program to support resident choice, interests, and physical, mental, and psychosocial well-being. Resident #15's diagnosis list indicated diagnoses that included, but were not limited to, Alzheimer's Disease with early onset, anxiety disorder, depression, bipolar disorder, and tracheostomy. The most recent quarterly MDS with an assessment reference date (ARD) of 10/17/25 assigned the resident a brief interview for mental status (BIMS) summary score of 0 out of 15 for cognitive abilities indicating the resident was severely impaired in cognition. On 12/9/25 at 1:30 PM, this surveyor observed Resident #15 lying in bed with eyes open. The television in the room was not observed to be turned on and the room was dark and quiet. A review of the clinical record disclosed the following: An activity progress note dated 4/24/25, read in part, .Resident participated in an in room visit by activity staff. She read a book to her (Resident #15) until she fell asleep. A review of an activities assessment dated [DATE] did not disclose any previous interests of the resident and was coded to reflect Resident #15 wished to participate in activities while in the center and wished for one-to-one activities and self-directed activities. The assessment also disclosed Resident #15 had mental and physical impairments that limited scope of activity participation, required 1:1 room visits as tolerated, and required assistance with mobility and daily routine. Activities would need to be modified to accommodate for cognitive deficits and assistance should be provided to get the resident to the activities. A review of the comprehensive person-centered plan of care disclosed a focus/goal which read in part, .Resident is most at ease when she can watch TV.encourage resident to participate in individual activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/25 at 10:21 AM this surveyor interviewed activity director#1 (AD#1) and reviewed the activity assessment mentioned above and Resident #15's activity plan of care. AD#1stated TV is Resident #15's individual preference, as she becomes overstimulated in group activity settings. She agreed staff should assist the resident with TV and should be providing individual activities. This surveyor requested evidence of activity participation for Resident #15 for October, November, and December 2025. On 12/10/25 at 10:33 AM, this surveyor observed Resident #15 in her room lying in bed. A television in the room was not observed to be turned on and the room was dark and quiet. On 12/10/25 at 10:55 AM, AD#1 informed surveyor she does not have anything documented for Resident #15's activity engagement and agreed the resident could not turn the TV on in her room independently. AD#1 informed surveyor resident used to enjoy cartoons when she was on another floor in the facility. She stated she had corrected the issue with the TV not being on in the resident's room. On 12/10/25 at 11:13 AM, AD#1 returned to this surveyor and provided with surveyor with the most recent activity assessment dated [DATE] and stated this was a staff assessment of the resident, as the resident could not communicate effectively and it is difficult to get in touch with the resident's family. AD#1 agreed there are no activity participation records for the resident since April 2025. On 12/11/25 at 9:30 AM, this surveyor observed Resident #15 lying in her bed and observed the television in her room to be on a cartoon channel. This concern was discussed at the end of day meeting on 12/11/25 at 3:30 PM with the administrator, director of nursing, and regional director of clinical services. Surveyor requested and received a facility policy titled, Activities Programming with an effective date of 11/1/23 which read in part, .The recreation department will provide, based on the comprehensive assessment and care plan and the preferences of each patient, an ongoing program to support patients in their choice of activities, both facility sponsored group, individual activities, and independent activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident encouraging both independence and interaction.1.activities must.Reflect the.preferences, goals, choices, and rights of patients.Are person appropriate.Are appropriate for those with cognitive impairments.Are related to the patient's previous work, life roles, life-long interests, culture, spiritual preference.Are inclusive indoors and outdoors.Allow for socializing with other patients, staff, and with people from outside the Center.Are routine on consistent days.Give the patients a sense of purpose or belonging.Encourage.interaction. No further information was provided to the survey team prior to exit on 12/12/25. 3. For Resident #75 the facility staff failed to provide an ongoing, person-centered, activity program to support resident choice, interests, and physical, mental, and psychosocial well-being. Resident #75's diagnosis list indicated diagnoses that included, but were not limited to, dementia, chronic pain, anxiety disorder, depression, muscle wasting and atrophy, and difficulty walking. The most recent quarterly MDS with an assessment reference date (ARD) of 10/29/25 coded the resident in Section C (Cognitive Patterns) as being rarely/never understood with short and long-term (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	memory problems. The resident was coded as being severely impaired in cognitive skills for daily decision making and never/rarely made decisions. On 12/9/25 at 2:40 PM, this surveyor observed Resident #75 lying in bed awake and the television in the room was not observed to be on. A review of the clinical record disclosed the following documentation: An activity progress note dated 6/30/24 read in part, .Picnic.6/26/24 14:00 (2:00 PM).Location: Activity Room.Resident Attended: Yes. A review of an activity assessment dated [DATE] disclosed that reading a variety of materials, being around animals (dogs), and keeping up with the news were somewhat important to Resident #75. Listening to country/gospel music and participating in religious services were coded to reflect that these activities were very important to the resident and the resident preferred Presbyterian services. The resident was coded to have wished to participate in activities while at the center and would enjoy self-directed activities. Resident #75 was also coded to have physical and mental impairments. A review of the most recent activity assessment dated [DATE] did not disclose any previous/current interests of the resident. The assessment was coded to reflect the resident wished to participate in self-directed activities without modifications to accommodate cognitive deficits and that assistance should be provided to get the resident to activities. The assessment also disclosed that Resident #75 had physical limitations. A review of the comprehensive person-centered plan of care disclosed a focus and interventions which read in part, .resident prefers to participate in self-directed activities such as watching tv programs in their room.assist the resident to perform self-directed activities as needed.provide materials for self-directed activities per resident request if able.review with resident what their self-directed preferences are. On 12/10/25 at 10:30 AM, in an interview with the activity director#1 (AD#1), this surveyor requested evidence of Resident #75's activity participation and/or any evidence of social activities completed with the resident. AD#1 informed this surveyor she did not have any evidence of activity engagement for the resident. On 12/10/25 at 1:41 PM, this surveyor interviewed the facility administrator, and she agreed Resident #75 did not have a person-centered activity care plan and agreed no evidence of documentation for activity participation could be located for the resident since 6/30/24. This concern was discussed at the end of day meeting on 12/11/25 at 3:30 PM with the administrator, director of nursing, and regional director of clinical services. Surveyor requested and received a facility policy titled, Activities Programming with an effective date of 11/1/23 which read in part, .The recreation department will provide, based on the comprehensive assessment and care plan and the preferences of each patient, an ongoing program to support patients in their choice of activities, both facility sponsored group, individual activities, and independent activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident encouraging both independence and interaction.1.activities must.Reflect the.preferences, goals, choices, and rights of patients.Are person appropriate.Are (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appropriate for those with cognitive impairments.Are related to the patient's previous work, life roles, life-long interests, culture, spiritual preference.Are inclusive indoors and outdoors.Allow for socializing with other patients, staff, and with people from outside the Center.Are routine on consistent days.Give the patients a sense of purpose or belonging.Encourage.interaction. No further information was provided to the survey team prior to exit on 12/12/25. 4. For Resident #13, the facility staff failed to provide an individualized on-going person-centered activity program. Resident #13's diagnoses included respiratory failure, altered mental status, hypotension, and muscle weakness. Section C (cognitive patterns) of Resident #13's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/26/25 included a brief interview for mental status (BIMS) score of 3 out of 15 points. Indicating Resident #13 was severely impaired in cognitive skills for daily decision making. Resident #13's comprehensive care plan included the focus area of has impaired vision related to macular degeneration, resident prefers self-directed activities such as watching tv programs in their room, stated she doesn't prefer group activities, she enjoys listening to tv in her room. Interventions included assist the resident to perform self-directed activities, respect choice in regard to limited/no group participation, and review with the resident what their self-directed preferences are. Resident #13's clinical record included an activities assessment completed 11/14/25. Under the questions how important is it to you to listen to music you like, be around animals such as pets, keep up with the news, go outside to get fresh air when the weather is good, and participate in religious services or practices the facility staff had marked Resident #13's response as Very important. On 12/10/25 at 9:55 a.m., Resident #13 was observed in their room, resting on bed, their TV was off, and an envelope/mail was observed on their over the bed table. When asked about this envelope/mail Resident #13 stated she was not aware she had any mail on her over the bedtable, and no one had read it to her. On 12/10/25 at 10:30 a.m., the surveyor requested from the Activities Director a 1:1 activity participation record and/or any evidence of social activities completed with this resident. The Activities Director stated she did not have the requested item(s), and she had not done any with this resident as she's usually lethargic. After this interview the surveyor and the Activities Director entered Resident #13's room. Resident #13's TV was again observed to be off. The Activities Director asked the resident if she would like a radio and the resident stated that would be nice. When asked about the unopened mail/envelope on the over the bed table this staff stated they had been the one to lay it on the over the bed table and the resident was asleep when she brought it in. Resident #13 stated she would like to have someone read it to her. On 12/10/25 at 1:05 p.m., the surveyor observed Resident #13 in their room, resting on bed. The TV remained off and there was no radio in the room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/25 during an end of the day meeting with the Administrator, Director of Nursing, and Regional Director of Clinical Services the above issues were reviewed. The Administrative staff provided the survey team with a copy of policy titled, Activities Programming. This policy read in part, The recreation department will provide, based on the comprehensive assessment and care plan and the preferences of each patient, an ongoing program to support patients in their choice of activities.designed to meet the interests of an support the physical, mental, and psychosocial well-being of each resident encouraging both independence and interaction in the community.These activities must.Reflect the schedule, preferences, goals, choices, and rights of the patients.Are person appropriate.Give the patient a sense of purpose or belonging. No further information regarding this issue was provided to the survey team prior to the exit conference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, resident interview, staff interview, and clinical record review the facility staff failed to ensure the resident received the provider ordered amount of oxygen for 1 of 35 residents, Resident #61.Resident #61's Oxygen was observed to be set at 4 1/2 liters and 5 liters a minute. The provider order was for 2 liters a minute.Resident #61's clinical record included the diagnosis chronic obstructive pulmonary disease (COPD).Section C (cognitive patterns) of Resident #61's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/26/25 included a brief interview for mental status (BIMS) score of 7 out of a possible 15 points. Per the MDS manual a score of 7=severe impairment in cognitive skills for daily decision making. Resident #61's clinical record included a provider order for Oxygen at 2 liters per minute via nasal cannula as tolerated every shift for COPD/hypoxia. Date of order 12/05/25. On 02/10/25 at 8:25 a.m., the surveyor observed Resident #61's Oxygen to be set at 4 1/2 liters a minute. Resident #61 stated it's usually at 2 liters a minute, he wasn't sure who changed it, but it does help when he's lying down at night. On 12/10/25 at 1:10 p.m., the surveyor observed Resident #61's Oxygen to be set at 5 liters a minute. This was confirmed by Licensed Practical Nurse (LPN) #7. This staff checked the order and adjusted the Oxygen level. LPN #7 stated the resident would change it. Resident #61's comprehensive care plan included the focus area at risk for respiratory complications. Interventions included administer Oxygen as ordered. The surveyor did not find anything on this care plan indicating Resident #61 would change their Oxygen settings. On 12/10/25 at 3:30 p.m., during an end of the day meeting with the Administrator, Director of Nursing, and Regional Director of Clinical Services the issue with Resident #61's Oxygen was reviewed.No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to use appropriate alternatives prior to the installation of side bed rails for 1 of 35 residents, Resident #2. The findings included: For Resident #2, the facility staff failed to provide evidence of appropriate alternatives prior to the installation of bilateral half-side rails. Resident #2's diagnosis list indicated diagnoses that included, but were not limited to, muscle weakness, difficulty in walking, dementia, macular degeneration, legal blindness, restless leg syndrome, and history of falling. The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 9/30/25 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities indicating the resident was severely impaired in cognition. Section GG (Functional Abilities) coded the resident as being dependent on staff for the ability to roll from lying on back to left and right side and return to lying on back on the bed. On 12/9/25 at 2:11 PM, this surveyor observed Resident #2 lying in bed sleeping with bilateral 1/2 side rails observed upright on the resident's bed. A review of a medical provider orders disclosed an order with a start date of 10/17/25 which read in part, .1/2 side rails for bed mobility, self-positioning and self-support. A review of Resident #2's comprehensive person-centered care plan revealed a focus and intervention that read in part, .resident is at risk for pressure ulcers related to impaired mobility.1/2 upper SR (side rail) x 2 for bed mobility, self-repositioning and self-support. with a created date of 9/23/25. A review of a Bed Side Rail Tool dated 9/30/25 produced no evidence of alternatives being attempted prior to the use of side rails for the resident. On 12/11/25 at 11:35 AM, this surveyor spoke with regional director of clinical services (RDCS) and she informed surveyor Resident #2's BIMs was higher at the time the bed rails were implemented and the resident may have requested them. She agreed the assessment indicated no alternatives were attempted prior to the installation of the rails. This concern was discussed at the end of day meeting on 12/11/25 at 3:30 PM with the administrator, director of nursing, and regional director of clinical services. Surveyor requested and received a facility policy titled, Device Assessment with an effective date of 1/29/24, which read in part, .All appropriate assessments.and documentation will be initiated. No further information was provided to the survey team prior to exit on 12/12/25.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure 1 of 35 sampled residents was free of significant medication errors, Resident #2. The findings included:For Resident #2, the facility staff failed to hold the medication Humalog for blood glucose levels less than (120) one-hundred twenty, as ordered by a medical provider. Resident #2's diagnosis list indicated diagnoses that included, but were not limited to, type 2 diabetes mellitus with diabetic polyneuropathy, hypertension, dementia, chronic kidney disease-stage 3, and muscle weakness. The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 9/30/25 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities indicating the resident was severely impaired in cognition. A review of a medical provider orders disclosed an order which read in part, .Humalog Solution 100 UNIT/ML (milliliters) (Insulin Lispro (Human)) Inject 2 unit subcutaneously (under the skin) before meals for diabetes Do not give if glucose < 120 (less than one-hundred twenty). A review of Resident #2's November and December 2025 MARs (medication administration records) indicated Humalog was administered on the following dates/times with BS (blood sugars) levels outside of the ordered parameter of holding the medication if BS <120: 11/16/25-BS 114 at 11:30 AM11/16/25-BS 102 at 16:30 (4:30 PM)11/26/25-BS 106 at 16:3011/29/25-BS 118 at 16:3012/9/25-BS 98 at 11:30 AM A review of Resident #2's comprehensive person-centered care plan included a focus area stating the resident had a diagnosis of type 2 diabetes mellitus with an intervention which read in part, .administer medications as ordered. This concern was discussed on 12/11/25 at 3:30 PM at the end of day meeting with the administrator, director of nursing, and regional director of clinical services. Surveyor requested and received a facility policy titled, General Guideline for Medication Administration which read in part, .Medications are administered as prescribed in accordance with good nursing principles and practices.II. Administration.2. Medications are administered in accordance with written orders of the prescriber.IV. Documentation (including electronic) 1.At the end of each medication pass, the person administering the medications reviews the MAR to ensure that necessary doses were administered. No further information regarding this concern was presented to the survey team prior to the exit conference on 12/12/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Rehabilitation and Nursing Center	940 East Lee Highway Chilhowie, VA 24319

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview and facility document review the facility staff failed to ensure a safe and functional environment for 4 of 85 resident rooms. The findings included: On 12/9/25 during the initial tour of the facility this surveyor identified four resident rooms on the second floor with package terminal air conditioners (PTACs) that were pulled loose from the wall causing safety concern, or with outdoors visible through the units and cold air coming in through and around the units. room [ROOM NUMBER] the PTAC was noted to be hanging crooked and loose from the wall. room [ROOM NUMBER], the surveyor could see daylight through the PTAC unit. room [ROOM NUMBER], the surveyor could see outdoors around the unit and the wall was crumbling around the unit. On 12/9/25 at 2:40 PM this surveyor interviewed resident #3. They stated, This whole room needs painting. I took my watercolors and tried to paint it right here, but it doesn't look too good. I thought it would match the other walls better. Resident #3 was talking about the area above the PTAC unit. This surveyor asked if the wall around the unit needed repair and the resident stated, There was rain blowing in through it before they fixed it. I can still feel some cool air coming in right here, (pointing to a hole in the wall on the right side of the unit) but I can't see through there and no rain is coming in anymore. This surveyor looked at the hole; there was no daylight visible through it but there was cool air coming in through it. Resident #3 denied being cold and stated, No, I'm not cold, I can't feel it unless I put my hand there. The whole wall needs patched and painted but they never came back to do it.On 12/11/25 at 12:15 PM this surveyor noted the PTAC unit in room [ROOM NUMBER] was crooked and pulled out and away from the wall causing a safety concern. There was an approximate 4-inch gap between the wall and the left edge of the unit.On 12/11/25 at 1:45 PM this surveyor met with the Administrator, Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) to review the allegations in this complaint. This surveyor discussed concerns with multiple PTAC's in the facility.According to the website http://thefurnaceoutlet.com, You should never be able to see directly outdoors through gaps around the main body of the PTAC unit or it's wall sleeve. PTAC units are installed within a wall sleeve that is designed to create a tight seal and proper insulation to block air leaks, water intrusion, and pests. The Administrator provided the policy entitled, HVAC Wall Units/PTAC with an effective date of 5/1/22 which read in part, Each through the wall heating and air conditioning unit will be inspected and serviced as scheduled to verify units are operational and safe. Under the heading Monthly, the document read in part, 1. Functionally inspect equipment to determine if repair/correction is needed. Check for proper operation and inspect belts and coils. 2. Initiate any necessary repairs or corrections immediately. On 12/12/25 at 12:30 the survey team met with the Administrator, Director of Nursing, and the Regional Director of Clinical Services (RDCS). This concern was discussed with them at this time.No further information was provided to the survey team prior to the exit conference.