STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495230	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhurst Health & Rehabilitation	4238 James Madson Highway Fork Union, VA 23055

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 abuse prevention policies for reporting and thoroughly investigating a behavioral incident with an allegation of mistreatment for one of seven residents in the survey sample (Resident #201).The findings include:An incident of verbal aggression/threats toward staff and an allegation of mistreatment by R201 was not thoroughly investigated or reported to the state agency and adult protective services as required in the facility's abuse prevention policies. Resident #201 (R201) was admitted to the facility with diagnoses that included cerebral infarction, diabetes, hypertension, peripheral vascular disease, history of myocardial infarction with defibrillator/pacemaker, dysarthria, anxiety, depression, chronic pain syndrome, heart failure, adult failure to thrive, history of prostate cancer, and congestive heart failure. The minimum data set (MDS) dated [DATE] assessed R201 as cognitively intact. R201's clinical record documented a psychiatry nurse practitioner note dated 7/30/25 documenting an assessment of R201 due to a verbal altercation between the patient and staff members this morning. This note documented that R201 reported that he called for assistance at 5:00 a.m. because he spilled urine on himself and that staff did not provide him with assistance. This noted documented, .Patient [R210] admits that when he was assisted up by staff, he went to the nurses station and demanded to speak to the charge nurse. Patient admits that he became belligerent towards other staff . This note documented the resident reported that law enforcement was called and that the administrator said she was afraid of R201. This note documented that R201 admitted to raising his voice, reported he had done nothing to harm others, that he felt his rights had been violated and that he had a right to freedom of speech. The facility's investigation of R201's incident of verbal aggression on 7/30/25 was reviewed. The investigation included statements from the nurse caring for R201 at the time of the incident (registered nurse #1), a certified nurse's aide (CNA #1) working on the unit, the maintenance director (other staff #1) that witnessed the incident, the former director of nursing (DON - administration #5) and the former administrator (administration #4). RN #1's statement dated 7/30/25 documented, .[R201] became highly aggressive and verbally threatening toward multiple staff members, including myself .[CNA #1], maintenance worker [other staff #1] . Statements from RN #1, the maintenance director and CNA #1 documented R201 made multiple verbal threats to slap staff members, physically attack them when they were not looking, have his family come with guns to shoot everyone in addition to calling staff members vulgar names. Statements documented attempts to redirect and calm R210 were unsuccessful with the verbal aggression/threats toward staff lasting over one hour.The former administrator (administration #4) and the former DON (administration #5) documented the police were contacted due to R201's aggressive verbal threats with R201 accompanied by the administrator to an office. The former administrator stated an emergency custody order was attempted with the magistrate indicating the resident/situation did not meet the criteria for involuntary removal of R201 from the facility. The former administrator documented R201 calmed down after the police talked with the resident. The former administrator documented the police did not deem R201's verbal threats as credible. The former administrator documented R201 returned to his room after talking with police, was monitored by staff with the resident calming and demonstrating no further aggressive behaviors on 7/30/25. The psychiatry nurse practitioner assessed R201 on 7/30/25 after the incident and determined there was no credible threat for harm to self or others.There was no report to the state agency or adult protective services (APS) regarding R201's verbal threats/aggression incident of 7/30/25 that included police involvement, an attempted emergency custody order and allegations from R201 regarding lack of assistance and violation of rights. The facility's investigation included no statement from the CNA assigned to R201 on the early morning of 7/30/25 (CNA #2) and documented no investigation addressing R201's allegation that assistance was not provided or that his rights had been violated. The investigation included no interviews with residents about the incident, did not document if any residents witnessed the incident or if any residents heard R201's verbal threats and vulgar language. On 9/9/25 at 9:40 a.m., the maintenance director (other staff #1) that witnessed the 7/30/25 incident was interviewed. The maintenance director stated on 7/30/25, R201 made verbal threats of physical violence toward him and the nursing staff. The maintenance director stated R201 directed aggressive comments toward the staff members but that there were several residents in the area when the incident took place. On 9/9/25 at 12:00 p.m., the current administrator and regional nurse consultant (administration #3) were interviewed about reporting/investigating of the 7/30/25 incident of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 report to the state agency and adult protective services, a behavioral incident with an allegation of mistreatment for one of seven residents in the survey sample (Resident #201).The findings include:Resident #201 (R201) was admitted to the facility with diagnoses that included cerebral infarction, diabetes, hypertension, peripheral vascular disease, history of myocardial infarction with defibrillator/pacemaker, dysarthria, anxiety, depression, chronic pain syndrome, heart failure, adult failure to thrive, history of prostate cancer, and congestive heart failure. The minimum data set (MDS) dated [DATE] assessed R201 as cognitively intact. R201's clinical record documented a psychiatry nurse practitioner note dated 7/30/25 documenting an assessment of R201 due to a verbal altercation between the patient and staff members this morning. This note documented that R201 reported that he called for assistance at 5:00 a.m. because he spilled urine on himself and that staff did not provide him with assistance. This noted documented, .Patient [R210] admits that when he was assisted up by staff, he went to the nurses station and demanded to speak to the charge nurse. Patient admits that he became belligerent towards other staff . This note documented the resident reported that law enforcement was called and that the administrator said she was afraid of R201. This note documented that R201 admitted to raising his voice, reported he had done nothing to harm others, that he felt his rights had been violated and that he had a right to freedom of speech. The facility's investigation of R201's incident of verbal aggression on 7/30/25 was reviewed. The investigation included statements from the nurse caring for R201 at the time of the incident (registered nurse #1), a certified nurse's aide (CNA #1) working on the unit, the maintenance director (other staff #1) that witnessed the incident, the former director of nursing (DON - administration #5) and the former administrator (administration #4). RN #1's statement dated 7/30/25 documented, .[R201] became highly aggressive and verbally threatening toward multiple staff members, including myself .[CNA #1], maintenance worker [other staff #1] . Statements from RN #1, the maintenance director and CNA #1 documented R201 made multiple verbal threats to slap staff members, physically attack them when they were not looking, have his family come with guns to shoot everyone in addition to calling staff members vulgar names. Statements documented attempts to redirect and calm R210 were unsuccessful with the verbal aggression/threats toward staff lasting over one hour.The former administrator (administration #4) and the former DON (administration #5) documented the police were contacted due to R201's aggressive verbal threats with R201 accompanied by the administrator to an office. The former administrator documented an emergency custody order was attempted with the magistrate indicating the resident/situation did not meet the criteria for involuntary removal of R201 from the facility. The former administrator documented R201 calmed down after the police talked with the resident. The former administrator documented the police did not deem R201's verbal threats as credible. The former administrator stated R201 returned to his room after talking with police, was monitored by staff with the resident calming and demonstrating no further aggressive behaviors on 7/30/25. The psychiatry nurse practitioner assessed R201 on 7/30/25 after the incident and assessed no credible threat for harm to self or others. There was no report to the state agency or adult protective services (APS) regarding R201's verbal threats/aggression on 7/30/25 that included police involvement, an attempted emergency custody order and allegations from R201 regarding lack of assistance and violation of rights. On 9/9/25 at 12:00 p.m. the current administrator and regional nurse consultant (administration #3) were interviewed about reporting/investigating of the 7/30/25 incident of verbal aggression. The administrator stated he was not working in the facility at the time of the incident and that the former administrator conducted the investigation. The administrator stated he thought the incident had not been reported to the state agency or APS because the verbal threats were directed toward staff members and not residents. The facility's policy titled Abuse (revised 10/20/22) documented, .The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility .to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) . This finding was

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 thoroughly investigate a behavioral incident with an allegation of mistreatment for one of seven residents in the survey sample (Resident #201).The findings include:Resident #201 (R201) was admitted to the facility with diagnoses that included cerebral infarction, diabetes, hypertension, peripheral vascular disease, history of myocardial infarction with defibrillator/pacemaker, dysarthria, anxiety, depression, chronic pain syndrome, heart failure, adult failure to thrive, history of prostate cancer, and congestive heart failure. The minimum data set (MDS) dated [DATE] assessed R201 as cognitively intact. R201's clinical record documented a psychiatry nurse practitioner note dated 7/30/25 documenting an assessment of R201 due to a verbal altercation between the patient and staff members this morning. This note documented that R201 reported that he called for assistance at 5:00 a.m. because he spilled urine on himself and that staff did not provide him with assistance. This noted documented, .Patient [R210] admits that when he was assisted up by staff, he went to the nurses station and demanded to speak to the charge nurse. Patient admits that he became belligerent towards other staff . This note documented the resident reported that law enforcement was called and that the administrator said she was afraid of R201. This note documented that R201 admitted to raising his voice, reported he had done nothing to harm others, that he felt his rights had been violated and that he had a right to freedom of speech. The facility's investigation of R201's incident of verbal aggression on 7/30/25 was reviewed. The investigation included statements from the nurse caring for R201 at the time of the incident (registered nurse #1), a certified nurse's aide (CNA #1) working on the unit, the maintenance director (other staff #1) that witnessed the incident, the former director of nursing (DON - administration #5) and the former administrator (administration #4). RN #1's statement dated 7/30/25 documented, .[R201] became highly aggressive and verbally threatening toward multiple staff members, including myself .[CNA #1], maintenance worker [other staff #1] . Statements from RN #1, the maintenance director and CNA #1 documented R201 made multiple verbal threats to slap staff members, physically attack them when they were not looking, have his family come with guns to shoot everyone in addition to calling staff members vulgar names. Statements documented attempts to redirect and calm R210 were unsuccessful with the verbal aggression/threats toward staff lasting over one hour.The former administrator (administration #4) and the former DON (administration #5) documented the police were contacted due to R201's aggressive verbal threats with the R201 accompanied by the administrator to an office. The former administrator documented an emergency custody order was attempted with the magistrate indicating the resident/situation did not meet the criteria for involuntary removal of R201 from the facility. The former administrator documented R201 calmed down after the police talked with the resident. The former administrator documented the police did not deem R201's verbal threats as credible. The former administrator stated R201 returned to his room after talking with police, was monitored by staff with the resident calming and demonstrating no further aggressive behaviors on 7/30/25. The psychiatry nurse practitioner assessed R201 on 7/30/25 after the incident and assessed no credible threat harm to self or others.The facility's investigation included no statement from the CNA assigned to R201 on the early morning of 7/30/25 (CNA #2) and documented no investigation addressing R201's allegation that assistance was not provided or that rights had been violated. The investigation included no interviews with residents about the incident, did not document if any residents witnessed the incident or if any residents heard R201's verbal threats and vulgar language. On 9/9/25 at 9:40 a.m., the maintenance director (other staff #1) that witnessed the 7/30/25 incident was interviewed. The maintenance director stated R201 made verbal threats of physical violence toward him and the nursing staff. The maintenance director stated R201 directed aggressive comments toward the staff members but that there were several residents in the area when the incident took place. On 9/9/25 at 12:00 p.m., the current administrator and regional nurse consultant (administration #3) were interviewed about the reporting/investigating of the 7/30/25 incident of verbal aggression. The administrator stated he was not working in the facility at the time of the incident and that the former administrator conducted the investigation. The administrator stated the investigation included statements from staff about R201's aggressive behaviors and described events surrounding R201's behaviors. The administrator presented no documentation the investigation addressed R201's report that assistance was not provided by staff. On 9/9/25 at 3:18 p.m., CNA #2 that cared for R201 at the time of the incident on 7/30/25 was interviewed. CNA #2 stated, prior to

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide timely incontinence care for one of seven residents in the survey sample (Resident #201).The findings include:Resident #201 waited approximately 35 to 40 minutes for staff assistance with incontinence care/spilled urine.Resident #201 (R201) was admitted to the facility with diagnoses that included cerebral infarction, diabetes, hypertension, peripheral vascular disease, history of myocardial infarction with defibrillator/pacemaker, dysarthria, anxiety, depression, chronic pain syndrome, heart failure, adult failure to thrive, history of prostate cancer, and congestive heart failure. The minimum data set (MDS) dated [DATE] assessed R201 as cognitively intact, occasionally incontinent of bladder and frequently incontinent of bowel. R201's clinical record documented a psychiatry nurse practitioner note dated 7/30/25 documenting an assessment of R201 due to a verbal altercation between the patient and staff members this morning. This note documented R201 reported that he called for assistance at 5:00 a.m. because he spilled urine when using the urinal and that staff did not provide him with assistance. On 9/8/25 at 1:50 p.m., R201 was interviewed about his concern with lack of staff assistance on 7/30/25. R201 stated in the early morning of 7/30/25, his brief was wet, and he had urine on the bed sheets from dropping his urinal. R201 stated he rang the call bell around 5:00 or 5:30 a.m. and waited 40 minutes for a staff person to clean/assist him with the urine spill. R201 stated he got loud, asked the nurse where the aide was and was told by the nurse that the CNA (certified nurse's aide) would come when she finished with another resident. R201 stated a CNA eventually came after about 40 minutes, who cleaned him and assisted him out of bed. R201 stated the CNA offered no explanation of why she did not respond earlier to his request for assistance and that he felt staff should have responded sooner since he was wet.On 9/9/25 at 3:18 p.m., CNA #2 that cared for R201 during the early morning on 7/30/25 was interviewed. CNA #2 stated she cared for R201 from 7/29/25 at 7:00 p.m. until 7/30/25 at 7:00 a.m. CNA #2 stated she changed R201's brief twice during the first part of that shift. CNA #2 stated prior to 4:00 a.m., she checked on R201 and the resident did not want his brief checked/changed at that time because he wanted to sleep. CNA #2 stated at around 5:00 a.m., she began getting several residents up, including one resident with an early appointment. CNA #2 stated R201 rang for assistance around 5:00 a.m. to 5:30 a.m. CNA #2 stated she went to R201 and told him she was assisting another resident that had an early appointment and that she would be back to assist him after getting the other resident ready. CNA #2 stated R201 said he was ok and agreed for me to finish and then assist him. CNA #2 stated the resident with the appointment wanted things in a certain order and it took a long time to get her ready. CNA #2 stated she returned to R201, cleaned him then assisted him with dressing and getting out of bed. CNA #2 stated R201's brief was wet and had leaked slightly on the sheets. CNA #2 stated R201 reported that he spilled his urinal, but that urine was still in the bottle, and she emptied the urinal during the care. CNA #2 stated R201 waited approximately 35 minutes before she assisted him with the wet brief/spilled urine. CNA #2 stated R201 thanked her and expressed no complaints to her but proceeded to the nursing desk and started cursing at the nurse about not getting assistance. CNA #2 stated the nurse was aware that R201 rang for assistance. CNA #2 stated she had not asked for assistance from other staff on the unit. CNA #2 stated R201 waited about 35 minutes for assistance because she took longer than anticipated with the other resident.On 9/10/25 at 11:50 a.m., the administrator, director of nursing (DON) and regional nurse consultant (administration #3) were interviewed about R201 waiting 35 to 40 minutes for assistance with incontinence care/urine spill. The administrator stated staff members needed to work as a team to provide timely assistance for residents. The DON stated that CNAs could ask for help from other aides and that nurses were also able to provide care if needed. The regional nurse consultant stated assistance could have been provided for the early appointment resident so that CNA #2 could help R201 more timely. The administrator stated again that staff members needed to work together to meet resident needs and requests. R201's plan of care (revised 6/2/25) documented the resident required assistance with activities of daily living (ADL) due to chronic health conditions, muscle weakness, bladder incontinence and used a urinal at times. Interventions to provide incontinence care and maintain ADLs included, Physical assist as needed with ADL care .resident uses disposable briefs. Change q [every] 2 hr [hours] and prn [as needed] .Provide supervision and cuing [cueing] as needed with ADL care .The facility's policy titled Answering the Call Light (undated) documented, The facility will maintain a functional call light system and will make all reasonable

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 staff interview and clinical record review, the facility staff failed to obtain a physician ordered urinalysis with culture for one of seven residents in the survey sample (Resident #201).The findings include:Resident #201 (R201) was admitted to the facility with diagnoses that included cerebral infarction, diabetes, hypertension, peripheral vascular disease, history of myocardial infarction with defibrillator/pacemaker, dysarthria, anxiety, depression, chronic pain syndrome, heart failure, adult failure to thrive, history of prostate cancer, and congestive heart failure. The minimum data set (MDS) dated [DATE] assessed R201 as cognitively intact. R201's clinical record documented on 7/1/25 that the resident reported burning with urination and discolored urine. The provider was notified, and a physician's order was entered dated 7/1/25 for a urinalysis with culture and sensitivity. A nursing note dated 7/5/25 documented, urine sample being sent to lab. R201's clinical record documented no results of the urinalysis with culture ordered on 7/1/25.On 9/9/25 at 3:50 p.m., the regional nurse consultant (administration #3) was interviewed about results of the urinalysis ordered on 7/1/25. The nurse consultant reviewed the clinical record and stated she did not find results of the urinalysis with culture.On 9/10/25 at 10:55 a.m., the regional nurse consultant stated she contacted the lab. The regional nurse consultant stated the lab picked up samples from the facility on 7/5/25, but there was no record that R201's urine sample was picked up or processed by lab personnel. A lab listing for R201 was presented with no urine sample sent or picked up by the lab in response to the 7/1/25 order. The regional nurse consultant was not sure why the sample was not provided to the lab.This finding was reviewed with the administrator and regional nurse consultant on 9/10/25 at 11:30 a.m. with no further information presented prior to the end of the survey.