STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain the dignity of multiple residents on one of two units during meal distribution. The findings included:The facility staff failed to serve all residents at the table at the same time. The facility staff failed to knock prior to entering resident rooms. The facility staff failed to provide adequate supervision during meals and failed to sit next to residents while assisting with meals. On 8/5/25 at 12:07 p.m., observations were conducted of the lunch meal service on the A-wing. At 12:07 p.m., the first cart of meal trays had just arrived on the unit and Resident #18 (R18) was observed sitting in the tv room with six other residents. R18 was served her meal. The facility staff then continued distributing meal trays to residents eating in their room. During the distribution of meal trays facility staff entered multiple resident rooms without knocking on the door or announcing themselves prior to entering the rooms. Multiple observations were made of facility staff assisting residents with meal set-up, exiting the room, retrieving another meal tray from the cart, and then distributing the tray to another resident without performing any hand hygiene. On 8/5/25 at 12:30 p.m., a second resident (Resident #16) was observed being served in the tv room was served their meal. On 8/5/25 at 12:36 p.m., when the third cart of meal trays arrived at the unit and staff started distributing food to additional residents in the tv room. Resident #16 (R16) reported to facility staff that Resident #17(R17) had taken her fork from her meal tray. The staff retrieved the fork from R17 and agreed to get R16 another fork so she could eat. On 8/5/25 at 12:51 p.m., the remaining residents in the tv room received their meal trays. This included one resident (Resident #13) who was totally dependent on facility staff to be fed, his tray was sat on the table in front of him without staff immediately available to assist him to eat. Resident #2 was observed pouring his tea/beverage over his food and a few minutes later when staff noticed, the staff responded by asking him to sit the cup down, no offer to provide a replacement meal was made. On 8/5/25 at 12:53 p.m., the unit manager was assisting to feed resident #15, standing next to the resident, who was seated. There was an available unoccupied chair next to the resident and two others against the wall. On 8/5/25 at 1 p.m., additional observations revealed two additional facility staff assisting to feed residents in the tv room and they were both standing next to the residents while feeding them. There were three available and unoccupied chairs in the tv room. On 8/5/25 at 2:34 p.m., an interview was conducted with the facility's director of nursing (DON), in the presence of the regional direct of clinical operations. When asked to explain how meal distribution is to be performed, the DON stated that the residents who need assistance were to be served last. The DON explained by doing that it gives the staff time to distribute the meal and then to sit and assist with feeding the residents who need assistance. When asked about serving residents in the tv room, the DON reported they were to be served last. When asked about supervision in the tv room the DON explained that staff should be supervising . to make sure they don't choke or anything. The DON was made aware of the lack of supervision as evidenced by one resident taking another resident's fork when no staff were present in the room and that while the unit manager was assisting to feed another resident, R2 poured his beverage over his food. The DON went on to explain that when staff are assisting residents to eat, they should be sitting beside the resident. The DON explained that it is . more personable when they are at eye level, we don't want them to feel like we are rushing them by standing over them. The DON explained that when staff enter a room, they are to knock prior to entering. When asked about hand hygiene, the DON said she expected hand hygiene to be performed between each resident during meal distribution. Review of the facility policy titled, Promoting/Maintaining Resident Dignity During Mealtimes, was conducted. This policy read in part, It is the practice of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhances his or her quality of life, recognizing each resident's individuality and protecting the rights or [sic] each resident. 1. All staff members involved in providing feeding assistance to residents promote and maintain resident dignity during mealtimes . 5. All staff will be seated, if possible, while feeding a resident. The facility was asked to provide a policy as it relates to the distribution of meals, but it reported they didn't have such a policy. On 8/6/25, during an end of day meeting, the facility administrator and director of nursing were made aware of the above concerns. No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to dress a resident in their personal clothing to maintain dignity for one resident (Resident #2-R2) in a survey sample of forty-one residents. The findings included:Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to dress a resident in their personal clothing to maintain dignity for one resident (Resident #2-R2) in a survey sample of forty-one residents. The findings included: On 8/5/25 at 12:07 p.m., observations were conducted of the lunch meal service on the A-wing. Resident #2 was sitting in the tv room with six other residents for the lunch meal. R2 was sitting in a geri-chair [medical recliner] with a hospital gown on and his back exposed. On 8/6/25, during an end of day meeting, the above observation was discussed with the facility administrator and director of nursing. On 8/7/25 at 8:15 a.m., R2 was observed sitting in the geri-chair in the hallway at the nursing station. R2 had a hospital gown on, he did have a blanket but had pulled it up and his legs and thighs were exposed. On 8/7/25 at 8:30 a.m., the surveyor went to R2's room and observed two pairs of shorts in his closet and a pair of lounge pants on the bed. On 8/7/25 at 9:30 a.m., R2 was observed in the tv room, which was on the main hall from the lobby to the A-wing, sitting at the table with his hospital gown on top of the table, which left his legs, incontinence brief and stomach exposed. The doorway was open, and the resident could be easily seen from the hallway by any staff, visitors or other residents entering or exiting the A-wing. The unit manager (LPN #3) was asked to come to the tv room. When the unit manager saw R2, she said, Oh, my. The unit manager said the resident should be covered and agreed it was a dignity concern. She went on to say that she saw him at the nursing station earlier and thought the staff were going to take him to the shower but she entered her office and hadn't been back out. LPN #3 then removed R2 from the tv room. On 8/7/25 at 10:30 a.m., the surveyor went to R2's room. R2 was not in his room. R2's roommate reported to the surveyor that the resident was not in there, but staff had come in and gotten clothes for the resident. On 8/7/25 at 10:50 a.m., R2 was observed in the tv room and had been showered. R2 was fully clothed in personal clothes that included a T-shirt, jeans, socks and shoes. An interview with R2 was attempted but was not successful due to R2's cognitive impairments. On 8/7/25 at 10:55 a.m., an interview was conducted with a certified nursing assistant (CNA #2), who confirmed she had showered R2. When asked about his clothing, she reported he didn't have a lot of clothes but was dressed in his personal clothes following the shower. When asked what they do if a resident doesn't have personal clothing available, CNA #2 reported that they have a lost and found they can go retrieve clothes from. On 8/7/25 at 11 a.m., the facility administrator and director of nursing were made aware of the above findings/observations. According to the facility policy titled, Resident Rights, which read in part, . 11. The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents. According to a facility document titled, Resident Rights it read, 1. Resident rights. The resident has the right to a dignified existence. 5. Respect and dignity. The resident has a right to be treated with respect and dignity, including: . b. The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. No additional information was received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive plan of care for four of forty-one residents in the survey sample (Residents #2, #13, #20 and #24).The findings include:1. Resident #2's plan of care was not revised to include the resident's do not resuscitate status, enrollment in hospice services, or that a fall occurred on 7/4/25. Resident #2 (R2) was admitted to the facility with diagnoses that included dementia, psychotic disturbance, mood disorder, anxiety, chronic kidney disease, gastroesophageal reflux disease, obesity, congestive heart failure, peripheral vascular disease and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed R2 with severely impaired cognitive skills. R2's clinical record documented a DDNR (Durable Do Not Resuscitate) form signed on 6/3/25, indicating no resuscitation was to be initiated in case of cardiac arrest. R2's clinical record documented a physician's order dated 6/3/25 for the DNR status and an order for no hospitalizations. R2's clinical record documented the resident was found on the floor on 7/4/25, with neurological checks initiated. R2's clinical record documented the resident was enrolled in hospice services on 7/25/25. R2's plan of care (revised 7/15/25) documented the resident's resuscitation status as Full Code, which contradicted the physician ordered DNR/do not hospitalize status. R2's care plan did not indicate the resident fell on 7/4/25 and the care plan had not been revised indicating the resident's enrollment in hospice services. On 8/6/25 at 10:35 a.m., the licensed practical nurse (LPN #2) caring for R2 was interviewed about the resident's resuscitation status. LPN #2 stated R2 currently had a DNR order. LPN #2 stated the unit manager was responsible for updating care plans. On 8/6/25 at 10:40 a.m., the unit manager (LPN #3) caring for R2 was interviewed about the plan of care. LPN #3 stated R2 was a full code when admitted but orders were entered on 6/3/25 changing the resident's status to DNR. LPN #3 stated the care plan should have been updated to indicate the DNR status. LPN #3 stated R2 was currently receiving hospice services and that the care plan should have been revised to include hospice. LPN #3 stated, It [care plan revisions] just got missed somehow. On 8/7/25 at 8:30 a.m., LPN #3 was interviewed about R2's fall on 7/4/25. LPN #3 stated R2 was found on the floor on 7/4/25 and therapy assessed the resident following the fall, regarding chair cushions and the use of a reclining chair. LPN #3 stated the fall of 7/4/25 should have been added to the care plan. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 8/6/25 at 4:10 p.m. with no further information presented prior to the end of the survey. 2. The facility staff failed to revise R24's care plan to reflect the current care needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/6/25 at 3:00 p.m., a clinical record review was conducted. R24's care plan, last revised on 4/11/24, indicated that R24 was to utilize assistive bars for bed mobility. However, no assistive bars were present on his bed. The care plan also listed a fall intervention to remind R24 to lock his wheelchair brakes. Yet, R24 has been bedridden for over three years, uses a stretcher for transport outside of his room, and does not have a wheelchair. The care plan further documented a pressure-relieving mattress and a concave mattress on his bed; however, orders were for a standard pressure reduction mattress. The care plan also included a wound treatment to the left above-knee amputation site, despite R24 having no wounds. On 8/6/25, during an end-of-day meeting with the administrator, director of nursing, and corporate staff, these care plan discrepancies were discussed. No additional information was provided. On 8/7/25 at 10:20 a.m., an interview was conducted with the Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse #4 (LPN4). LPN4 stated she had updated R24's assessment on 7/2/25 and the care plan was updated at that time. When asked about the assistive bars for bed mobility, LPN4 said, They aren't on there. I didn't know they had been removed. LPN4 further stated that R24 had no trunk strength and could not sit up in a wheelchair. When asked why the fall intervention to lock wheelchair brakes was still in the care plan, LPN4 responded, He has not had a wheelchair for a while; I'm not sure why locking the brakes is still on the care plan. 3. For Resident #13 (R13), the facility staff failed to review and revise the care plan to accurately reflect the ordered seating system. On 8/5/25, 8/6/25, and 8/7/25, observations were conducted of R13. R13 was observed in each of the observations to be sitting in the tv room on the unit, in a broda chair [type of wheelchair capable of reclining]. On 8/6/25, a clinical record review was conducted, which noted that R13 had a fall on 6/9/25. According to the progress note which read, Resident rolled onto floor. Bed was in lowest position. Abrasion to right thigh and small abrasion to top of head. Review of R13's care plan identified R13 as a fall risk, but didn't reference that he had a fall and sustained injuries on 6/9/25. There was no mention of the abrasions, nor the treatment required for those injuries. Within the activities of daily living care plan were interventions regarding the residents' seating when out of bed, that was contradictory and unclear. One intervention dated 8/6/25 read, [R13's name redacted] is to be in a full tilt/reclining position when up in his broda chair except mealtimes when he can be upright. Another active intervention dated 1/23/25 read, Resident has geri chair r/t [related to] muscle weakness from Huntington's Disease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/6/25 at approximately 2:30 p.m., an interview was conducted with registered nurse #2 (RN #2) and licensed practical nurse #4 (LPN #4), who were both care plan coordinators. RN #2 and LPN #4 both explained that the care plan is to personalize care and make sure individual needs are met. They explained that everyone uses the care plan. They said, With the certified nursing assistants we make sure everything is put on their activities of daily living care plan, like how they transfer, if they are continent, etc. It tells the staff what care needs they have and how to take care of the resident. When RN #2 and LPN #4 were made aware of the varying seating for R13 on the care plan, RN #2 said, I've only been here since the end of April. They explained that the unit managers are responsible for daily updates. They confirmed that when the broda chair was implemented they failed to remove the geri chair. They confirmed that the care plan did not reflect the resident's fall with injury on 6/9/25. On 8/6/25, interviews were conducted with three of the nursing assistants on the unit. Only one, certified nursing assistant #3 (CNA #3) reported having worked on the unit for more than a month. During the interview with CNA #3, she reported she had worked at the facility for at least two years and was very familiar with R13. CNA #3 reported that R13 had been in a broda chair when out of bed for at least two years and a geri chair was not used. 4. For Resident #20 (R20), who sustained two falls, one resulting in a hip fracture, the facility staff failed to review and revise the care plan to include the falls sustained or the hip fracture. On 8/6/25, during a clinical record review, it was noted that R20 was discharged on 4/26/25 and was readmitted on [DATE]. According to a hospital Discharge summary dated [DATE], which noted that R20 was hospitalized and underwent a right intertrochanteric femur fracture with cephalomedullary implant [hip fracture with surgical repair]. Within R20's clinical chart the only documentation regarding a fall that resulted in a hip fracture was from the on-call provider in a progress note dated 4/26/25, which read in part, . Patient fell unwitnessed and fell on right hip. Abrasion and hematoma to right knee. Patient complained of 10/10 sharp stabbing pain to right hip and leg. Fall unwitnessed. Administered pain medication not effective. Recommendation/request: Sent to ER [emergency room] . According to a Post Fall Review under the assessment tab dated 5/30/25, R20 had a fall that required first aide. According to R20's care plan there was no documentation of the falls on 4/26 or 5/30. There was no revisions to include R20's hip fracture and non-weight bearing status to his right lower extremity as documented in the physician orders. On 8/6/25 at approximately 2:30 p.m., an interview was conducted with registered nurse #2 (RN #2) and licensed practical nurse #4 (LPN #4), who were both care plan coordinators. RN #2 and LPN #4 both explained that the care plan is to personalize care and make sure individual needs are met. They explained that everyone uses the care plan. They said, With the certified nursing assistants we make sure everything is put on their activities of daily living care plan, like how they transfer, if they are continent, etc. It tells the staff what care needs they have and how to take care of the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R20's care plan was discussed with RN #2 and LPN #4. Both confirmed that during daily clinical meetings progress notes, physician orders, and new admissions are reviewed and discussed, and care plans are to be updated by the unit managers. Both confirmed that the care plan should have been reviewed and revised following falls and to reflect the hip fracture. According to the facility policy titled, Care Plan Revisions Upon Status Change, which read in part, 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. a. Upon identification of a change in status, the nurse or any member of the interdisciplinary team will notify the MDS Coordinator, the physician, and resident representative, if applicable. d. The care plan will be updated with the new or modified interventions. F. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. On 8/6/25, during an end of day meeting, the facility administrator and director of nursing were made aware of the above concerns. No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 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, facility document review and clinical record review, the facility staff failed to follow professional standards of care for two of forty-one residents in the survey sample (Residents #2 and #20).The findings include:1. Nursing staff failed to document in the clinical record an unwitnessed fall for Resident #2, including immediate assessments, actions taken and circumstances of the fall. Resident #2 (R2) was admitted to the facility with diagnoses that included dementia, psychotic disturbance, mood disorder, anxiety, chronic kidney disease, gastroesophageal reflux disease, obesity, congestive heart failure, peripheral vascular disease and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed R2 with severely impaired cognitive skills. R2's clinical record documented a nurse practitioner progress note dated 6/18/25 at 11:59 p.m. This note documented, .The patient sustained a fall yesterday [6/17/25], but no injuries were reported. Neuro checks initiated and have been unremarkable. Patient has been at baseline mental status since fall. Did not hit head or have LOC that staff is aware of . R2's clinical notes on 6/17/25 had no documentation regarding the fall and included no record of an immediate assessment of the resident, or circumstances surrounding the fall. The notes made no mention of how staff were aware the resident did not hit his head. There was no documentation of neurological assessments initiated or completed following this fall. The last note documented prior to the practitioner's note on 6/18/25 was on 6/12/25. The nurse practitioner documented that R2 was assessed on 6/18/25 with no injuries or complications from the fall. On 8/7/25 at 8:30 a.m., the licensed practical nurse unit manager (LPN #3) was interviewed about R2's fall on 6/17/25. LPN #3 reviewed the clinical record and stated she found a nursing note about the fall but stated she found no resident assessment or documentation regarding the circumstances surrounding the fall in the clinical record prior to the practitioner's note on 6/18/25. LPN #3 stated that she did not see where neurological assessments were initiated or completed following the fall. LPN #3 stated that regarding the lack of documentation, You would think there would be a note. LPN #3 stated nurses were expected to document a fall in the nursing notes along with any assessments, notifications, and actions taken regarding the incident. LPN #3 stated that a risk management form was completed for the fall of 6/17/25, but nothing was documented in the clinical record. On 8/7/25 at 10:00 a.m., the director of nursing (DON) was interviewed about lack of documentation regarding R2's fall on 6/17/25. The DON stated it was a standard of practice for nurses to document incidents at the time they happened, including falls. The DON stated the circumstances of the fall, and any resident assessments should have been documented in the clinical record. The DON presented the risk management form for R2's fall on 6/17/25, which was labelled Not Part of the Medical Record. This form documented R2 was found on the floor beside his bed on 6/17/25 at 11:00 p.m., that the resident was assessed with no injuries, and that notifications were made to the physician and family. Although none were found in the clinical record, this form also noted that neurological checks were initiated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Fall Prevention Program (revised 12/1/24) documented, .When any resident experiences a fall, the facility will .Assess the resident .Complete a Post-fall Review and a Post Fall Follow Up note in PCC [electronic health record] .Notify physician and family .review the resident's care plan and update as indicated .Document all assessments and actions . The Lippincott Manual of Nursing Practice 11th edition on page 15 lists that common departures from standards of care include failure to make prompt, accurate entries in a patient's medical record and documented, .A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events . (1) This finding was reviewed with the administrator and director of nursing on 8/7/25 at 12:30 p.m. with no further information presented prior to the end of the survey. (1) [NAME], [NAME] M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/[NAME] & [NAME], 2019. 2. For Resident #20 (R20), the facility staff failed to follow professional standards of practice by failure to document an incident and assessment of the resident following a fall resulting in a hip fracture. On 8/6/25 a clinical record review was conducted of R20's chart. According to the census tab and progress notes, R20 was admitted to the facility on [DATE], after being involved in a car accident and sustaining a right shoulder blade fracture with a T11 spinal compression fracture. According to the census tab, R20 discharged on 4/26/25 and was readmitted on [DATE]. According to a hospital Discharge summary dated [DATE], which noted that R20 was hospitalized and underwent a right intertrochanteric femur fracture with cephalomedullary implant [hip fracture with surgical repair]. Within R20's clinical record, the only documentation regarding a fall that resulted in a hip fracture was from the on-call provider in a progress note dated 4/26/25, which read in part, . Patient fell unwitnessed and fell on right hip. Abrasion and hematoma to right knee. Patient complained of 10/10 sharp stabbing pain to right hip and leg. Fall unwitnessed. Administered pain medication not effective. Recommendation/request: Sent to ER [emergency room] . There was no documentation within R20's clinical record as to the circumstances of the fall, the location and details of the fall, condition resident was found in, facility staff's assessment of the resident, nor that the resident's condition was discussed and orders were obtained to send the resident to the hospital for evaluation. There was no documentation that the facility nursing staff had assessed the resident, his condition at the time of the fall, injuries, pain, etc. On 8/6/25, during an interview with the facility's director of nursing (DON), in the presence of the regional director of clinical services, the DON was made aware of the above findings. The DON reviewed R20's clinical record and confirmed the above findings. The DON did provide the surveyor with an event synopsis, which she did confirm was not part of R20's clinical record. The DON stated that the expectation is that the facility staff would document any fall incidents in the resident's chart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/25, during an end of day meeting, the facility administrator was made aware of the above findings. On the morning of 8/7/25, interviews were conducted with licensed practical nurses #9 & #10 (LPN #9 and LPN #10). Both LPN #9 and LPN #10 reported that following a fall, the facility's nursing staff assess the resident for injury, obtain vital signs and initiate neuro checks, notify the doctor and family, and then document within the clinical record all of the details. According to the facility policy titled, Fall Prevention Program, which read in part, . 9. When any resident experiences a fall, the facility will: A. Assess the resident. B. Complete a post-fall review and post fall follow-up note in PCC. C. Complete an incident report in PCC. D. Notify physician and family. E. Review the residents' care plan and update as indicated. F. Document all assessments and actions. G. Obtain witness statements in the case of injury. H. If there are signs of serious injury or there are concerns about the circumstances of the fall, notify the Director of Nursing and/or the Administrator. I. Begin neurologic assessment using the Neurological Record assessment tool in PCC. According to the American Associated of Post-Acute Care Nursing, standards of care following a fall included: . 1. Immediate Assessment: Evaluate the resident's vital signs, level of consciousness, and any visible injuries. Check for signs of head, neck, or spinal injuries, and assess for fractures or significant bleeding. 4. Documentation and Investigation: Record the circumstances of the fall, the resident's outcome, and the staff's response. Investigate the possible causes of the fall to prevent future incidents. Accessed online at aapacn.org No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to follow physician orders for six residents (Resident #13- R13, Resident #14-R14, Resident #20-R20, Resident #21-R21, Resident 2-R2, and Resident #24-R24) in a survey sample of forty-one residents. The findings included:1. For R13, the facility staff failed to assess and obtain neurological checks following a fall. On 8/5/25 at 12:10 p.m., R13 was observed in the dining room seated in a Broda chair [a wheelchair with reclining capabilities]. Attempts were made to converse with R13 but were not successful. On 8/6/25, a clinical record review was conducted of R13's chart. This review revealed a progress note dated 6/9/25 at 1:30 a.m., that read, Resident rolled onto floor. Bed was in lowest position. Abrasion to right thigh and small abrasion to top of head. On call nurse notified as well as the resident's sister who is emergency contact. [On-call medical provider name redacted] contacted as well. Vital signs were 115/83; 97.3; 123; 18; 90% RA. Will continue to monitor resident closely. According to a 6/9/25 entry, the on-call medical provider documented orders as, Neuro checks, monitor for mental status changes, N/V [nausea and vomiting], HA [headache] Head to toe assessment to identify any injuries. Monitor for c/o [complaints of] pain or s/s [signs and symptoms of] injury. According to a document titled, Neurological Record found under the assessment tab of R13's chart, a neurological evaluation/assessment was conducted at 2:15 a.m., which was 45 minutes after documentation of the fall in the nursing progress notes. According to the facility protocol, evaluations are to be conducted at the time of the fall and every fifteen minutes for an hour. The second scheduled neurological evaluation was also dated and time stamped as 2:15 a.m., noting that the level of consciousness was not assessed. According to this neurological record, the next recorded assessment of R13's neurological status post the fall did not occur until 7:45 p.m. that evening. 2. For R20, who had two unwitnessed falls, one with injury resulting in a hip fracture, the facility staff failed to have evidence of an assessment of the resident, including neurological assessments as indicated by facility protocol. On 8/6/25, during a clinical record review, it was noted that R20 was discharged on 4/26/25 and was readmitted on [DATE]. According to a hospital Discharge summary dated [DATE], which noted that R20 was hospitalized and underwent a right intertrochanteric femur fracture with cephalomedullary implant [hip fracture with surgical repair]. Within R20's clinical chart, the only documentation regarding a fall that resulted in a hip fracture was from the on-call provider in a progress note dated 4/26/25, which read in part, . Patient fell unwitnessed and fell on right hip. Abrasion and hematoma to right knee. Patient complained of 10/10 sharp stabbing pain to right hip and leg. Fall unwitnessed. Administered pain medication not effective. Recommendation/request: Sent to ER [emergency room] . There was no documentation or evidence of a nursing assessment of R20 following the fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For the second fall that occurred on 5/30/25, there was a post-fall review under the assessment tab of the clinical record. It noted that the fall was unwitnessed, first aide was performed, but the vital signs noted were from the previous day and there no evidence that any further assessment was performed. Also found was an assessment titled, Neurological record dated 5/30/25, but it was incomplete. The first four evaluations were completed every 15 minutes as per the facility protocol and assessment form. The next scheduled assessment was to be done thirty minutes later at 1:15 a.m. on 5/30/25, but noted that the recorded vital signs were from 5/29/25 at 2:38 p.m. The subsequent two assessments still had recorded the same vital signs from 5/29/25 at 2:38 p.m., indicating that the vital signs were not obtained. This documented revealed that the neurological evaluation numbers 9-12 and number 17 were not performed. On 8/6/25 at 4:05 p.m., an interview was conducted with the director of nursing (DON). The DON explained that neuro checks are to be conducted on any resident who had an unwitnessed fall or hit their head. She also stated that staff are to do a post-fall documentation for three days following a fall. She explained that it was important to identify if there are any latent injuries. The DON was unsure of the frequency of neuro checks and stated she would like to reference their policy. The facility policy was requested. On 8/6/25, during an end of day meeting, the facility's regional director of clinical services reported to the survey team that they did not have a policy for neuro checks. The above findings regarding R13 and R20 were reviewed. On 8/7/25, interviews were conducted with licensed practical nurses #9 & #10 (LPN #9 & LPN #10). Both explained that when a resident falls the nurse is to complete a full head to toe assessment, initiate neurological evaluations, notify the doctor and family of the resident and document all the details of the fall, assessment, etc. in the resident's medical record. When asked about the frequency of the neurological evaluations, LPN #10 provided the surveyor with a document titled, Post Fall Assessment Checklist that noted post-fall assessments were to be completed every eight hours for 72 hours following a fall. LPN #10 also provided an untitled document and stated the neurological evaluations and vital signs were to be obtained according to the frequency noted on that form that was initially after the fall, every 15 minutes four times (for a total of an hour), then every thirty minutes twice (for an hour), every hour for four hours, every four hours for six occurrences and then the subsequent two shifts. According to the facility policy titled, Fall Prevention Program, which read in part, . 9. When any resident experiences a fall, the facility will: a. asses the resident. B. complete a post-fall review and post fall follow up note in PCC [the electronic health record system]. 3. Complete an incident report in PCC [electronic health record]. D. Notify the physician and family. E. Review the residents' care plan and update as indicated. F. Document all assessments and actions.i. begin neurologic assessment using Neurological Record assessment tool in PCC. No additional information was provided. 3a. For Resident #21, who fell and sustained a right proximal humerus (shoulder) fracture, facility staff failed to ensure that the therapy ordered by the orthopedic surgeon for range of motion was carried out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/6/25, R21 was visited in her room. R21 reported that the doctor had told her yesterday she no longer needed to wear the sling, and the arm sling was observed lying on the bed. During the interview, R21 was noted to have cognitive impairments and was unable to recall the details of the event resulting in the fracture, when she had gone to the doctor, etc. R21 was also unclear if she had been receiving therapy services regarding her right humeral fracture. On 8/5/25-8/6/25, a clinical record review was conducted. According to a progress note dated 6/25/25, which read, Resident observed in floor across from nurses' station and non-witnessed at 2020 [8:10 p.m.]. Vital signs/neuros obtained with pupils equal reactive to light, ROM limited right arm with arm swollen elbow/shoulder. Supervisor, resident son emergency contact #1 made aware approved to send to [hospital name redacted] ER [emergency room] for evaluation right arm pain/discomfort with swelling and limited ROM [range of motion]. Tylenol administered and ineffective. According to a progress note from the nurse practitioner dated 6/25/25, the resident was admitted to the facility on [DATE] and had sustained three falls since admission. According to the physician orders, R21 had orders to see the orthopedic surgeon on 7/1/25, 7/15/25, and 8/5/25. There was a report from the visit on 7/1/25 with the orthopedic doctor that noted the resident was non-weight bearing to her right upper arm. There was no documentation within the record as to the appointment outcome on 7/15/25. On 8/6/25, the unit manager reviewed R21's chart but could not find any documentation, stating that medical records may have it and it had not been uploaded into the clinical record. On 8/6/25, the surveyor visited the medical records employee who reported that she didn't have anything for R21 with regards to the orthopedic appointment on 7/15/25. The medical records employee did state that sometimes the staff up front assist with uploading documents, she would check with them. On 8/6/25 at 2:59 p.m., an interview was conducted with the occupational therapy assistant/other employee #8 (OE#8) and the rehab director/other employee #5 (OE#5). They reviewed R21's therapy chart and reported that R21 was on occupational therapy caseload and was non-weight bearing. On the morning of 8/7/25, the facility's assistant director of nursing provided the surveyor with a progress note from the orthopedic surgeon dated 7/15/25. When asked where they had found the note, the ADON reported they called the doctor's office and had them fax it over. Review of the note dated 7/15/25 revealed in part, . sling may be removed for hygiene and physical therapy. Orders written for therapy to start assisted active range of motion as guided by pain. On 8/7/25 at 9 a.m., a follow-up interview was conducted with the rehab director and occupational therapy assistant. Both reported they were not aware of the orders from the orthopedic surgeon to start range of motion on 7/15/25, but the resident was going to be re-evaluated that day. 3b. For R21, the facility staff failed to obtain weights as ordered by the physician. On 8/6/25, during a clinical record review it was noted that on 6/24/25, a physician order was written that read, Daily weights for three days. There was another order dated 6/24/25, with an effective date of 6/30/25 that read, Weekly weight every day shift every Mon for monitoring for 4 weeks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the weight and vital sign tab of R21's chart, the only weights obtained were on 6/24/25, 7/2/25, 7/10/25, and 7/15/25, indicating that the order for daily weights for three days was not carried out. These dates also indicated that the order for weekly weights on Mondays was not carried out as none of the three weights in July were obtained on a Monday. On 8/6/25, in the afternoon, the surveyor met with the unit manager. The unit manager reviewed R21's chart and confirmed the order for daily weights for three days was not completed. She also verified that the weekly weights on Monday order was not carried out, confirmed that the weights recorded were not obtained on Mondays, and weights had not been done for four weeks as ordered. The unit manager stated that if the order was written for weights to be done on Mondays the expectation would be for them to be obtained on Monday. 4. For R14, who had physician orders for daily weights for three days, the facility staff failed to obtain the weights in accordance with the order. On 8/7/25, during a clinical record review, it was noted that R14 had a physician order dated 7/31/25 that ready Daily weight x 3 days. According to the treatment administration record, the area for the weight to be recorded was blank for 7/31 and 8/2. On 8/1/25 it noted NA not applicable. According to the weight tab in R14's chart, only one weight was recorded since admission and that was on 7/28/25. On 8/7/25, an interview was conducted with the unit manager. After reviewing R14's physician orders and documentation, the unit manager stated that the weights had not been obtained as ordered by the doctor. A review of the facility policies titled, Provision of Physician Ordered Services and Weight Monitoring was conducted, but neither addressed following physician orders other than for diagnostic procedures. On 8/7/25, during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings regarding R21 and R14. No additional information was provided. 5. Resident #2 did not have neurological assessments initiated and/or thoroughly completed after having unwitnessed falls as required in the plan of care. Resident #2 (R2) was admitted to the facility with diagnoses that included dementia, psychotic disturbance, mood disorder, anxiety, chronic kidney disease, gastroesophageal reflux disease, obesity, congestive heart failure, peripheral vascular disease and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed R2 with severely impaired cognitive skills. R2's clinical record documented a nurse practitioner's note dated 6/18/25 stating that R2 fell yesterday, was assessed with no injuries and had neurological checks initiated. R2's clinical record documented the resident had an unwitnessed fall on 7/4/25 when he was found on the floor in the day room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's clinical record documented no neurological (neuro) assessments following the resident's unwitnessed fall on 6/17/25. Neuro checks were initiated immediately following the fall of 7/4/25, but were not completed as scheduled. R2's Neurological Record started on 7/4/24 at 2:15 p.m. listed spaces for assessments over the next 72 hours following the fall (every 15 minutes x 4, every 30 minutes x 2, every hour x 4, every 4 hours x 6 and every shift x 2) for monitoring possible neurological complications resulting from the unwitnessed fall. R2 had neuro assessments completed seven times following the fall of 7/4/25. The remaining eleven scheduled assessments were not completed. R2's neuro checks on 7/4/25 at 2:15 p.m., 2:30 p.m., 2:45 p.m. and 3:00 p.m. documented the resident's pupil assessments indicating reactivity and response to light, were not done. R2's plan of care (revised 7/15/25) documented the resident was at risk of falls and had experienced falls due to poor gait/balance. Interventions to prevent injury and maintain current status included neuro checks per protocol. On 8/6/25 at 8:05 a.m., the director of nursing (DON) was interviewed about neuro assessments following falls. The DON stated if a fall resulted in head trauma or if the fall was unwitnessed, neurological assessments were expected to be completed for 72 hours following the incident. On 8/6/25 at 4:00 p.m., the licensed practical nurse unit manager (LPN #3) caring for R2 was interviewed. LPN #3 reviewed the clinical record and stated the neuro assessments started for R2 on 7/4/25 were started but were not completed. On 8/6/25 at 4:30 p.m., LPN #2 that performed the initial four assessments for R2 on 7/4/25, was interviewed about why pupil checks were not done. LPN #2 reviewed the assessment form and stated, I just didn't assess them [pupils]. LPN #2 offered no explanation of why the pupils were not assessed and again stated the pupil assessments were just not done. On 8/7/25 at 8:30 a.m., the unit manager (LPN #3) was interviewed about any neurological assessments following R2's 6/17/25 unwitnessed fall. LPN #3 reviewed the clinical record and stated she did not find neurological checks following the fall of 6/17/25. LPN #3 stated, I don't see where they [neuro checks] were started. The facility's policy titled Fall Prevention Program (revised 12/1/24) documented, .When any resident experiences a fall, the facility will .Assess the resident .Document all assessments and actions .Begin neurologic assessment using Neurological Record assessment tool in PCC [electronic health record] . This finding was reviewed with the administrator and director of nursing on 8/7/25 at 12:30 p.m. with no further information provided prior to the end of the survey. 6. Facility staff failed to follow a physician's order to obtain vital signs every morning for R24. On 8/7/25 at 8:20 a.m., an interview was conducted with R24. R24 was asked if the facility staff were taking his vital signs every morning. R24 said, they check my blood pressure here, but I have full sets at dialysis on Monday, Wednesday and Friday. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/7/25 at 9:00 a.m., an interview was conducted with a licensed practical nurse, LPN#5 (LPN5). LPN5 was asked what does monitoring vital signs mean and she said, it means a full set of vitals, but we only check blood pressure on [R24 name was redacted]. LPN5 said, the order needs to be changed to just blood pressure not vitals. On 8/7/25 a clinical record review was conducted. R24's physician's order dated 6/14/25 read, Monitor Vital Signs every morning at 9am in the morning, and the order was to start on 6/15/25. The review of R24's medication administration record indicated only the blood pressure monitoring not the full set of vital signs. On 8/7/25 at 10:00 a.m., the above concerns were brought to the administrator, director of nursing and corporate staff. On 8/7/25 the policy for Following Physician Orders was requested twice but was never received. No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review and facility documentation review the staff failed to provide care and services related to dialysis for three residents, Resident # 24 (R24), #25 (R25) and #14 (R14) out of a survey sample of 41 residents.The findings included:1. There was no order for facility staff to monitor R24's dialysis fistula site in the left upper arm. On 8/7/25 at 8:40 a.m., an interview was conducted with R24. R24 was asked if his fistula site was monitored and he said, Dialysis checks it every Monday, Wednesday and Friday, but here no. Maybe once or so a nurse came in listen to it but don't see that nurse often here. On 8/7/25 at 9:00 a.m., an interview was conducted with a licensed practical nurse, LPN#5 (LPN5). LPN5 stated that the dialysis access site was to be monitored. She stated the bruit and thrill at the fistula site was to be checked. LPN5 stated that the dressing on the fistula site was to be removed every 24 hours and checked. She stated this treatment was to be signed off on the treatment administration record. LPN5 said, when he was readmitted that the admitting nurse forgot to add order and I would bring this to their attention or get batch orders to check dialysis site. She stated R24 was just recently readmitted from the hospital and LPN5 checked the date it was 6/14/25. On 8/7/25 a clinical record review was conducted. R24's physician's orders was reviewed and there were no orders for monitoring R24's dialysis fistula site to left upper arm. On 8/7/25 at 10:00 a.m., the above findings were discussed with the administrator and no additional information was provided. 2. There was no transportation set up for R25 to go to his scheduled dialysis appointments. On 8/5/25 at 3:00 p.m., an interview was conducted with the administrator. The administrator stated that upon admission the facility was not aware R25 was a dialysis patient. On that day, 6/28/23 I was trying to get transport set up by stretcher for R25 but was not able to get transport and dialysis center to accommodate at the same day and time. The administrator said, Error on our part we didn't know from hospital that he was dialysis. Notified nurse practitioner as soon as it happened and received orders to send out to emergency department. We were between social workers. On 8/5/25 at 3:20 p.m., an interview was conducted with the director of nurses (DON). The DON stated she was not aware of whether transport was set up for R25 to go to his scheduled dialysis appointments. The DON stated to check with the transport coordinator, and she can see if she has a transport sheet for R25. On 8/5/25 at 3:30 p.m., an interview was conducted with the transport coordinator, other staff #3 (OS3). OS3 stated that she was not over transportation set up then but was unable to find a transport sheet for that time (6/28/23). She stated that transportation was not set up for R25 at that time. On 8/6/25 at 4:30 p.m., at the end of day meeting the administrator stated that the facility was aware that R25 went to dialysis but was not aware he had to go by stretcher which was the issue of getting transport for him that day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. For Resident #14(R14), the facility staff failed to monitor the dialysis access port in accordance with professional standards of practice and failed to notify the medical provider when the resident declined to attend a dialysis treatment session. On 8/5/25, R14 was identified and placed in the survey sample due to being a dialysis patient. On 8/6/25, a clinical record review was conducted, which revealed R14 was admitted on [DATE]. The only indication that R14 had a dialysis access site was in the nursing admission assessment which noted a right upper arm av fistula and within the care plan developed on 8/3/25. There was no mention in the nursing progress notes of checking for thrill and bruit, no physician order, nor did the care plan address this. According to a nursing progress note written by licensed practical nurse #8 (LPN #8) dated 7/30/25 at 6:46 a.m., read, CNA [certified nursing assistant] in to do rounds on resident and get resident up for dialysis. Resident refusing to go to dialysis due to not feeling well and being in pain. This nurse gave resident PRN [as needed] oxycodone. Transport arrived and alerted that resident was refusing to go. There was no indication that the medical provider/doctor was made aware of this missed dialysis appointment. On 8/6/25 at 11:12 a.m., an interview was conducted with LPN #8. LPN #8 confirmed that on 7/30/25 R14 did not go to her scheduled dialysis appointment. When asked if the doctor was made aware of this, LPN #8 stated no. LPN #8 confirmed that this would be important because the resident would be at risk for side effects due to missing dialysis and the doctor may want to order for lab work to be done. During the above interview with LPN #8 she was asked about checking the dialysis access site, LPN #8 stated they should be listening for thrill and bruit every shift and document on the treatment administration record. LPN #8 indicated it is important to make sure the access is working properly; there is no blockage or anything. LPN #8 went on to say, We need to monitor for signs and symptoms of bleeding/hemorrhage. LPN #8 reviewed R14's chart and confirmed that there was no evidence that nursing staff had been checking for thrill and bruit. LPN #8 stated she would enter it into R14's orders at that time so that staff could start checking and documenting it. The facility policy titled, Peritoneal Dialysis with a revision date of 12/15/23, was reviewed. It read in part, . 15. Before, during and after receiving the peritoneal dialysis, the facility staff must, based on physician's orders and professional standards of practice, do the following: a. Obtain vital signs, weights, assess the resident's stability, level of consciousness, and comfort or distress. B. Monitor for post-dialysis complications and symptoms such as, but not limited to dizziness, nausea, fatigue, or hypotension. d. Documentation of ongoing evaluation of the peritoneal catheter, including assessment of catheter related infections and tunnel for condition, monitoring for patency, leaks, infection, and bleeding at the site. 16. The facility will communicate with the attending physician, dialysis facility and/or nephrologist of any canceled or postponed dialysis treatments and document any responses to the changes in treatment in the medical record. According to the nursing standard of practice, When assessing an arteriovenous (AV) fistula, it's important to check for both a thrill and a bruit to ensure the fistula is functioning properly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Thrill: This is a palpable vibration over the fistula. You should feel a continuous, gentle, rhythmic vibration when you place your fingers over the fistula site. The presence of a thrill indicates that blood is flowing through the fistula. Bruit: This is a sound heard using a stethoscope. It is a whooshing or swishing sound caused by turbulent blood flow through the fistula. A continuous bruit indicates good blood flow, while changes in the sound can indicate potential issues like stenosis or thrombosis. Regular monitoring of these signs is crucial as they help in early detection of complications. If you notice any changes in the thrill or bruit, it should be reported immediately for further evaluation. Accessed online at allnurses.com On 8/6/25, during an end-of-day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interviews and clinical record review the facility staff failed to obtain an x-ray timely for one resident, Resident ##26 (R26) out of a survey sample of 41 residents.The findings included:There was an x-ray ordered stat (as soon as possible), and the facility did not follow up and the x-ray was not obtained timely.On 8/7/25 at 8:10 a.m., an interview was conducted with the nurse practitioner (NP). The NP stated if concern for a fracture we ordered the x-ray stat, and the expectation was for the x-ray to be obtained within eight hours. If the x-ray was longer than eight hours, we will send out to the emergency department and will send out sooner if the family wants the resident sent out for evaluation. NP also said, I will give more orders like frequent vitals, neuro checks and if pain is not controlled to send out.On 8/7/25 at 8:30 a.m., interview was conducted with a licensed practical nurse, LPN#7 (LPN7). LPN7 stated that R26 was in the dining room and fell. She stated that R26 was complaining about her left lower extremity and left hip area hurting. LPN7 stated that the nurse practitioner was notified and ordered a stat x-ray of the hip unilateral with or without pelvis on 6/17/25 at 3:51 p.m. LPN7 stated that R26 was receiving scheduled Tylenol and being repositioned frequently. The daughter was visiting the evening of 6/18/25 and was upset because the x-ray had not been obtained and her mother was in pain. LPN7 stated that R26 was complaining about discomfort in her left hip area while the daughter was in to visit. LPN7 stated that it was typical for the mobile x-ray to take a day to come to the facility to obtain an x-ray. LPN7 stated that there was no warmth or bruising in the left hip area and she was more concerned with R26 left lower extremity, from the knee down to the ankle and that area was bruised, red and swollen. LPN7 stated that R26 was not returned to the facility as a resident and said, I do believe she had a fracture to her left hip.On 6/17/25 at 3:51 p.m., a stat x-ray was ordered for R26 left hip. On 6/17/25 at 4:40 p.m., an x-ray order was obtained for an x-ray to ankle complete and knee 1 or 2 views. The x-rays were ordered due to pain from trauma. On 8/7/25 at 8:45 a.m., an interview was conducted with LPN#1 (LPN1). LPN1 stated that R26 had a fall in the dining room area. She stated that R26 was assessed after her fall and first aid was provided in the dayroom. LPN1 stated R26 was complaining of left knee pain, left hip pain and a x-ray was ordered. LPN1 said, [R26 name was redacted] was complaining of aches and pains. She was not screaming too much in the dining room with pain not enough screaming for 911 to be called. LPN1 stated R26 had a fall with a fracture and didn't return to the facility.On 8/7/25 a meeting was held with the administrator, director of nursing (DON) and corporate staff and they were informed of the above concerns. The administrator and DON were going to see if they had any other information concerning the x-ray. The DON provided two x-ray orders that were sent to the mobile x-ray company by LPN7 on 6/17/25. The DON was not able to provide evidence of facility staff following up with mobile x-ray company about the x-rays ordered prior to R26 being sent out to the emergency department.On 8/7/25 a clinical record review was conducted. The progress notes on 6/17/25 from LPN7 read, Resident was reportedly ambulating in dining room without assistance and fell into the floor. Fall was witnessed by family member, reports no head trauma. Resident voices c/o left hip pain while bearing weight, ROM WNL. First aid provided to left hand skin tear by wound nurse. Neuro checks WNL. On call provider notified of fall, order given to obtain 2 views Left hip Xray to rule out fracture. [director of nursing name redacted] and [resident's daughter name redacted] VS 160/78-98.1-78-18-96%RA. Post falls note on 6/18/25 at 11:23 a.m., read, Note Text: Current Vital Signs 145/76 - 6/18/2025 08:23 Position: Sitting l/arm 98.0 - 6/18/2025 08:24 Route: Tympanic 80 - 6/18/2025 08:24 Pulse Type: Regular R 18 - 6/18/2025 08:24PainResident reports pain. Resident states pain is 4/10.Non-verbal pain indicators: Comments: pain with weight bearing Observations Bruising (specify location below) Skin Tear(s) (specify location below) Observation notes (Action taken and resident response to observations listed above: First aid provided Physician Orders New orders post fall: Xray ordered for Left ankle, knee, and hip Resident was not referred to therapy.On 6/18/25 at 4:26 p.m., LPN7 wrote a note when R26 was going to be sent out to the emergency department. The note read, Patient's daughter came into the facility to visit. Insisted that she be sent to [name of hospital redacted] for evaluation d/t left sided pain from fall. VM left for RP [responsible person] to contact facility. There was no note in the clinical record when R26 was sent out to the emergency department. R26's discharge date was 6/19/25.According to the facility policy titled, Fall Prevention Program, which read in part, . 9. When any resident experiences a fall, the facility will: a. asses the resident. B. complete a post-fall review and post fall follow up note in PCC [the electronic health record system]. 3. Complete an incident report in PC. D. Notify the physician and family. E. Review the residents' care plan and update as indicated. F. Document all assessments and actions i. begin neurologic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations and staff interview the facility staff failed to follow menu for residents on two of two units. The findings included:On 8/5/25 at 12:00 p.m., an observation of the posted menu was conducted. The menu listed Salisbury steak, steamed rice, squash, brown gravy, dinner roll, strawberry shortcake, condiments and beverage of choice. However, during the observations of the lunchtime meal being plated and served, the food provided did not match the posted menu.On 8/5/25 at 12:30 p.m., the dietary manager was interviewed about the menus. The dietary manager stated that the cook changed the menus without informing me. The dietary manager stated he would have changed the posted menus if he was aware of the changes. The dietary manager stated the cook; after preparing the meal, told me the ground beef was not thawed to make the Salisbury steak today, so he swapped today's menu with tomorrow's menu. The dietary manager stated that the residents were supposed to be informed when the meal menus were changed.On 8/5/25 at 1:00 p.m., an interview was conducted with several residents in the main dining room. The residents reported that they were not aware the lunch menu had been changed for the day and had been expecting a Salisbury steak meal. They stated that, although the menu on the board was sometimes served as posted, there were occasions when the posted menu was not provided, and they were not informed of the change in advance.On 8/6/25 at 4:30 p.m., an end of day meeting was held with the administrator, director of nursing and corporate staff. They were made aware of the above concerns.No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 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 and staff interviews the facility staff failed to store, label and distribute food in a sanitary manner in the main kitchen. The findings included:On 8-5-25 at 11:45 AM, a tour of the main kitchen revealed multiple deficiencies related to food storage and labeling practices. Several opened food items in the reach-in refrigerator, walk-in refrigerator, and walk-in freezer were found without proper labels or dates indicating when they were opened.Specifically, personal beverages and snacks were stored in the reach-in refrigerator alongside facility food items. In the walk-in refrigerator, items such as three-bean salad, vanilla pudding, cooked spaghetti noodles, corn, ham slices, mayonnaise, and cottage cheese were observed without any labels or open dates.Additionally, in the walk-in freezer, sandwich meats, meatballs, and peppers were also stored without proper labeling. Some containers showed signs of spoilage, such as a film on top of the water in the ham container. These practices pose significant risks including potential cross-contamination, food spoilage, and foodborne illness.On 8-5-25 at 11:50 AM, the dietary manager was interviewed regarding the observed unlabeled and undated food items. The dietary manager acknowledged awareness of the items lacking labels and dates. He stated that all food items must be labeled with an open date and a use-by date prior to placement in the walk-in freezer, walk-in refrigerator, or reach-in refrigerator. On 8/6/25 at 4:30 p.m., an end of day meeting was conducted with the administrator, director of nursing and corporate staff. They were made aware of the above concerns.No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews, clinical record review and facility documentation review the facility staff failed to maintain a complete and accurate clinical record for four residents, Resident #31 (R31), Resident #2 (R2), Resident #20 (R20) and Resident #21 (R21) out of a survey sample of 41 residents. The findings included:1. Daily documentation for R31's treatment was not present on the treatment administration record. On 8/6/25 at 2:00 p.m., an interview was attempted with R31. R31 was not able to recall whether treatments had been completed and was also unable to remember that he had wounds requiring daily treatment. On 8/6/25 at 1:50 p.m., an interview was conducted with licensed practical nurse, LPN#1 (LPN1), who was the wound nurse. She stated that she completed the resident's treatments daily during the week, and the floor nurses provided the treatments on weekends. She further stated that if the treatment was not signed off, it meant it was not done, then later clarified that if it was not signed off, it may simply mean it was not documented. LPN1 stated she would check the nurse's notes for evidence of the treatment being completed. LPN1 was unable to find any documentation for the treatments being completed on the days that the treatment administration record was not signed off. On 8/6/25 at 2:00 p.m., LPN#5 (LPN5) was interviewed regarding R31's daily treatment. LPN5 stated that there were occasions when she arrived for her shift and the treatment had not been completed, estimating that this occurred once or twice per week. She added that R31 does not refuse treatment and generally does not interact with others. On 8/6/25, a review of R31's clinical record, including the Treatment Administration Record (TAR), was conducted. In April, the treatments on the 5th, 19th and 26th were not signed off. In May, the treatment on the 23rd was not signed off. In July, the treatment on the 18th, 26th, and 31st were not signed off. The progress notes were reviewed, and there were no entries on the dates when the TAR for R31's treatment was not signed off to indicate that the treatment was completed. 2. R2's clinical record included no documentation of a fall, and no resident assessment performed at the time of the incident. Resident #2 (R2) was admitted to the facility with diagnoses that included dementia, psychotic disturbance, mood disorder, anxiety, chronic kidney disease, gastroesophageal reflux disease, obesity, congestive heart failure, peripheral vascular disease and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed R2 with severely impaired cognitive skills. R2's clinical notes on 6/17/25 had no documentation regarding the fall and included no record of an immediate assessment of the resident, or circumstances surrounding the fall. Notes made no mention of how staff were aware the resident did not hit his head. There were no neurological assessments initiated or completed following this fall. The last note documented prior to the practitioner's note on 6/18/25 was on 6/12/25. The nurse practitioner assessed R2 on 6/18/25 with no injuries or complications from the fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/7/25 at 8:30 a.m., the licensed practical nurse unit manager (LPN #3) was interviewed about R2's fall on 6/17/25. LPN #3 reviewed the clinical record and stated she did find a nursing note about the fall. LPN #3 stated she found no resident assessment or documentation regarding the circumstances surrounding the fall in the clinical record prior to the practitioner's note on 6/18/25. LPN #3 stated she did not see where neurological assessments were initiated or completed following the fall. LPN #3 stated regarding the lack of documentation, You would think there would be a note. LPN #3 stated nurses were expected to document a fall in the nursing notes along with any assessments, notifications and actions taken regarding the incident. LPN #3 stated a risk management/incident form was completed for the fall of 6/17/25 that listed assessments done, but nothing was documented in the clinical record. On 8/7/25 at 10:00 a.m., the director of nursing (DON) was interviewed about lack of documentation regarding R2's fall on 6/17/25. The DON stated it was a standard of practice for nurses to document incidents at the time they happened, including falls. The DON stated the circumstances of the fall, and any resident assessments should have been documented in the clinical record. The DON presented the incident form for R2's fall on 6/17/25. This incident form documented R2 was found on the floor beside his bed on 6/17/25 at 11:00 p.m., that the resident was assessed with no injuries and notifications were made to the physician and family. This form documented neurological checks were initiated but none were documented in the clinical record. This form was labelled Not Part of the Medical Record. The facility's policy titled Fall Prevention Program (revised 12/1/24) documented, .When any resident experiences a fall, the facility will .Assess the resident .Complete a Post-fall Review and a Post Fall Follow UP note in PCC [electronic health record] .Notify physician and family .review the resident's care plan and update as indicated .Document all assessments and actions . This finding was reviewed with the administrator and DON on 8/7/25 at 12:30 p.m. with no further information presented prior to the end of the survey. 3a. For Resident #21 (R21), the facility staff failed to maintain a complete clinical record to include documentation of an orthopedic appointment. On 8/6/25 R21 was visited in her room. R21 reported that the doctor had told her yesterday she no longer needed to wear the sling, and the sling was observed lying on the bed. During the interview R21 was noted to have cognitive impairments and was unable to recall the details of the event resulting in the fracture, when she had gone to the doctor, etc. R21 was also unclear if she had been receiving therapy services regarding her right humeral fracture. On 8/5/25-8/6/25, a clinical record review was conducted. According to a progress note dated 6/25/25, it read, Resident observed in floor across from nurses' station and non-witnessed at 2020 [8:20 p.m.]. Vital signs/neuros obtained with pupils equal reactive to light, ROM limited right arm with arm swollen elbow/shoulder. Supervisor, resident son emergency contact #1 made aware approved to send to [hospital name redacted] ER [emergency room] for evaluation right arm pain/discomfort with swelling and limited ROM [range of motion]. Tylenol administered and ineffective. According to a progress note from the nurse practitioner dated 6/25/25, the resident was admitted to the facility on [DATE] and had sustained three falls since admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to R21's physician orders, she had orders to see the orthopedic surgeon on 7/1/25, 7/15/25 and 8/5/25. There was a report from the visit on 7/1/25 with the orthopedic doctor that noted the resident was non-weight bearing to her right upper extremity. There was no documentation within the record as to the appointment on 7/15/25. On 8/6/25, the unit manager looked in R21's chart and could not find any documentation and stated that medical records may have it and it had not been uploaded into the clinical record. On 8/6/25, the surveyor visited the medical records employee who reported she didn't have anything for R21 with regards to the orthopedic appointment on 7/15/25. The medical records employee did state that sometimes the staff up front assist with uploading documents, she would check with them. On 8/6/25 at 2:59 p.m., an interview was conducted with the occupational therapy assistant/other employee #8 (OE#8) and the rehab director/other employee #5 (OE#5). They reviewed R21's therapy chart and reported that R21 was on occupational therapy caseload and was non-weight bearing. On the morning of 8/7/25, the facility's assistant director of nursing provided the surveyor with a progress note from the orthopedic surgeon dated 7/15/25. When asked where they had found the note, the ADON reported they called the doctor's office and had them fax it over. Review of the note dated 7/15/25 read in part, . sling may be removed for hygiene and physical therapy. Orders written for therapy to start assisted active range of motion as guided by pain. 3b. For R21 who sustained a fall, the facility failed to document neuro checks accurately as the document titled, neuro checks only recorded vital signs. On 8/5/25-8/6/25, a clinical record review was conducted. Within the documents tab was a document labeled as neuro checks. The document was accessed and titled, Neuro Checks, which only recorded vital signs that included blood pressure, temperature, pulse, respirations. On 8/6/25, interviews were conducted with a licensed practical nurse #8 (LPN #8). LPN #8 explained that neuro checks included checking pupil response, range of motion, hand grasp and signs or symptoms of head injury such as nausea and vomiting. LPN #8 was shown the document titled, Neuro checks and she agreed that it was not neuro checks it was vital sign recordings. On 8/6/25, an interview was conducted with the unit manager, licensed practical nurse #3 (LPN #3). LPN #3 confirmed that the document titled neuro checks was not that it was vital signs and had gaps that indicated the resident was sleeping. The neurological record under the assessment tab of R21's chart was also incomplete. LPN #3 was asked about the notations that R21 was asleep when the neuro check was due, LPN #3 said, Absolutely we should be waking them up to do a neuro assessment. On 8/6/25 at 4:05 p.m., an interview was conducted with the director of nursing (DON). The DON explained that neuro checks are to be conducted on any resident who had an unwitnessed fall or hit their head. She also stated that staff are to do a post-fall documentation for three days following a fall. She explained that it was important to identify if there are any latent injuries. The DON was shown R21's document that was titled, neuro checks and she agreed it was not accurate, that it only documented vital signs. The DON then accessed the neurological record in R21's chart under the assessment tab and confirmed they were incomplete. The DON was unsure of the frequency of neuro checks and stated she would like to reference their policy. The facility policy was requested. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/6/25, during an end of day meeting, the facility's regional director of clinical services reported to the survey team that they did not have a policy for neuro checks. The above findings were reviewed and discussed. According to the facility policy titled, Fall Prevention Program, which read in part, . 9. When any resident experiences a fall, the facility will: a. asses the resident. B. complete a post-fall review and post fall follow up note in PCC [the electronic health record system]. 3. Complete an incident report in PCC [electronic health record]. D. Notify the physician and family. E. Review the residents' care plan and update as indicated. F. Document all assessments and actions.i. begin neurologic assessment using Neurological Record assessment tool in PCC. No additional information was provided. 4. For Resident #20 (R20), who had two falls, one that resulted in a hip fracture, the facility failed to maintain a complete and accurate clinical record to include the fall details and injuries sustained. On April 26, 2025, Resident #20 experienced a fall, which resulted in a hip fracture and subsequent hospitalization. Review of the medical record revealed no documentation of the fall incident, the circumstances surrounding the fall, or the immediate actions taken by the staff. Additionally, there was no record of the residents' condition before and after the fall. On 8/6/25, an interview was conducted with R20, but he had no recall of the fall resulting in a hip fracture. On 8/6/25 a clinical record review was conducted of R20's chart. According to the census tab and progress notes, R20 was admitted to the facility on [DATE], following hospitalization after a car accident and sustaining a right scapula fracture and T11 compression fracture. According to the census tab, R20 discharged on 4/26/25 and was readmitted on [DATE]. According to a hospital Discharge summary dated [DATE], it noted that R20 was hospitalized for a right intertrochanteric femur fracture with cephalomedullary implant [hip fracture with surgical repair]. Within R20's clinical chart the only documentation regarding the fall that resulted in a hip fracture was from the on-call provider in a progress note dated 4/26/25, which read in part, . Patient fell unwitnessed and fell on right hip. Abrasion and hematoma to right knee. Patient complained of 10/10 sharp stabbing pain to right hip and leg. Fall unwitnessed. Administered pain medication not effective. Recommendation/request: Sent to ER [emergency room] . There was no documentation within R20's clinical record as to the circumstances of the fall, the location and details of the fall, condition resident was found in, facility staff's assessment of the resident, nor that the resident was being sent to the hospital for evaluation. According to a Post Fall Review under the assessment tab dated 5/30/25, R20 had a fall that required first aide. The assessment listed a fall date of 5/30/25, noted it was unwitnessed and required first aide. The residents' vital signs were populated into the form. Questions 5-6 that would have noted the description of the fall was blank. Sections B & C with the interdisciplinary team review and interventions was blank. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/6/25, during an interview with the facility's director of nursing (DON), in the presence of the regional director of clinical services, the DON was made aware of the above findings. The DON accessed R20's clinical record and confirmed the above findings. The DON did provide the surveyor with an incident report, which she did confirm was not part of R20's clinical record. The DON stated that the expectation is that the facility staff would document any fall incidents in the resident's chart. On 8/6/25, during an end of day meeting, the facility administrator was made aware of the above findings. No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Edge Rehabilitation and Nursing	1221 Rosser Ave Waynesboro, VA 22980

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to follow infection control practices during meal distribution on one of two wings (A-wing). The findings included:On 8/5/25 at 12:07 p.m., observations were conducted of the lunch meal service on the A-wing by the surveyor who was accompanied by a federal surveyor. Resident #18 (R18) who was sitting in the tv room was served her meal. On 8/5/25 at 12:19 p.m., certified nursing assistant #4 (CNA #4) took a tray from the meal tray cart and entered the room of resident #14 (R14). R14's room door had signage to indicate the resident was on enhanced barrier precautions and personal protective equipment was outside of the door. CNA #4 left the door open, and the surveyor observed the meal tray sitting on the over bed table. A few minutes later, CNA #4 exited the room, carrying the meal tray and returned the tray to the cart. The cart contained approximately ten additional meal trays that had yet to be distributed. Following this observation, the surveyor approached CNA #4 and interviewed her about returning the tray to the cart with other trays. CNA #4 stated that she had not pulled the over bed table in front of R14 so therefore it was ok to place it back on the cart. CNA #4 went on to explain that since the trays aren't touching that it was ok. During the above observations, another staff member approached the meal cart and placed the tray of R18, that had been eaten from that contained her uneaten food, plate, utensils, and paper trash, into the meal tray cart, which still had resident's meals that had yet to be distributed. On 8/5/25 at 2:34 p.m., an interview was conducted with the director of nursing (DON) in the presence of the regional director of clinical services/nurse consultant (RDCS). The DON stated that all resident trays should be distributed before they begin retrieving meal trays from residents who have eaten. When asked why, the DON explained that you can't put dirty trays with trays that have not been distributed. When asked why this is, the DON said, Because of infection control. On 8/5/25 at 2:40 p.m., the facility administrator entered the DON's office and the administrator, DON and RDCS were made aware of the above observations. A review of the facility policy titled, Food Safety Requirements was conducted. The policy read in part, . 5. Foods and beverages shall be delivered to residents in a manner to prevent contamination. No additional information was provided.