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	04/28/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 staff failed to ensure one of seven residents (Resident #107) followed protocols for safe smoking.The findings include:Resident #107 was observed smoking without supervision and with a cigarette that had not been provided or lit by facility staff.Resident #107 (R107) was admitted to the facility with diagnoses that included major depressive disorder, COPD (chronic obstructive pulmonary disease), anemia, dementia, anxiety, insomnia and protein-calorie malnutrition. The minimum data set (MDS) dated [DATE] assessed R107 with moderately impaired cognitive skills.On 4/27/26 at 2:40 p.m., R107 was observed seated in the corner of the outdoor courtyard that was designated as the smoking area for residents. R107 was actively smoking holding a lighted cigarette. R107 was interviewed at this time about smoking. R107 stated a staff member had been in the courtyard and just went back inside. R107 put out the cigarette on the concrete surface and stated that smoking in the facility was usually supervised. R107 demonstrated no unsafe behavior while smoking and the resident's clothes had no indication of burns/dropped ashes. The courtyard area was posted with smoking times listed as 10:30 a.m., 2:30 p.m. and 7:30 p.m.R107's clinical record documented a smoking assessment dated [DATE] listing the resident as low risk for safety concerns with smoking and included a requirement for supervision with smoking. The assessment documented that the resident had no visual impairment, no range of motion or balance issues, no fine motor skill difficulty, no lethargy during tasks, did not drop ashes, had no history of burns to clothing/skin, and as able to light, hold and extinguish a cigarette safely. The assessment documented the resident required no adaptive or protective equipment (apron) and that the resident was able to follow facility smoking protocols for safety. This assessment documented the resident as safe to smoke with supervision.R107's plan of care (revised 3/13/26) documented the resident was deemed to be a safe smoker with staff supervision. Interventions to ensure smoking safety included supervision with smoking, education to the resident on the facility's smoking policy that included location, times and safety precautions and smoking assessments performed as needed.On 4/28/26 at 8:10 a.m., R107 was interviewed about smoking on 4/27/26 without supervision. R107 stated that staff members supervised smoking each day at the designated times (10:30 a.m., 2:30 p.m. and 7:30 p.m.). R107 stated yesterday (4/27/26) that she was finishing up my last cigarette. R107 stated the staff person supervising allowed her to finish the last couple of puffs and that was when the surveyors walked up. R107 stated she did not require an apron or device for smoking and that she had never had any safety issues during smoking. R107 denied having cigarettes or lighter on her person or in her room. R107 stated residents were not allowed to keep smoking materials in their room and that nursing kept supplies locked in the medication room. R107 stated she did not remember the name of the staff person supervising smoking yesterday afternoon (4/27/26).On 4/28/26 at 8:20 a.m., accompanied by licensed practical nurse (LPN #1), resident smoking materials were observed locked in the second-floor medication room. The box contained 3 packs of cigarettes with a lighter and was secured in the locked room. LPN #1 stated at this time that all the current smokers in the facility (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were supervised by staff at the designated times and that no residents were allowed to keep smoking materials in their possession. LPN #1 stated two certified nurses' aides (CNAs) from 3rd floor provided smoking supervision on the afternoon of 4/27/26.On 4/28/26 at 8:25 a.m., CNA #1 that supervised resident smoking on the afternoon of 4/27/26 was interviewed. CNA #1 stated she was passing out ice on 3rd floor and was a little late going out with the smokers on 4/27/26. CNA #1 stated she and CNA #2 did not go out with the smokers on 4/27/26 until approximately 2:45 p.m. CNA #1 stated there were three other smokers in the courtyard during the session in addition to R107. CNA #1 stated R107 was not smoking when she arrived in the courtyard, and she did not see the resident with any smoking materials. CNA #1 stated, We hand out cigarettes individually, one at a time, and light them. CNA #1 stated R107 smoked two cigarettes during the session and consumed both prior to ending the smoking session. CNA #1 stated if R107 was smoking prior to 2:45 p.m., she had no idea where she got the cigarette or lighter as the smoking supplies stayed locked in the medication room. CNA #1 stated regarding the observation of R107 actively smoking at 2:40 p.m., We were not down there yet [in the courtyard]. CNA #1 stated none of the residents were smoking when she arrived in the courtyard with the smoking supplies. CNA #1 stated R107 had never demonstrated any safety issues during smoking and did not require an apron or adaptive equipment.On 4/28/26 at 8:35 a.m. CNA #2 that supervised smoking on the afternoon of 4/27/26 was interviewed. CNA #2 stated she was with CNA #1 supervising smoking on the afternoon of 4/27/26. CNA #2 state she and CNA #1 were not out with residents at 2:30 p.m. as scheduled but were late taking the smokers out. CNA #2 stated she and CNA # 1got the smoking box from the medication room and took it to the courtyard. CNA #2 stated R107 was already in the courtyard and there was no smoking going on by any residents when they arrived in the courtyard. CNA #2 stated she and CNA #1 watched R107 smoke two cigarettes during the session with both cigarettes consumed and extinguished/discarded in the receptacle prior to the end of the session. CNA #2 stated R107 was given two cigarettes, one at a time and that staff always lighted the cigarettes for residents. CNA #2 stated she was not aware R107 had been smoking and she did not know how the resident got a cigarette or lighter. CNA #2 stated R107 was always a safe smoker, never dropping ashes or cigarettes and that the resident did not require an apron or device. CNA #2 stated R107 smoked two cigarettes in front of us and that all cigarettes and the lighter were returned and locked in the medication room after the session.On 4/28/26 at 9:10 a.m., the administrator and director of nursing (DON) were interviewed about R107 observed actively smoking unsupervised. The administrator stated all resident smoking required supervision and that he was unsure where R107 got the cigarette and/or lighter. The administrator stated that residents that smoked were required to follow facility policies to ensure safe smoking.The facility's policy titled Smoking Permitted (revised 10/20/22) documented, .The facility will implement processes to respect the resident's right to smoke and will provide an environment for safe smoking in a manner that does not infringe on any resident's rights.Residents who desire to smoke will be educated on the facility policy and practices for safe smoking.The resident will verbalize understanding of the facility policy and practices and will sign acknowledgement of receipt of the policy.Resident who desire to smoke may not keep smoking related materials [i.e. cigarettes, electronic smoking devices (e-cigarettes), refill cartridges/fluid, cigars, pipes, tobacco, lighter, lighter fluid, match, etc.] on their person when not smoking or in their room.Resident who are determined by the interdisciplinary team as needing supervision will be within eyesight of staff, family, or designated volunteer during the time that the resident is smoking.Non-compliance with smoking safety requirements is taken very seriously.The facility may initiate discharge planning for a violation of any part of this policy and for any unsafe smoking practice that poses risk to residents or for repeated non-compliance with the facility safe smoking policy/practices.This finding was reviewed with the administrator and DON on 4/28/26 at 3:00 p.m. with no further information presented prior to the end of the survey.