STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Staunton Post Acute & Rehabilitation	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on resident interviews, staff interviews, clinical record review, and facility document review the facility failed to protect the residents' rights to be free from abuse, including physical and verbal abuse for four of eleven residents in the survey sample, (resident #'s 2, 3, 4, 5) resulting in immediate jeopardy (IJ) and substandard quality of care. After accepting the plan for removal of Immediate Jeopardy from the Administrator, and determining that the Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity level of level 2, pattern. The Findings Include:For Resident #1 (R1) who had repeated aggressive behaviors towards multiple residents including R2, R3, R4, and R5, the facility staff failed to implement interventions to respond to and intervene in R1's continued abuse towards others. Diagnoses for R1 included heart failure, diabetes, dementia, hemiplegia, and seizure disorder. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/16/2025. R1 was assessed with a cognitive score of 5 out of 15, which indicated severe cognitive impairment. R1's behavior notes were reviewed and documented the following: Effective Date: 12/19/2025 09:03 Type: *Behavior Note Please describe the behavior demonstrated: a resident from the upstairs unit [identified as R2] came down to say hello to his friends, [name, R1] started yelling, he's a [expletive]!! Leave! you can't be here, you {expletive]! Effective Date: 12/20/2025 19:00 Type: *Behavior Note Please describe the behavior demonstrated: another resident [identified as R2] was sitting across the dividing wall of the dining room, speaking to another resident who asked him to come see her. [resident name, R1] began staring at said resident and grinding his teeth. He then yelled, NO! very loud frightening 2 female residents [identified as R3 and R4]. One yelled out STOP IT as the other female was trying to get out of the dining room. [R1] then rammed the w/c of the resident [identified as R3] trying to leave. He then went toward female resident [identified as R4] who was standing with her walker, he jumped toward the resident standing swinging his arms attempting to hit her, however male nurse was able to intervene, and [R1[made no contact with standing female resident. both nurses, removed [R1] from dining area to his room. [R1] came back out of his room yelling NO. Male nurse and this nurse attempted to speak with [R1], explaining we would go to the dining area after he is better able to control himself. [R1] stated, I'll move you! [R1] then kicked this nurse in the right shin and punched in center of chest, leaving bruising and a knot on the shin and bruising on the chest. This nurse fell against the wall, and male nurse stepped in to help. How often did this behavior occur/last: >6-7 times a week Describe any Interventions attempted: separate [name R1] to quiet location Effectiveness of Interventions: not effective he continued to curse and yell at others Effective Date: 12/25/2025 10:20 Type: *Behavior Note Please describe the behavior demonstrated: [R1] was going to get a Dr. Pepper. When the elevator opened on the first floor, another resident who he does not like was awaiting [SIC] the elevator to go back upstairs. As soon as [R1] saw the other resident he began screaming, [repeated expletive]![R1] then started kicking the other resident [identified as R2] and swinging to hit [R2]. The other resident [R2] back up into the wall and started yelling. [expletive] other resident was told to go upstairs and he did, this resident came back to the unit and began yelling at whoever he came into contact with, including the nurse who was on the phone. Male (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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nurse separated [R1] away from other as he was scaring the other residents. How often did this behavior occur/last: daily Describe any Interventions attempted: separated from other residents Effectiveness of Interventions: ineffective [name of nurse]. Effective Date: 02/10/2026 18:38 Type: *Behavior Note Please describe the behavior demonstrated: : [R1] started yelling out NO! in repetition another resident [identified as R5] stated , please stop and at that time [name, R1] went toward the female attempting to attack her, male nurse arrived standing in front of [residents name] who began yelling, move ma'am move to get to female resident he was moved back to his table, where he became increasingly angry grinding his teeth and glaring those around him shaking with anger How often did this behavior occur/last : >5x's a week Describe any Interventions attempted: : separate him from others Effectiveness of Interventions : a female staff member he will continue and attack that female, when it is a male, he will not. Effective Date: 03/10/2026 19:09 Type: *Behavior Note Please describe the behavior demonstrated: [R1] was in his room watching TV. When another resident [identified as R2] came off the elevator and he heard them talking, he came out of his room and began yelling garbled word, was shaking and grinding his teeth. The other resident was socializing with one of his friends. [R1] continued to yell as he started coming down the hallway towards the other resident who was still socializing. This nurse stepped in front of him so he could not attack the two residents socializing. He started yelling at this nurse NO! another staff member took the other two residents away from the elevator, as soon as they were out of [R1] sight he went directly back to watching TV. Review of psychiatric notes indicated causes of aggressive behavior was possibly related to underlying vascular dementia and unspecific mood disorder. The notes' indicated medications were being adjusted, and laboratory tests were being performed. The treatment plan included observations and assessments of triggers that may cause aggression, redirection, one-to-one staffing ratio, reinforce positive behaviors and psychosocial sensory interventions. Review of the care plan also included these interventions. On 3/17/26 at 1:05 p.m. certified nursing assistant (CNA #1, assigned to R1) was interviewed. CNA #1 verbalized R1 has a temper and when he wants something, it must be done right away or he becomes aggressive. CNA #1 said that when R1 becomes aggressive, the staff will remove R1 from the area and try to do activities or place R1 on one-to-one. CNA #1 said that R2 was a trigger for R1 and R2 was moved upstairs and felt like it has helped the situation, but R1 will still exhibit aggression towards other residents and staff. On 3/17/26 at 1:15 p.m. license practical nurse (LPN #2, assigned to R1) was interviewed. LPN #2 verbalized taking care of R1 for several years and R1's behaviors can be sporadic and can be directed at any one at any time. LPN #2 said that R1 and R2 used to be roommates and got along fine, but then R1 was getting increasingly aggressive with R2, and a room change occurred, the aggressive actions continued and R2 was then moved to another unit which seemed to have helped along with medication changes. LPN #2 said that when R1 does become aggressive the staff try to redirect, put R1 on one-to-one and offer snacks and sodas. On 3/17/26 at 1:45 p.m. a contracted mental health therapist (other staff, OS #1) was interviewed. OS #1 said she was hired to provide talk therapy, and R1 was offered the therapy but declined and is currently being followed by the psychiatric nurse practitioner. On 3/17/26 at 2:00 p.m. the psychiatric nurse practitioner (OS #2) was interviewed. OS #2 verbalized only being in the facility for the past two weeks and R1 has been on the list of residents to see but has not been seen yet. OS #2 verbalized awareness that R1 had been seen by the previous nurse practitioner. OS#2 said R4 and R5 had been seen and did not feel there were any concerns regarding fearfulness. Diagnoses for R4 included cerebral palsy, anxiety, bipolar disorder, and psychotic disorder. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/15/2025. R4 was assessed with a cognitive score of 15 indicating cognitively intact. On 3/17/26 at 3:00 p.m. R4 and R5 (roommates) were interviewed. R4 verbalized there has not been any physical contact by R1, but R1 is a bully, loud, rude and begins yelling when he wants something and yells at residents, which can be startling. Diagnoses for R5 include asthma, bipolar, alcohol induced dementia, attention deficit disorder. The most current MDS (minimum data set) was a significant change (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assessment with an ARD (assessment reference date) of 1/1/2026. R5 was assessed with a cognitive score of 9 indicating moderately cognitively impaired. R5 said that R1 thinks he's God and should get everything he wants, R1 is hateful and loud. R5 said that R1 had not attacked her but had come toward her aggressively and was stopped. R5 then mouthed the words He's tried it with her. Pointing towards R4 (the privacy curtain was pulled between the beds). R4 and R5 both verbalized feeling safe. Diagnoses for R3 include heart failure, kidney disease, dysphagia, and cognitive communication deficit. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/28/2026. R3 was assessed with a cognitive score of 12 indicating moderately impaired. On 3/17/26 at 3:20 p.m. R3 was interviewed. R3 verbalized R1 has been aggressive with R3, is loud, hateful, and is a bully. R3 verbalized trying to stay to herself and felt safe and was not afraid of R1. Diagnoses for R2 include intracerebral hemorrhage, hemiplegia, and dysphagia. The most current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 3/5/2026. R2 was assessed with a cognitive score of 12 indicating moderately impaired. On 3/18/26 at 9:00 a.m. R2 was interviewed. R2 verbalized that R1 had a verbal confrontation and that R1 can be a bully and always wants his way. R2 was asked about R1 kicking him in the elevator, R2 said yes that happened and did not have injuries from it. R2 said that he felt safe, and both residents now ignore each other. On 3/18/26 at 10:15 a.m. registered nurse (RN #2, nurse that wrote behavior note on 12/20/25 and 12/25/25) was interviewed. RN #2 said that the residents involved were separated and R1 had kicked and punched RN #2. The director of nursing (DON) was notified and instructed RN #2 to call the police. The police came and took a report and R1 remained at the facility. The DON was told about R3 and R4 being involved in the altercation (on 12/20/25), skin assessments were completed and did not show injuries, but R3 and R4 were upset at the time but currently does not show signs of being fearful of R1. On 3/18/26 at 11:30 a.m. unit manager LPN #5 was interviewed regarding R1. LPN #5 verbalized that there's nothing specific to what sets R1 off, R1 is unpredictable to any person around. R1 wants what R1 wants and wants it immediately. When R1 gets his way then R1 deescalates. One-to-one was imposed for twenty-four hours a day for several days and then was reduced to as needed which is when R1 becomes aggressive or shows anger or can't be redirected, it's removed when R1 becomes calm. LPN #5 verbalized R1 sits in dining room most of day and staff are reactive to R1's behavior. On 3/18/26 at 12:00 p.m. the social services assistant (OS #3) was interviewed. OS #3 said that R1's behaviors are sporadic, no one thing sets R1 off. When R1 wants something, it must be done right away or R1 will escalate until he gets it. OS #3 said to keep residents safe the facility is looking at alternate placement for R1. OS #3 said in the past, R1 has been sent to the hospital on an ECO (emergency custody order) but was sent back indicating R1 was stable. OS #3 said that a 30-day discharge notice has been issued for R1, but multiple attempts have been made to discharge R1 without success. On 3/18/26 at 12:30 p.m. the facilities nurse practitioner (NP) was interviewed. The NP verbalized R1 is unpredictable towards residents and needs separation when angry. NP verbalized that something needs to be put in place to have more consistency and would be fine with putting R1 on one-to-one monitoring.The facility did present an incident summary for the incident regarding R1 and R2 having a resident-to-resident altercation dated 12/25/25 and indicated an investigation was performed and R1 was issued a thirty-day discharge. The facility did not present an incident summary or investigation for the incident dated 12/20/25 involving R1, R3, and R4.On 3/18/26 at 2:12 p.m., the survey team contacted state agency supervision and discussed concerns regarding the facility's failure to ensure residents were free from abuse for residents #2, #3, #4, and #5. On 3/18/26 at 3:50 p.m. the administrator and DON were advised that immediate jeopardy (IJ) was identified regarding the facility's failure to ensure residents were free from abuse for Residents #2, # 3, #4, and #5. The administrator was informed that immediate action was needed for development and implementation of a process to ensure protection from abuse for residents and a documentation plan of IJ removal was requested.On 3/18/26 at 8:05 p.m., a plan for IJ removal regarding protection from abuse was (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	provided by the facility. The plan was reviewed and approved by the state agency survey team/supervision and included the following.F600 Immediate Jeopardy (IJ) Removal Plan 3/18/26Resident #1 was placed on 1 to 1 supervision 3/18/2026 at 1605. The resident will remain on 1 to 1 supervision while out of bed until the resident discharges or significant change in condition limits the resident's physical ability to encounter another resident. Residents are unable to transfer from bed to wheelchair independently therefore not a risk to other residents while in bed. Residents 2, 3, 4, and 5 have been seen previously by psychiatric services and/or talk therapist between the dates of 2/19/2026 and 3/18/2026. Residents 2, 3, 4, and 5 residents receive follow up psychosocial support from facility staff on 3/18/2026. The facility will continue to attempt to find alternative placement for resident #1. All residents of the facility have the potential to be affected by this deficient practice. All residents residing in the facility will be screened for evidence of abuse and neglect starting at 16:00 on 3/18/2026. Residents who are interviewable (BIMS score of 8 or greater) will be interviewed utilizing an abuse questionnaire, non-verbal residents and residents with a BIMS score of 7 or will be assessed, head to toe, to validate the absence of signs of physical abuse. Identified concerns will be addressed according to the facility Abuse Policy. All residents will be assessed/reviewed for similar behaviors as exhibited by resident #1 by reviewing all Facility Reportable Incidents (FRIs) dating back to 12/19/2025 and care plans will be reviewed and revised with interventions for any identified residents. All staff of the facility/agency will be reeducated on the facility Abuse Policy. This education will include abuse prevention, types of abuse, and abuse reporting. All staff will receive education starting on 3/18/2026. Any staff who are not present on 3/18/2026 will be required to receive mandatory education prior to the start of their next shift. No staff member will be allowed to return to work after 3/18/2026 until this mandatory education has been completed. New hire orientation will include this training as part of the new hire process and all agency staff will be required to complete this education prior to starting work in the facility. The facility leadership team including but not limited to the NHA, DON, Social services, and activities will be provided reeducation on assessing triggers, root causes, and escalation patterns and development of an effective and sustained supervision and separation intervention for residents with behavioral disturbances by the Regional Director of Clinical Operations and Regional Director of Operations on 3/18/2026. The Medical Director was notified of the situation on 3/18/2026. The facility conducted an Ad Hoc QAPI committee to accept IJ Removal Plan on 3/18/2026. Date of completion 3/18/2026 at 23:59 On 3/19/26 starting at 9:00 a.m., the survey team verified that the above removal plan had been implemented through review of clinical records, interviews of staff of all disciplines. At the time of the verification, the facility obtained an order for an ECO [emergency custody order- which is an order for a mental health evaluation] for R1 and R1 was sent to the hospital for evaluation. Implementation of the IJ removal plan was deemed sufficient and completed as documented. The immediacy was removed as of 3/19/25 at 11:30 a.m. The scope/severity was reduced to level 2 pattern following the removal of immediate jeopardy.

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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. Based on staff interview, clinical record review, and facility document review the facility failed to report incidents of resident-to-resident abuse involving three of eleven residents in the survey sample (Resident #1, Resident #3, and Resident #4). The Findings Include: The facility did not report resident to resident abuse between Resident #1 (R1), R3, and R4. Diagnoses for R1 included heart failure, diabetes, dementia, hemiplegia, and seizure disorder. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/16/2025. R1 was assessed with a cognitive score of 5 indicating severely cognitively impaired. Diagnoses for R3 include heart failure, kidney disease, dysphagia, and cognitive communication deficit. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/28/2026. R3 was assessed with a cognitive score of 12 indicating mild cognitive impairment. Diagnoses for R4 included cerebral palsy, anxiety, bipolar disorder, and psychotic disorder. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/15/2025. R4 was assessed with a cognitive score of 15 indicating cognitively intact. Review of R1's progress notes indicated on 12/20/25 R1, R3, and R4 were in the dining area when R1 began yelling No to R2 (another resident close to the dining area). The note indicted one of the female residents (R3 or R4) said to stop it. R1 then rammed R3's wheelchair and started swinging and trying to attack R4. All residents were separated by staff. On 3/18/26 at 10:15 a.m. registered nurse (RN #2, nurse that wrote behavior note on 12/20/25) was interviewed. RN #2 said that the residents involved were separated. The director of nursing (DON) was told about R3 and R4 being involved in the altercation, skin assessments were completed and did not show injuries, but R3 and R4 were upset at the time but currently does not show signs of being fearful of R1. The administrator was asked to present all investigations and incident summaries regarding R1's aggressive behavior toward other residents. An incident synopsis and investigation were presented regarding R1's altercation with R2. However, there was no evidence of an investigation or reporting incident synopsis regarding the altercation dated 12/20/25 with R3 and R4. On 3/18/26 at 3:40 p.m. the administrator and director of nursing (DON) were interviewed. The above information was presented regarding not completing an investigation or reporting the incident to the state agency for R3 and R4 related to R1. The DON verbalized there wasn't an incident synopsis was not reported or investigation because there was no actual physical abuse due to the staff separated the residents involved. On 3/19/26 at 11:50 a.m. the administrator was asked to review R3's progress note dated 12/20/25 which indicated R3 was pushed R1. The administrator verbalized he would look to see if there were any incident synopsis or investigations completed. The administrator returned and verbalized, nothing regarding this incident was found and an investigation and incident summary should have been reported. The facilities Abuse policy read in part The organization will maintain systems to ensure that all alleged violations involving abuse [.] are reported immediately, but no later than 2 hours after the allegation is made [.]. No other information was presented prior to exiting on 3/19/26.

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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. Based on staff interview, clinical record review, and facility document review, the facility failed to investigate an incident of resident-to-resident abuse involving three of eleven residents in the survey sample (Resident #1, Resident #3, and Resident #4). The Findings Include: The facility did not investigate resident to resident abuse between Resident #1 (R1), R3, and R4. Diagnoses for R1 included heart failure, diabetes, dementia, hemiplegia, and seizure disorder. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/16/2025. R1 was assessed with a cognitive score of 5 indicating severely cognitively impaired. Diagnoses for R3 include heart failure, kidney disease, dysphagia, and cognitive communication deficit. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/28/2026. R3 was assessed with a cognitive score of 12 indicating cognitively intact. Diagnoses for R4 included cerebral palsy, anxiety, bipolar disorder, and psychotic disorder. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/15/2025. R4 was assessed with a cognitive score of 15 indicating cognitively intact. Review of R1's progress notes indicated on 12/20/25 R1, R3, and R4 were in the dining area when R1 began yelling No to R2 (another resident close to the dining area). The note indicted one of the female residents (R3 or R4) said to stop it. R1 then rammed R3's wheelchair and started swinging and trying to attack R4. All residents were separated by staff. On 3/18/26 at 10:15 a.m. registered nurse (RN #2, nurse that wrote behavior note on 12/20/25) was interviewed. RN #2 said that the residents involved were separated. The director of nursing (DON) was told about R3 and R4 being involved in the altercation, skin assessments were completed and did not show injuries, but R3 and R4 were upset at the time but currently does not show signs of being fearful of R1. The administrator was asked to present all investigations and incident summaries regarding R1's aggressive behavior toward other residents. An incident synopsis and investigation were presented regarding R1's altercation with R2. However, there was no evidence of an investigation or incident summary regarding the altercation dated 12/20/25 with R3 and R4. On 3/18/26 at 3:40 p.m. the administrator and director of nursing (DON) were interviewed. The above information was presented regarding not completing an investigation for R3 and R4 related to R1. The DON verbalized there wasn't an incident synopsis or investigation because there was no actual physical abuse due to the staff separated the residents involved. On 3/19/26 at 11:50 a.m. the administrator was asked to review R3's progress note dated 12/20/25 which indicated R3 was pushed R1. The administrator verbalized he would look to see if there were any incident synopsis or investigations completed. The administrator returned and verbalized, nothing regarding this incident was found and an investigation and incident summary should have been completed. The facilities Abuse policy read in part Investigation, Designated staff will immediately review and investigate all allegations or observations of abuse. The results of all investigations are to be communicated to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident [.]. No other information was presented prior to exiting on 3/19/26.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff interview and clinical record review, the facility staff failed to develop and implement a comprehensive care plan regarding behaviors for one of eleven residents, Resident #1. The findings included: Resident #1's (R1) comprehensive care plan did not have parameters for an intervention of one to one observation in the behavior care plan. Diagnoses for R1 included heart failure, diabetes, dementia, hemiplegia, and seizure disorder. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/16/2025. R1 was assessed with a cognitive score of 5 indicating severely cognitively impaired. Review of R1's care plan for behaviors listed an intervention put in place on 12/30/25 that read 1:1 supervision as indicated. There was no information regarding timeframe, whether the intervention was continuous, based on behavior, what consititued when it was to be used, or the duration. On 3/19/26 at 12:15 p.m. the director of nursing (DON) was interviewed. The DON reviewed R1's care plan and verbalized that R1 is placed on 1:1 when he becomes aggressive towards another resident and remains on 1:1 until R1 deescalates. The DON verbalized that the care plan should be more specific regarding 1:1 supervision. No other information was provided prior to exiting the facility on 3/19/26.