

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Staunton Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 512 Houston Street Staunton, VA 24401	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**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 two of eleven residents in the survey sample (Residents #1 and #11).The findings include:1. Facility staff failed to follow abuse prevention policies regarding reporting and investigating after Resident #1 tested positive for marijuana and methamphetamine during an emergency room visit.</p> <p>Resident #1 (R1) was admitted to the facility with diagnoses that included traumatic hemorrhage of cerebrum, post-traumatic hydrocephalus, epilepsy, dementia, history of substance abuse, depression, hypertension, dry eye syndrome and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed R1 as cognitively intact.</p> <p>Resident #5 (R5) was admitted to the facility with diagnoses that included paraplegia, osteomyelitis, sacral pressure ulcer, history substance abuse, chronic pain, depression, polyneuropathy and neurogenic bladder. The MDS dated [DATE] assessed R5 as cognitively intact.</p> <p>R5 was roommate to R1 from 12/5/24 until 1/16/25.</p> <p>R1's clinical record documented a nursing note dated 1/13/25 stating, .Went into resident's room to give AM [morning] medicine, resident was not in bed. Found resident lying on floor in front of bathroom door. Resident had a sweatshirt under his head using it for a pillow. Resident denied falling stated he was just sleeping there, eyes glassed over and pupil's pinpoint .abrasions noted to left arm and elbow. Resident slow and sluggish answering questions .Provider aware and ordered to send to [emergency department] for evaluation .exited facility at 0853 [8:53 a.m.] .Night shift reported that room smelled of marijuana and a chemical smell last night .</p> <p>R1's emergency room records dated 1/13/25 documented R1 was assessed at baseline with no acute injuries or findings. R1 returned to the facility 1/14/25 at 3:39 a.m.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R5's clinical record documented a social worker note dated 1/15/25 at 10:00 a.m. stating there had been reports of a chemical smell coming from the resident's room. This note documented, Director of social services (DSS), administrator, and director of nursing went to speak with resident after there were reports of a 'chemical smell' coming from the room . The social worker documented that R5 gave consent for search of his room/personal belongings and the DSS documented finding items that included 4 vape devices, 2 cans of pepper spray, 3 glass smoking devices, 3 empty containers of THC-a smoking material, half-smoked cigarette and 2 bottles of over-the-counter antacids. This note documented, .All items removed and taken to the social service office. Items were secured in the safe in the office .Resident stated that he does like to go off property to smoke . Interventions documented in response to the items found in R5's room included, removal and locking items in facility safe, education to R5 that all smoking materials had to be obtained at the time of signing out of the facility and returned to nursing upon return, resident given options to quit smoking with the resident expressing interest in nicotine gum, and bottles of antacid given to nursing for storage in medication cart.</p> <p>R1's clinical record documented a nursing note dated 1/15/25 stating that at 12:35 p.m., R1 was observed with .seizure-like activity while lying in bed .resemble generalized tonic-clonic .stiffening of the body, contraction to hands bilat [bilaterally], facial muscles. Seizure-like activities occurred x 3 appear to last 30 secs [seconds] each .Patient positioned laterally .Supplemental Oxygen was provided @ 2 LPM [liters per minute] . The note documented the physician was notified and ordered the resident to the emergency room for evaluation/treatment with emergency personnel listed as arriving at 1:05 p.m.</p> <p>The emergency room (ER) report dated 1/15/25 documented, .presenting today with chief concern for seizure. Per EMS he had 2 seizures witnessed by staff at facility and 2 witnessed by EMS .Someone from the facility called and asked if we can add on a drug screen because his roommate of 3 weeks they were concerned may have been giving him some substances .History of polysubstance/alcohol abuse prior to stroke . The drug screen performed at the emergency room on 1/15/25 documented the resident tested positive for marijuana and methamphetamines. The ER physician documented, .Psychosocial issue - I spoke with his wife about the drug screen, she will speak with the facility to ensure that it does not happen again . The resident had CT scans and x-rays performed which were negative for any findings. The resident was given a trial of Narcan, intravenous fluids and was discharged to the facility with instructions for continued use of previous anti-seizure medications.</p> <p>R1 returned to the facility on 1/15/25 at 10:00 p.m. with one-to-one supervision for R1 and R5 implemented by staff due to positive drug findings. The clinical record documented on 1/16/25 that staff witnessed R5 using vulgar language and verbal threats toward R1. The facility issued R5 a 30-day discharge notice on 1/16/25 due to his possession of prohibited items and verbal aggression. The police were called and R5 was sent to the emergency room on 1/16/25 with an emergency custody order.</p> <p>There was no facility reported incident (FRI) form sent to the state agency or notification to other agencies (adult protective services, law enforcement) regarding R1's positive drug tests results and related drug devices found in R5's room on 1/15/25. There was no documented investigation regarding R1's positive drug tests.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/29/25 at 3:00 p.m., the administrator was interviewed about a report to the state agency, police and adult protective services (APS) regarding R1's positive drug test for marijuana and methamphetamine. The administrator stated he did not initiate a FRI on 1/15/25. The administrator stated on 1/13/25 that R1 was thought to have a medical issue related to a seizure diagnosis and he did not suspect drugs use by R1. On 7/30/25 at 8:45 a.m., the administrator was interviewed again about a FRI. The administrator stated he did not enter a FRI about the drugs but sent a FRI on 1/16/25 regarding R5's verbal aggression and the transfer due to aggressive behaviors. The administrator stated actions had been taken following R1's positive drug test (1:1 supervision, discharge notice to R5, R5 discharged on emergency custody order, R5 moved to another floor/room with increased supervision) but that he focused that investigation on R5's unmanageable behaviors. The administrator stated he had a verbal conversation with APS about R5, the police were notified on 1/16/25 regarding the aggressive behaviors and were given the prohibited items found in R5's room on 1/15/25. The administrator stated he did not initiate a formal FRI to the stage agency, APS, or written notification to the police specifically about R1's positive drug test.</p> <p>The FRI dated 1/16/25 and the related investigation were reviewed. The alleged incident, witness statement and investigation summary referenced R5's aggressive verbal behaviors and subsequent transfer to the emergency room. There was no documentation on this FRI of R1's positive drug results and R5's possession of prohibited items found/removed on 1/15/25.</p> <p>The facility's policy titled Abuse (revised 10/20/22) documented, .The facility is committed to developing and operationalizing policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property .Designated staff will immediately review and investigate all allegations or observations of abuse . The facility's policy titled Abuse Investigating and Reporting (revised 10/1/21) documented, .All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown and thoroughly investigated by facility management. Findings of abuse investigations will also be reported .All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies .State licensing/certification agency responsible for surveying/licensing the facility .local/State Ombudsman . Resident's Representative .Adult Protective Services .Law enforcement officials (if applicable) .Attending Physician .Medical Director .An alleged violation .will be reported immediately but not later than .Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury .Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury .The Administrator .will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident .</p> <p>This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 7/30/25 at 4:15 p.m. with no further information presented prior to the end of the survey.</p> <p>2. The facility did not implement facility abuse policy regarding resident-to-resident altercation investigation documentation for resident #11 (R11).</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Diagnoses for R11 included: Alzheimer's disease, dementia, anxiety, and depression. The most recent MDS was a discharge assessment dated [DATE], assessed R11 with short-term memory problems and moderately impaired cognitive skills.</p> <p>In reviewing a resident-to-resident altercation investigation conducted by the facility regarding R11 (the aggressor) and three female residents (identified as R7, R8, and R9) being touched inappropriately on 5/18/25, witness statements were missing from the investigation.</p> <p>On 7/29/25 at 1:30 p.m. the director of nursing (DON) was made aware of the missing witness statements. The DON verbalized that she had completed the witness statements and would look for them.</p> <p>On 7/29/25 at 2:00 p.m. the DON returned and said that she thought the witness statements were on her computer but could not find them.</p> <p>On 7/29/25 at 7:55 p.m. two of the witnesses named in the investigation were interviewed via telephone (identified as certified nursing assistant, CNA #1 and licensed practical nurse, LPN #2). CNA #1 verbalized reporting everything that was observed to the DON. LPN #2 verbalized no recall of giving a witness statement.</p> <p>On 7/30/25 at 4:30 p.m. the above information was presented to the administrator and DON.</p> <p>A facility policy titled Abuse Investigation and Reporting read in part; d. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it.</p> <p>No other information was presented prior to the exit conference on 7/31/25.</p>		

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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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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, adult protective services and law enforcement of a positive test result for illicit drugs for one of eleven residents in the survey sample (Resident #1).The findings include: Facility staff failed report to the state agency, adult protective services and law enforcement after Resident #1 tested positive for marijuana and methamphetamine of unknown source. Resident #1 (R1) was admitted to the facility with diagnoses that included traumatic hemorrhage of cerebrum, post-traumatic hydrocephalus, epilepsy, dementia, history of substance abuse, depression, hypertension, dry eye syndrome and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed R1 as cognitively intact.Resident #5 (R5) was admitted to the facility with diagnoses that included paraplegia, osteomyelitis, sacral pressure ulcer, history substance abuse, chronic pain, depression, polyneuropathy and neurogenic bladder. The MDS dated [DATE] assessed R5 as cognitively intact. R5 was roommate to R1 from 12/5/24 until 1/16/25. R5's clinical record documented a social worker note dated 1/15/25 at 10:00 a.m. stating there had been reports of a chemical smell coming from the resident's room. This note documented, Director of social services (DSS), administrator, and director of nursing went to speak with resident after there were reports of a 'chemical smell' coming from the room . The social worker documented that R5 gave consent for search of his room/personal belongings and the DSS documented finding items that included 4 vape devices, 2 cans of pepper spray, 3 glass smoking devices, 3 empty containers of THC-a smoking material, half-smoked cigarette and 2 bottles of over-the-counter antacids. This note documented, .All items removed and taken to the social service office. Items were secured in the safe in the office .Resident stated that he does like to go off property to smoke . Interventions documented in response to the items found in R5's room included, removal and locking items in facility safe, education to R5 that all smoking materials had to be obtained at the time of signing out of the facility and returned to nursing upon return, resident given options to quit smoking with the resident expressing interest in nicotine gum, and bottles of antacid given to nursing for storage in medication cart. R1's clinical record documented a nursing note dated 1/15/25 stating that at 12:35 p.m., R1 was observed with .seizure-like activity while lying in bed .resemble generalized tonic-clonic .stiffening of the body, contraction to hands bilat [bilaterally], facial muscles. Seizure-like activities occurred x 3 appear to last 30 secs [seconds] each .Patient positioned laterally .Supplemental Oxygen was provided @ 2 LPM [liters per minute] . The note documented the physician was notified and ordered the resident to the emergency room for evaluation/treatment with emergency personnel listed as arriving at 1:05 p.m.The emergency room (ER) report dated 1/15/25 documented, .presenting today with chief concern for seizure. Per EMS he had 2 seizures witnessed by staff at facility and 2 witnessed by EMS .Someone from the facility called and asked if we can add on a drug screen because his roommate of 3 weeks they were concerned may have been giving him some substances .History of polysubstance/alcohol abuse prior to stroke . The drug screen performed at the emergency room on 1/15/25 documented the resident tested positive for marijuana and methamphetamines. The ER physician documented, .Psychosocial issue - I spoke with his wife about the drug screen, she will speak with the facility to ensure that it does not happen again . The resident had CT scans and x-rays performed which were negative for any findings. The resident was given a trial of Narcan, intravenous fluids and was discharged to the facility with instructions for continued use of previous anti-seizure medications. R1 returned to the facility on 1/15/25 at 10:00 p.m. with one-to-one supervision implemented by staff due to positive drug findings. The clinical record documented on 1/16/25 that staff witnessed R5 using vulgar language and make verbal threats toward R1. The facility issued R5 a 30-day discharge notice on 1/16/25 due to his possession of prohibited items and verbal aggression. The police were called and R5 was sent to the emergency room on 1/16/25 upon an emergency custody order. There was no facility reported incident (FRI) form sent to the state agency or notification to adult protective services or law enforcement regarding R1's positive drug tests and related drug devices found in R5's room on 1/15/25. On 7/29/25 at 3:00 p.m., the administrator was interviewed about a report to the state agency, police and adult protective services (APS) regarding R1's positive drug test for marijuana and methamphetamine. The administrator stated he did not initiate a FRI on 1/15/25. On 7/30/25 at 8:45 a.m., the administrator was interviewed again about a FRI and notification to the required agencies. The administrator stated he did not enter a FRI about the drugs but sent a FRI on 1/16/25 regarding R5's verbal aggression and the transfer with</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility failed to ensure a complete and thorough investigation of an allegation of abuse and/or unusual event for two of eleven residents (Residents #1 and #11).The findings include: 1. The facility failed to ensure witness statement documentation regarding resident-to-resident altercation investigation for resident #11 (R11).</p> <p>Diagnoses for R11 included: Alzheimer's disease, dementia, anxiety, and depression. The most recent MDS was a discharge assessment dated [DATE], assessed R11 with short-term memory problems and moderately impaired cognitive skills.</p> <p>In reviewing a resident-to-resident altercation investigation conducted by the facility regarding R11 (the aggressor) and three female residents (identified as R7, R8, and R9) being touched inappropriately on 5/18/25, the investigation listed three staff members as witnesses to the altercation however, witness statements were missing from the investigation. The witnesses were identified as license practical nurse (LPN #2), certified nursing assistant (CNA #1), and CNA #3 (no longer employed at the facility).</p> <p>On 7/29/25 at 1:30 p.m. the director of nursing (DON) was made aware of the missing witness statements. The DON verbalized that she had completed the witness statements and would look for them.</p> <p>On 7/29/25 at 2:00 p.m. the DON returned and said that she thought the witness statements were on her computer but could not find them.</p> <p>On 7/29/25 at 7:55 p.m. two of the witnesses named in the investigation were interviewed via telephone (CNA #1 and LPN #2). CNA #1 verbalized reporting everything that was observed to the DON. LPN #2 verbalized no recall of giving a witness statement.</p> <p>On 7/30/25 at 4:30 p.m. the above information was presented to the administrator and DON.</p> <p>A facility policy titled Abuse Investigation and Reporting read in part; d. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it.</p> <p>No other information was presented prior to the exit conference on 7/31/25.</p> <p>2. Facility staff failed to thoroughly investigate drug use of unknown source after Resident #1 tested positive for marijuana and methamphetamine during an emergency room visit.</p> <p>Resident #1 (R1) was admitted to the facility with diagnoses that included traumatic hemorrhage of cerebrum, post-traumatic hydrocephalus, epilepsy, dementia, history of substance abuse, depression, hypertension, dry eye syndrome and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed R1 as cognitively intact.</p> <p>Resident #5 (R5) was admitted to the facility with diagnoses that included paraplegia, osteomyelitis, sacral pressure ulcer, history substance abuse, chronic pain, depression, polyneuropathy and neurogenic bladder. The MDS dated [DATE] assessed R5 as cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R5 was roommate to R1 from 12/5/24 until 1/16/25.</p> <p>R1's clinical record documented a nursing note dated 1/13/25 stating, .Went into resident's room to give AM [morning] medicine, resident was not in bed. Found resident lying on floor in front of bathroom door. Resident had a sweatshirt under his head using it for a pillow. Resident denied falling stated he was just sleeping there, eyes glassed over and pupil's pinpoint .abrasions noted to left arm and elbow. Resident slow and sluggish answering questions .Provider aware and ordered to send to [emergency department] for evaluation .exited facility at 0853 [8:53 a.m.] .Night shift reported that room smelled of marijuana and a chemical smell last night .</p> <p>R1's emergency room records dated 1/13/25 documented R1 was assessed at baseline with no acute injuries or findings. R1 returned to the facility 1/14/25 at 3:39 a.m.</p> <p>R5's clinical record documented a social worker note dated 1/15/25 at 10:00 a.m. stating there had been reports of a chemical smell coming from the resident's room. This note documented, Director of social services (DSS), administrator, and director of nursing went to speak with resident after there were reports of a 'chemical smell' coming from the room . The social worker documented that R5 gave consent for search of his room/personal belongings and the DSS documented finding items that included 4 vape devices, 2 cans of pepper spray, 3 glass smoking devices, 3 empty containers of THC-a smoking material, half-smoked cigarette and 2 bottles of over-the-counter antacids. This note documented, .All items removed and taken to the social service office. Items were secured in the safe in the office .Resident stated that he does like to go off property to smoke . Interventions documented in response to the items found in R5's room included, removal and locking items in facility safe, education to R5 that all smoking materials had to be obtained at the time of signing out of the facility and returned to nursing upon return, resident given options to quit smoking with the resident expressing interest in nicotine gum, and bottles of antacid given to nursing for storage in medication cart.</p> <p>R1's clinical record documented a nursing note dated 1/15/25 stating that at 12:35 p.m., R1 was observed with .seizure-like activity while lying in bed .resemble generalized tonic-clonic .stiffening of the body, contraction to hands bilat [bilaterally], facial muscles. Seizure-like activities occurred x 3 appear to last 30 secs [seconds] each .Patient positioned laterally .Supplemental Oxygen was provided @ 2 LPM [liters per minute] . The note documented the physician was notified and ordered the resident to the emergency room for evaluation/treatment with emergency personnel listed as arriving at 1:05 p.m.</p> <p>The emergency room (ER) report dated 1/15/25 documented, .presenting today with chief concern for seizure. Per EMS he had 2 seizures witnessed by staff at facility and 2 witnessed by EMS .Someone from the facility called and asked if we can add on a drug screen because his roommate of 3 weeks they were concerned may have been giving him some substances .History of polysubstance/alcohol abuse prior to stroke . The drug screen performed at the emergency room on 1/15/25 documented the resident tested positive for marijuana and methamphetamines. The ER physician documented, .Psychosocial issue - I spoke with his wife about the drug screen, she will speak with the facility to ensure that it does not happen again . The resident had CT scans and x-rays performed which were negative for any findings. The resident was given a trial of Narcan, intravenous fluids and was discharged to the facility with instructions for continued use of previous anti-seizure medications.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1 returned to the facility on 1/15/25 at 10:00 p.m. with one-to-one supervision implemented by staff due to positive drug findings. The clinical record documented on 1/16/25 that staff witnessed R5 using vulgar language and verbal threats toward R1. The facility issued R5 a 30-day discharge notice on 1/16/25 due to his possession of prohibited items and verbal aggression. The police were called and R5 was sent to the emergency room on 1/16/25 with an emergency custody order.</p> <p>There was no facility reported incident (FRI) form sent to the state agency or notification to other agencies (adult protective services, law enforcement) regarding R1's positive drug tests and related drug devices found in R5's room on 1/15/25. There was no documented investigation regarding R1's positive drug tests.</p> <p>On 7/29/25 at 3:00 p.m., the administrator was interviewed about a report to the state agency, police and adult protective services (APS) regarding R1's positive drug test for marijuana and methamphetamine. The administrator stated he did not initiate a FRI on 1/15/25. On 7/30/25 at 8:45 a.m., the administrator was interviewed again a FRI and investigation. The administrator stated he did not enter a FRI about the drugs but sent a FRI on 1/16/25 regarding R5's verbal aggression and the transfer due to aggressive behaviors. The administrator stated actions had been taken following R1's positive drug test (1:1 supervision, discharge notice to R5, R5 discharged on emergency custody order, R5 moved to another floor/room with increased supervision, discharge from facility) but that he focused that investigation on R5's unmanageable behaviors. The administrator stated he had a verbal conversation with APS about R5, the police were notified on 1/16/25 regarding the aggressive behaviors and were given the prohibited items found in R5's room on 1/15/25. The administrator stated he did not have documentation regarding a formal investigation about R1's positive drug test results.</p> <p>The FRI dated 1/16/25 and the related investigation were reviewed. The alleged incident, witness statements and investigation summary referenced R5's aggressive verbal behaviors and subsequent transfer to the emergency room. There was no documented investigation about R1's positive drug results.</p> <p>The facility's policy titled Abuse Investigating and Reporting (revised 10/1/21) documented, .All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown and thoroughly investigated by facility management. Findings of abuse investigations will also be reported .All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies .State licensing/certification agency responsible for surveying/licensing the facility .local/State Ombudsman .Resident's Representative .Adult Protective Services .Law enforcement officials (if applicable) .Attending Physician .Medical Director .An alleged violation .will be reported immediately but not later than .Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury .Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury .The Administrator .will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident .</p> <p>This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 7/30/25 at 4:15 p.m. with no further information presented prior to the end of the survey.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Staunton Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 512 Houston Street Staunton, VA 24401	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, staff interview and facility document review, the facility staff failed to follow professional standard of care for medication administration on two of four units (2NW and 2NS). The findings include: Facility staff observed medications left unattended in resident rooms on unit 2NW and 2NS (skilled unit). On 7/30/25 at 3:10 p.m., the director of nursing (DON) was interviewed about any issues during the last three months with medications left unattended. The DON stated unattended medications had been observed/reported on two occasions during June and July (2025) with one incident occurring on the 2NW unit and the other on 2NS unit. The DON stated the two nurses involved were re-educated and a correction plan was initiated to address the concern. On 7/30/25 at 3:30 p.m., the administrator was interviewed about the observed incidents of medication left unattended. The administrator stated there had been social media posts in the area about the facility that alleged medications were left unattended in resident rooms. The administrator stated audits were conducted to identify/validate this concern. The administrator stated there were two observations made of medications left unattended, so this issue was included in their quality improvement program with a plan of correction implemented to address the issue. The facility's policy titled General Guidelines for Medication Administration (revised 8/2020) documented. Medications are administered as prescribed in accordance with good nursing principles and practices. At a minimum, the 5 Rights - right resident, right drug, right dose, and right time - should be applied to all medication administration and reviewed. When medications are administered by mobile cart taken to the resident's location (room, dining area, etc.), medications are administered at the time they are prepared. The resident is always observed after administration to ensure that the dose was completely ingested. The administrator presented a QAPI (Quality Assurance and Process Improvement) action plan initiated on 6/26/25 listing the issue/concern as Social media post alleged that medications were being left at bedside. The root cause analysis/related factors were identified as the 5 rights of medication administration and policy/procedures were allegedly not being followed by nursing staff. The plan listed that the media post identified no nurses or residents. The plan documented that all residents had the potential to be affected. Actions taken included the following. 100% audit of all residents' rooms looking for medications left at bedside by DON or designee - completed on 7/1/25. Medication administration observation with competency checks completed each shift for 3 days by DON or designee - completed on 7/1/25. All nursing staff were educated on the policy regarding medications left at the bedside by DON or designee - completed 7/5/25. All licensed nursing staff were educated on the 5 Rights of Medication Administration by DON or designee - completed 7/5/25. A 12-week monitoring plan initiated that included medication at bedside audits 5 times per week for two weeks (completed 7/10/25), medication at bedside audit performed 3 times per week for two weeks (completed 7/24/25), and medication bedside audit weekly for eight weeks (ongoing). The compliance date for this concern was listed as 7/27/25. The audits, education and monitoring were documented at listed and training verified. Areas of improvement were identified, and nurses re-educated as needed. Resident rooms were observed upon the initial tour of the facility on 7/29/25 starting at 10:50 a.m. with no unattended medications found. Observations were made throughout the current survey with no medications observed unattended. No non-compliance regarding failure to follow professional standards was identified during the current survey and since the correction date of 7/27/25. The plan of correction was deemed acceptable and implemented as listed. This finding was reviewed with the administrator, DON and regional nurse consultant during a meeting on 7/30/25 at 4:15 p.m. This deficiency was cited as past non-compliance.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 promote a safe, drug free environment for one of eleven residents in the survey sample (Resident #1). The findings include: Facility staff failed to promptly implement interventions following reports of marijuana and a chemical smell in Resident #1's room on 1/13/25. During an emergency room visit for seizures, Resident #1 tested positive for marijuana and methamphetamine following suspected illicit drug use by the resident's roommate (Resident #5). Resident #1 (R1) was admitted to the facility with diagnoses that included traumatic hemorrhage of cerebrum, post-traumatic hydrocephalus, epilepsy, dementia, history of substance abuse, depression, hypertension, dry eye syndrome and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed R1 as cognitively intact. R1's clinical record documented no drug/alcohol use since July 2021. Resident #5 (R5) was admitted to the facility with diagnoses that included paraplegia, osteomyelitis, sacral pressure ulcer, history substance abuse, chronic pain, depression, polyneuropathy and neurogenic bladder. The MDS dated [DATE] assessed R5 as cognitively intact. R1 and R5 were roommates from 12/5/24 until 1/16/25. Clinical records for R1 and R5 made no mention of marijuana/chemical smells or concerns for prohibited drugs until 1/13/25. R1's clinical record documented a nursing note dated 1/13/25 stating, .Went into resident's room to give AM [morning] medicine, resident was not in bed. Found resident lying on floor in front of bathroom door. Resident had a sweatshirt under his head using it for a pillow. Resident denied falling stated he was just sleeping there, eyes glassed over and pupil's pinpoint .abrasions noted to left arm and elbow. Resident slow and sluggish answering questions .Provider aware and ordered to send to [emergency department] for evaluation .exited facility at 0853 [8:53 a.m.] .Night shift reported that room smelled of marijuana and a chemical smell last night .R1's emergency room records dated 1/13/25 documented R1 was assessed at baseline with no acute injuries or findings. R1 returned to the facility 1/14/25 at 3:39 a.m. Clinical records for R1 and R5 documented no interventions taken in response to the report of marijuana and chemical smell documented on 1/13/25 until 1/15/25. R1 and R5's clinical records on 1/14/25 documented scheduled medication administration, wound care/assessments for both residents and a nurse practitioner visit for R1. Clinical notes/assessments on 1/14/25 made no mention or reference to the marijuana/chemical smell documented on 1/13/25 or of any current smell of marijuana/chemicals. R5's clinical record documented a social worker note dated 1/15/25 at 10:00 a.m. stating there had been reports of a chemical smell coming from the resident's room. This note documented, Director of social services (DSS), administrator, and director of nursing went to speak with resident after there were reports of a 'chemical smell' coming from the room . The social worker documented that R5 gave consent for search of his room/personal belongings and the DSS documented finding items that included 4 vape devices, 2 cans of pepper spray, 3 glass smoking devices, 3 empty containers of THC-a smoking material, half-smoke cigarette and 2 bottles of over-the-counter antacids. This note documented, .All items removed and taken to the social service office. Items were secured in the safe in the office .Resident stated that he does like to go off property to smoke . Interventions documented in response to the items found in R5's room included, removal and locking items in facility safe, education to R5 that all smoking materials had to be obtained at the time of signing out of the facility and returned to nursing upon return, resident given options to quit smoking with the resident expressing interest in nicotine gum, and bottles of antacid given to nursing for storage in medication cart. R1's clinical record documented a nursing note dated 1/15/25 stating that at 12:35 p.m., R1 was observed with .seizure-like activity while lying in bed .resemble generalized tonic-clonic .stiffening of the body, contraction to hands bilat [bilaterally], facial muscles. Seizure-like activities occurred x 3 appear to last 30 secs [seconds] each .Patient positioned laterally .Supplemental Oxygen was provided @ 2 LPM [liters per minute] . The note documented that the physician was notified and ordered the resident to the emergency room for evaluation/treatment with emergency personnel arriving at 1:05 p.m. The emergency room (ER) report dated 1/15/25 documented, .presenting today with chief concern for seizure. Per EMS he had 2 seizures witnessed by staff at facility and 2 witnessed by EMS .Someone from the facility called and asked if we can add on a drug screen because his roommate of 3 weeks they were concerned may have been giving him some substances .History of polysubstance/alcohol abuse prior to stroke . The drug screen performed at the emergency room on 1/15/25 documented the resident tested positive for marijuana and methamphetamines. The ER physician documented, Psychosocial issue - I spoke with his wife about the</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>(continued on next page)</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility failed to provide medically related social services for psychosocial well-being for four of eleven residents in the survey sample. Resident 's 7, 8, 9, and 10 were not assessed by the social worker after a resident-to-resident altercation. The findings include: 1. Residents 7, 8, and 9 were not assessed by the social worker after a resident-to-resident altercation. Review of a facility investigation regarding resident-to-resident altercation dated 5/18/25 included Resident 11 (R11, the aggressor) and three female residents identified as R7, R8, R9. The investigation report indicated R11 newly admitted to the facilities dementia unit for respite care on 5/17/25 had become aggressive and started touching/grabbing three females' breasts while in the dining area. R11 was removed from the area, monitored and sent to the emergency room and was later discharged from the facility on 5/19/25. R7 diagnoses include dementia, schizophrenia, depression, and cognitive communication deficit. The most recent MDS was a quarterly assessment dated [DATE]. R7 was assessed with a conative score of 7 indicating moderately impaired. R8 diagnoses include Alzheimer's disease, dementia, and anxiety. The most recent MDS was a quarterly assessment dated [DATE]. R8 was assessed severely cognitively impaired. R9 diagnoses include Alzheimer's disease, dementia, and depression. The most recent MDS was a quarterly assessment dated [DATE]. R9 was assessed with short and long-term memory problems and severely impaired conatively. Review of the clinical records for the three female residents involved did not evidence that social services had completed any emotional/psychosocial assessments related to the incident. On 7/29/25 at 4:30 p.m. the social worker (other staff, OS #1) was interviewed. OS #1 verbalized awareness of the incident but didn't recall if any assessments were completed on the residents involved and would check on this. OS #1 was unable to evidence assessments had been completed. R7, R8, and R9 were not able to be interviewed due to cognitive status, however review of clinical records and observations made throughout the survey did not indicate an emotional negative effect. The residents involved in the incident were observed in various activities and did not appear depressed, isolated, or withdrawn. Interviews with nursing staff on the dementia unit did not evidence the residents being emotionally distressed over the incident. On 7/30/25 at 4:30 p.m. the above information was presented to the administrator and DON. No other information was provided prior to the exit conference on 7/31/25. 2. Resident 10 (R10) was not assessed by the social worker after a resident-to-resident altercation. The findings include: Diagnoses for Resident #10 (R10) included: dementia, depression, insomnia, and kidney disease. The most recent MDS (Minimum Data Set) was a quarterly dated 4/17/25, R10's BIMS score was 3, indicating severely cognitively impaired. Review of a facility investigation regarding resident-to-resident altercation dated 5/19/25 included Resident 11 (R11, the aggressor) and R10. The investigation report indicated R11 newly admitted to the facilities dementia unit for respite care on 5/17/25 had become aggressive hit R10 in the face. R11 was removed from the area, placed on one-to-one monitoring and sent to the emergency room and was later discharged from the facility on 5/19/25. Review of the R10's clinical record did not evidence that social services had completed any emotional/psychosocial assessments related to the incident. On 7/29/25 at 4:30 p.m. the social worker (other staff, OS #1) was interviewed. OS #1 verbalized awareness of the incident but didn't recall if any assessments were completed on the residents involved and would check on this. OS #1 was unable to evidence assessments had been completed. Clinical records and observations made throughout the survey did not indicate an emotional negative effect from the incident. R10 was observed in various activities and did not appear depressed, isolated, or withdrawn. Interviews with nursing staff on the dementia unit did not evidence the residents being emotionally distressed over the incident. On 7/30/25 R10 was interviewed. R10 did not recall the incident, but verbalized that the staff are good, feel safe and enjoy cleaning his room. On 7/30/25 at 4:30 p.m. the above information was presented to the administrator and DON. No other information was provided prior to the exit conference on 7/31/25.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for two of eleven residents in the survey sample (Residents #6 and #10).The findings include:1. Documented neurological checks following a fall with injury were not included in Resident #6's clinical record.</p> <p>Resident #6 (R6) was admitted to the facility with diagnoses that included dementia with behavioral disturbance, anxiety, depression, gastroesophageal reflux, insomnia, cataracts, and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed R6 with severely impaired cognitive skills.</p> <p>R6's clinical record documented the resident had an unwitnessed fall on 3/4/25. A nursing note dated 3/4/25 documented the resident was found on the floor in her room. This note documented physical and neurological checks were completed. The resident was observed with a large hematoma on the forehead and bruising on the upper bridge of the nose with a small break in skin. This note stated neurological checks were initiated.</p> <p>R6's clinical record documented a nursing note dated 3/9/25 stating the resident was tearful, holding her forehead in pain with some dizziness noted. The nurse practitioner note dated 3/9/25 documented review of this change in condition and listed, Neuro assessments are not available.</p> <p>Review of R6's clinical record on 7/29/25 revealed no documented neurological (neuro) checks.</p> <p>On 7/29/25 at 4:20 p.m., the director of nursing (DON) was interviewed about neuro checks following R6's fall on 3/4/25. The DON reviewed the clinical record and stated, No neuro checks were found. The DON stated the facility was switching from computerized assessment to paper assessments around the time of that fall and she was unable to locate the checks.</p> <p>On 7/30/25 at 8:10 a.m., the medical records clerk (other staff #5) was interviewed about R6's missing neuro checks. The medical records clerk presented paper copies of R6's neuro checks starting on 3/4/25. The medical records clerk was interviewed about why the neuro checks were not part of the electronic health record. The medical records clerk stated the neuro checks were documented on paper and had not been scanned into the clinical record. The medical records clerks stated she received the documents one to two weeks ago and had not prioritized scanning them because the records were old. The medical records clerk stated she thought the documents had been filed on the nursing unit, and when files were cleaned, the checks were sent to medical records.</p> <p>This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 7/30/25 at 4:15 p.m. with no further information presented prior to the end of the survey.</p> <p>2. Assessments and an incident were not documented in resident #10's clinical record regarding a resident-to-resident altercation.</p> <p>The findings include:</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Diagnoses for Resident #10 (R10) included: dementia, depression, insomnia, and kidney disease. The most recent MDS (Minimum Data Set) was a quarterly dated 4/17/25, R10's BIMS score was 3, indicating severely cognitively impaired.</p> <p>A review of the facilities investigation dated 5/19/25 indicated R10 was involved in a resident-to resident altercation. According to the investigation, R10 was assessed for physical and emotional concerns and was within normal limits. Review of R10's clinical record did not evidence any assessments or progress notes related to the altercation.</p> <p>On 7/30/25 at 3:00 p.m. the director of nursing (DON) was interviewed. DON said on 5/19/25 she was notified that R11 was being combative towards staff and had hit R10. The DON said that the responsible party (RP) and physician were notified. 911 was called and R11 was sent to the hospital for aggressive behavior and did not return to the facility. The DON was asked about missing documentation of incident and assessments. The DON verbalized that assessments were done at the time of the event and should have been documented by nursing staff.</p> <p>The facilities policy titled Resident-To-Resident Altercations read in part: h. [...] document the incident, findings, and any corrective measures taken in the resident's medical/clinical record.</p>		