

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Alleghany Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Main Street Clifton Forge, VA 24422	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review, facility documentation reviews the facility staff failed to give notification of a room change to one resident, Resident #1(R1) out of a survey sample of eight residents. The findings included: The facility failed to provide a room change consent form, obtain the resident's signature on such a form, or notify the resident or their representative regarding the room change. On 9/9/25 at 11:25 a.m., an interview was conducted with R1 regarding her room change. She stated that she initially did not want to move and did not understand the reason for the change. Staff then explained that the move was for her safety due to the possibility of another incident. After this explanation, she agreed to relocate. On 9/10/25 at 8:40 a.m., an interview was conducted with the Social Worker Director. She explained that the standard process for a room change includes obtaining permission from the resident or their representative, contacting the representative, escorting the resident to the new room, and having a consent form signed. Room changes are also discussed during the morning meeting. She said, that no paperwork was completed for R1 room change by me. On 9/10/25 at 8:50 a.m., the Administrator was interviewed regarding the room change for R1. She stated that she had assumed the social worker completed the paperwork for the room change. She stated that a meeting was held with R1, during which staff explained that the move was for her safety and would be beneficial. R1 agreed to the room change. On 9/10/25 at 2:45 p.m., the director of nursing (DON) stated that R1 requested the room change because she wanted a private room due to not getting along with roommates. On 9/10/25 a clinical record review was conducted. The record contained no signed consent form or documentation that the resident or their representative was notified of the room change. The only note in the chart, dated 7/9/25, indicated that R1's personal belongings were moved to the new room. On 9/10/25 a facility document was reviewed. The document titled, Room changes, read in part, .2. Prior to the room change, we will give the resident's legal representative twenty-four-hour notice to all the resident's legal representative time to prepare for the room change. 4. All room changes will be documented in the resident's chart. The documentation will include a. reason for the change b. notification of resident, family, and their assent. c. the resident's reaction. d. the roommate's reaction. e. follows up on resident and roommate adjustment to the change by visiting within forty-eight hours. Room [NAME] notice Consent to room transfer. On 9/10/25 a meeting was held with the DON, administrator, regional director of clinical services and the vice president of operations. They were made aware of the above concerns. No additional information was provided.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 495141
		If continuation sheet Page 1 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Alleghany Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Main Street Clifton Forge, VA 24422	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Alleghany Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Main Street Clifton Forge, VA 24422	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on resident interview, staff interview, clinical record review, facility documentation reviews the facility staff failed to conduct an accurate investigation of an allegation for two residents, Resident #1 (R1) and Resident #2 (R2) out of a survey sample of eight residents. The findings included: 1. The facility failed to obtain a witness statement from the staff that reported the incident and there was no witness statements from the residents involved in the incident. On 9/9/25 at 11:25 a.m., an interview with R1 was conducted about the allegation she reported on 6/11/25 about R2 touching her thigh in the hallway while she was writing a letter to her sister. R1 stated that R2 was touching her thigh area as he was rolling in his wheelchair after lunch, but the staff told me there was no way he did that. She stated that the staff was going to investigate the situation. On 9/9/25 at 11:35 a.m., an interview was conducted with R2 about the allegation reported on him by R1. R2 stated he was unable to recall that event, and he does not touch anyone. On 9/10/25 at 8:50 a.m., the administrator was interviewed regarding the allegation investigation that was completed on 6/11/25. The administrator stated that she was present with R1 when R1 was reporting that R2 touched her thigh. The administrator stated that it was no way that R2 did that because I had sat R1 up in the hallway with a table and chair to write a letter and had placed her rollator in front of the table, so there was no way R2 could have rolled up to her to touch her thigh. Also, R2 was always the first one out of the dining room and was in his room in the bed for a nap right after lunch. On 9/10/25 at 10:15 AM, the Administrator stated that the Activities Director did not provide a written statement, only a verbal report. The Administrator did not require the Activities Director to complete a witness statement. She further stated that the Activities Director was the one who reported the incident on 6/11/25, in which R1 alleged that R2 touched her thigh. On 9/10/25, incident reports for 6/11/25 involving R1 and R3 were reviewed. The incident on 6/11/25 investigation was missing a witness statement from the Activities Director who submitted the incident report, and there was no witness statements from the residents involved in the incident. 2. The facility staff failed to obtain witness statements from the residents involved and inaccurately reported an incident in which the resident was alleged to have been touched by another resident. On 9/9/25 at 11:25 AM, R1 was interviewed regarding an incident that occurred on 7/6/25. The resident stated that she was in the weight room to be weighed and then went to get ice. While standing by the ice container, R2, who was in a wheelchair, touched her inappropriately by rubbing his hand between her legs. She stated that this made her feel uncomfortable at the time. Staff immediately separated the residents and removed R2 from the room. Since the incident, R1 has received follow-up care from psychological services and the facility's nurse practitioner. She reported that she currently feels safe and does not feel uncomfortable, except if R2 was close to me. Staff have ensured safety by moving R1 to a different wing to prevent further contact. On 9/9/25 at 11:35 a.m., R2 was interviewed regarding the incident. He stated that he did not recall touching anyone, did not remember any details about rubbing anyone or being in the weight room, and expressed that he does not worry about these matters. This witness statement was not included in the investigation. On 9/9/25 at 2:30 PM, an interview was conducted with a Certified Nursing Assistant, CNA#1 (CNA1) regarding an incident she witnessed on 7/6/25 in the weight room. She stated that R2 was on the weight machine when R1 entered the room. The CNA1 assisted R2 off the weight machine and R1 walked up onto the weight machine. The CNA1 was assisting R1 with her sweater, and while R1 was standing next to the ice cart, R2 rolled up in his wheelchair and inappropriately touched her, rubbing her between the legs and in her crotch area, according to CNA1. This information was not in the incident investigation report. On 9/10/25 at 10:44 AM, the Nurse Practitioner was interviewed by phone. She stated that when she followed up with R1, the resident denied feeling uncomfortable during their interaction and reported feeling safe in her room if R2 is not nearby. The residents were placed in separate areas to prevent contact. The Nurse Practitioner (NP) recommended visual aid materials to help address R2's sexual behaviors. She noted that the incident did not appear to affect R1's psychosocial well-being. This information from the NP was not included in the investigation. On 9/10/25, the investigation of the incident for 7/6/25 involving R1 and R3 was reviewed. The 7/6/25 investigation inaccurately documented the incident regarding where R1 touched R2. Additionally, the original investigation did not include a statement from the CNA1 who witnessed the incident; however, the Administrator was able to provide the CNA1's statement later in the day. The investigation did not have witness statements from the residents involved in the incident. On 9/10/25 at 2:45 PM, a meeting was held with the Administrator, the Director of Nursing (DON), the Regional Director of Clinical Services, and the INAMEI President of Operations. During the meeting, they were</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Alleghany Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Main Street Clifton Forge, VA 24422	
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on staff interview, clinical record review, facility documentation reviews the facility failed to follow professional standards of care for two residents, Resident #2 (R2) and Resident #3 (R3) out of a survey sample of eight residents. The findings included:1.The facility staff failed to implement recommendations from the nurse practitioner to assist with R2's behaviors.On 09/10/25 at 10:44 a.m., the Nurse Practitioner (NP) was interviewed and stated that on 07/17/25 she recommended staff provide visual aid materials for R2 to decrease inappropriate touching behaviors. She was unsure if this intervention was ever implemented.On 09/10/25 at 11:35 a.m., the Director of Nursing (DON) was interviewed and stated R2 was never given any materials to watch or use. The DON explained that when NPs make recommendations, staff look at them and provide feedback on whether they work or not, but confirmed the NP was not informed that her recommendation had not been implemented.On 9/10/2025, a clinical record review was conducted. There was a psychiatry NP note documenting R2 was on 1:1 observation for safety due to inappropriate sexual behaviors, including touching staff and residents. The NP documented that, despite 1:1 observation, that R2 continued the behaviors. The NP recommended: Allowing private time to relieve sexual frustration, developing strategies to maintain safety of staff and residents, Considering alternative interventions.A NP progress note documented that R2 admitted to grabbing CNA's breast and buttocks and another resident's genitals, reporting sexual frustration. The NP's plan included: Increasing R2's medication, consulting psychiatry for further evaluation, continuing 1:1 supervision, implementing behavior charting each shift, and spoke with the unit manager about considering materials to help relieve sexual frustration as a potential intervention.The care plan included 15-minute checks and instructions to notify the physician if sexual behaviors continued. However, the care plan did not include or document the NP's recommendations for visual aids, private time, or alternative interventions.On 9/10/2025, a review of facility documentation was conducted. The care plan policy states: A comprehensive care plan must include measurable objectives and timetables to meet medical, nursing, mental, and psychosocial needs. The care plan must be reviewed and updated at least every 90 days. All problems not triggered by the MDS must be addressed. Documentation must support the fact that approaches in the care plan are followed. Staff must know and follow the care plan and notify the clinical nurse or MDS coordinator if they are unable to implement any part of the plan so documentation and updates can occur. The facility failed to follow its own policy and ensured the care plan was updated to reflect NP recommendations for behavioral interventions.2. For Resident #3 (R3), the facility staff failed to follow professional standards of practice by failure to document a complete assessment of the resident following an unwitnessed fall.On 09/10/25 at 9:40 a.m., the Director of Nursing (DON) was interviewed. The DON confirmed that neuro checks were missing from R3's clinical record and stated, yes, you are correct that neuro checks were missing. There was no documentation for neuro checks on some of the days after this unwitnessed fall.On 9/10/25, a clinical record review was conducted. A progress note documenting that R3 experienced an unwitnessed fall on 08/29/25. Neuro checks were initiated; however, the documentation showed the neuro checks were not consistently completed and not done on all required days following the unwitnessed fall.On 9/10/25, a review of facility documentation was conducted. A facility document titled, Steps to Follow When a Fall Occurs, states staff must: Assess the resident for injury, Provide treatment, Notify the doctor and family, Complete an incident report, and Document in the medical record and 24-hour report The facility failed to follow its own fall management procedure by not ensuring neuro checks were consistently completed after R3's unwitnessed fall.On 9/10/25 at 2:45 p.m., an end of day meeting was conducted with the administrator, DON, regional director of clinical services and vice president of operations. They were made aware of the above concerns.No additional information was provided.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Alleghany Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Main Street Clifton Forge, VA 24422	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on staff interview, clinical record review, facility documentation reviews the facility staff failed to implement fall interventions for two residents, Resident #2 (R2) and Resident #3 (R3) out of a survey sample of eight residents. The findings included:1.The facility failed to implement interventions for several falls on R2's care plan.The Director of Nursing (DON) was interviewed on 09/10/25 at 9:40 a.m. The DON stated, I know interventions need to be on the care plan, I get that, but sometimes we have other things. The DON was unable to provide any evidence that fall-related interventions had been placed on the care plan.A clinical record review conducted on 09/10/25 revealed R2 had documented falls on 7/17/25. Review of the care plan showed that no new fall interventions were added following this fall. The facility failed to implement interventions on the resident's care plan after a fall, as required to address ongoing risk and ensure resident safety.2.The facility staff failed to implement interventions for a fall on R3's care plan. The Director of Nursing (DON) was interviewed on 09/10/25 at 9:40 a.m. The DON stated, I know interventions need to be on the care plan, I get that, but sometimes we have other things. The DON was unable to provide any evidence that fall-related interventions had been placed on the care plan.A clinical record review conducted on 09/10/25 revealed R3 had documented falls on 05/17/25, 05/21/25, 08/23/25, and 08/29/25. Review of the care plan showed that no new fall interventions were added following these falls. The facility failed to implement interventions on the resident's care plan after multiple falls, as required to address ongoing risk and ensure resident safety. A facility document titled, Steps to Follow When a Fall Occurs, (reviewed on 09/10/25) states staff must: hold an immediate team meeting with current staff to determine interventions to prevent further falls, establish new interventions and place them on the care plan, and implement interventions on the care plan. The facility failed to follow its own procedure and ensure R3's care plan was updated with interventions following multiple falls.A meeting was held with the administrator, DON, regional director of clinical services, and vice president of operations. They were made aware of the above concerns.No additional information was provided.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Alleghany Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Main Street Clifton Forge, VA 24422	
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)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observations, resident interview, staff interview, facility documentation reviews the facility staff failed to maintain a sanitary environment on two of three units. The findings included: The facility failed to maintain a sanitary environment for one bathroom on B wing and one resident's room on A wing. On 9/9/25 at 10:30 a.m., an observation was made on the B wing in room B6 revealed dried brownish material consistent with feces on the base of the commode, on the floor around the commode, and down the side of the commode. On 9/9/25 at 10:45 a.m., an interview was conducted with the housekeeper. She stated that when cleaning resident rooms, staff are responsible for dusting the blinds, cleaning the sink, cleaning the bathroom, dusting surfaces and above the lights, mopping and sweeping the floors, and removing the trash. She further said, there are times I feel like the rooms are not cleaned like they should be, and we could do a better job. The housekeeper observed the bathroom in room B6 and said, that is feces, and I feel like it's getting up under the floor tiles. I don't have a scrubber to scrub with, so I just do the best I can with a rag and mop. She also said, I feel like the facility could be cleaner, but we're contracted. We're not allowed to touch personal belongings, and sometimes it's a struggle to get the nursing staff to remove the belongings so we can clean. On 9/9/25 at 11:45 a.m., observation of the resident room on the A wing in room A6 revealed wallpaper that was puckered and moist. An odor resembling cat urine was noted in the room. On 9/9/25 at 11:45 a.m., an interview was conducted with Resident #4 (R4). She stated that her room had been painted, but the wallpaper was puckered and the room smelled like cat urine. She said, it was hard to sleep. She stated when she asked the staff about it, they told me the roof leaks, and that maybe an animal or person peed in the corner, R4 stated that she has difficulty sleeping with the odor, said, I sleep turned toward the window, and it makes it hard to rest. On 9/10/25 at 10:00 a.m., an interview was conducted with the Maintenance Director. He observed the wall in room A6 and agreed that the wallpaper was puckered. He said, There's a drain right outside that window where it's puckered, and it could be sweating and causing the wallpaper to pucker. The maintenance director further stated that he did not notice an odor at the time of observation but said, if there is an odor, it might be coming from that wallpaper. He also stated that no worker had been submitted for this concern. On 9/10/25 at 10:20 a.m., an interview and observation were conducted with the Administrator, the Director of Nursing (DON), and the regional director of clinical services (RDCS). Upon entering room A6, the DON and RDCS stated that they smelled the odor. All three individuals observed the wallpaper, felt the wall and stated it was moist. The Administrator stated she did not smell an odor. On 9/10/25 a facility policy was requested for room sanitation and cleanliness. The administrator provided a form titled, Job to be done. Complete room cleaning. No policy was provided. On 9/10/25 at 2:45 p.m., a meeting was held with the administrator, DON, RDCS and [NAME] president of operations and they were made aware of the above concerns. No additional information was provided.</p>		