STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495279	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Culpeper Health & Rehabilitation Center	602 Madison Road Culpeper, VA 22701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on resident interview, staff interview, and facility document review, it was determined that the facility staff failed to treat one of five residents in the survey sample, in a dignified manner, Resident #3.The findings include:For Resident #3 (R3) the facility staff failed to treat a resident in a dignified manner.On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/6/25, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions.The facility synopsis of events dated 6/13/25, documented the incident occurred on 6/3/25, documented in part, On 6/13/25 the Administrator was notified by patient (R3) of an allegation of verbal abuse that occurred on 6/3/25 by dietary cook, (other staff member) (OSM) #4. During dinner. Patient BIMS is 14. NP (nurse practitioner), RP (responsible party) and (name of local) police department notified. (OSM #4) suspended. Facility investigation initiated.The resident statement dated 6/13/25 documented in part, I was asking for a sandwich and (OSM #4) started yelling and arguing with me. She slammed the door on me and got very mad and was rude and told me to (explicative) off. I want her to apologize. She did not need to do all that.An interview was conducted with R3 on 7/28/25 at 4:00 p.m. R3's statement was reviewed with him. He stated he had never had that happen to him before. It affected him for quite a while. When asked how the incident made him feel, R3 stated he felt disrespected. R3 stated no one had asked him before how it made him feel.An interview was conducted with OSM (other staff member) #2, the director of discharge planning/social services, on 7/28/25 at 4:39 p.m. When asked her role when there is an allegation of abuse by a staff member, OSM #2, stated if a patient comes to her and alleges abuse, she files a complaint and informs the administrator. OSM #2 further stated that if the resident goes directly to the administrator, she doesn't get involved. When asked if she does a psychosocial assessment to determine if the resident needs any services, OSM #2 stated she goes and talks to the resident to see if they need to see their psychiatric nurse practitioner or clinical psychologist. Most of the time the resident is already seeing psych (psychological) services. Every time there is an allegation - she stated she would do a trauma informed screening. When asked what she talks to the residents about the incident, OSM #2 stated she speaks with them about the incident, if they want to talk about the incident, do they feel safe in the facility, and what they want done related to the allegation. When asked where she documents that she's spoken to the residents, OSM #2 stated, Honestly, I don't. OSM #2 stated she did was not aware of the incident with R3 and OSM #4.An interview was conducted with ASM (administrative staff member) #1, the administrator, on 7/29/25 at 10:40 a.m. When asked if a staff member is yelling at a resident, is that resident being treated in a dignified manner, ASM #1 stated no.The facility policy, Your Rights and Protections as a Nursing Home Resident documented in part, You have the right to be treated with respect: You have the right to be treated with dignity and respect.ASM (Administrative staff member) #1, ASM #2, the director of nursing, and ASM #4, regional director of clinical services, were made aware of the above concern on 7/29/25 at 1:04 p.m.No further information was provided prior to exit.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure three of five residents were free from verbal abuse, Residents #3, #4 and #5.The findings include:1. For Resident #3 (R3), the facility staff failed to protect the resident from verbal abuse from a staff member. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/6/25, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. The facility synopsis of events dated 6/13/25, documented the incident occurred on 6/3/25, documented in part, On 6/13/25 the Administrator was notified by patient (#3) of an allegation of verbal abuse that occurred on 6/3/25 by dietary cook, (other staff member) (OSM) #4. During dinner. Patient BIMS is 14. NP (nurse practitioner), RP (responsible party) and (name of local) police department notified. (OSM #4) suspended. Facility investigation initiated. The resident statement dated 6/13/25 documented in part, I was asking for a sandwich and (OSM #4) started yelling and arguing with me. She slammed the door on me and got very mad and was rude and told me to (explicative) off. I want her to apologize. She did not need to do all that. An interview was conducted with R3 on 7/28/25 at 4:00 p.m. R3's statement was reviewed with him. He stated he had never had that happen to him before. It affected him for quite a while. When asked how the incident made him feel, R3 stated he felt disrespected. R3 stated no one had asked him before how it made him feel. The email dated 6/13/25 at 10:17 a.m. documented an interview between OSM #2, the kitchen manager and OSM #4, the dietary staff member. It documented in part, she (OSM #4) was able to tell that she did yell at the resident because he yelled at her and she did shut the door on him. OSM #2 documented she informed that her behavior was not acceptable, and it was being investigated and OSM #4 kept pointing out things that the resident did and said. OSM #4 really didn't see that she did anything wrong. An interview was conducted with LPN (licensed practical nurse) #5, the unit manager on 7/28/25 at 4:56 p.m. LPN #5 stated if a resident tells her or it is reported to her that someone has been verbally abused, she first separates the resident from the abuser for safety. She then notifies her director of nursing and the administrator. LPN #5 was not aware of the incident between R3 and OSM #4. An interview was conducted with OSM #2, the kitchen manager, on 7/29/25 at 8:08 a.m. OSM #2 stated upon interview, OSM #4 stated she had yelled at the resident. OSM #4 told OSM #2 that she felt she was defending herself and yelled back. OSM #4 stated she did not do anything wrong. OSM #2 informed OSM #4 the facility was the resident's home and OSM #2 tried to stress the resident needed to be treated with kindness and respect. OSM #2 stated that OSM #4 never accepted responsibility for her actions. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Abuse/Neglect/Misappropriation/Crime, documented in part, There is zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center. 1. Patients of the Center have the legal right to be free from verbal, sexual, mental and physical abuse, corporal punishment, involuntary seclusion including abuse facilitated or enabled through the use of technology, and free from chemical and physical restraints except in an emergency and/or as authorized in writing by a physician. ASM (administrative staff member) #1, ASM #2, the director of nursing, and ASM #4, regional director of clinical services, were made aware of the above concern on 7/29/25 at 1:04 p.m. No further information was provided prior to exit. 2. For Resident #4 (R4) and Resident #5 (R5), the facility staff failed to ensure the residents were free from verbal abuse on 6/12/25. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/21/25, R4 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On the most recent MDS, a quarterly assessment with an ARD of 5/30/25, R5 scored 14 out of 15 on the BIMS, indicating the resident was cognitively intact for making daily decisions. An initial facility synopsis of events dated 6/12/25 documented, The Administrator was notified by patient (R4), of an allegation of verbal abuse today by (LPN [licensed practical nurse] #1). Patient BIMs of 15. NP (Nurse Practitioner), RP (Responsible Party) notified and [NAME] Police Department notified. (LPN #1) sent home and suspended. Facility investigation initiated. A written statement obtained from R4 on 6/18/25 documented, Sitting in the smoking courtyard with (R5). Nurse (LPN #1) came outside and started yelling at (R5). I told her that she could not speak to (R5) that way. (LPN #1) then yelled at me and told me to shut up. I then asked for her name and she gave it to me. A written statement obtained from R5 on 6/18/25 documented, I was outside in the smoking courtyard sitting beside (R4). Nurse (LPN #1) came out there and started yelling at me to come give her a urine sample. I told her I already did it then (R4) said to (LPN #1) to not speak to me that way then (LPN #1) yelled at him and told him to shut up then (R4) asked for her name and she said (name). A final facility synopsis of events dated 6/20/25 documented, On 6/12/2025 the Administrator was notified by staff that patient (R4) reported an allegation of verbal abuse by (LPN #1). Patient BIMs of 15. NP, RP notified, and [NAME] Police Department notified. (LPN #1) was sent home and suspended. Facility investigation initiated. During our comprehensive investigation, the other resident present [sic] with a BIMs of 14 who witnessed said alleged interaction was interviewed. The interview revealed that (LPN #1) yelled at (R4) and told him to shut up. We are therefore substantiating the allegation of verbal abuse. (LPN #1) has been terminated and reported to the Virginia Board of Nursing . (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/28/25 at 2:53 p.m., an interview was conducted with R4. R4 stated that on the date of the incident, LPN #1 came out to the smoking courtyard screaming at R4, and yelling, We have been over this, you have to get inside right now. R4 stated he told LPN #1, Excuse me, you can't talk to her like that and LPN #1 began yelling at him, This is none of your business. Why don't you get away. R4 stated he felt LPN #1 was verbally abusive and really rude. On 7/28/25 at 3:53 p.m., an interview was conducted with R5. R5 stated one day a staff member (whose name she could not recall) came out to the courtyard hollering and yelling at her that she needed to come inside for a urine sample. R5 stated she told the staff member that she had already provided a urine sample, but the staff member continued to yell at her and said she needed to come inside right away. R5 stated a gentleman told the staff member, You don't need to talk to her like that but could not remember the staff member's response. R5 stated she felt the staff member was verbally abusive and the incident made R5 feel angry. On 7/29/25 at 10:40 a.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated there have been instances when residents begin yelling at a staff member and the staff member raises his or her voice so the residents can hear what the staff member is saying. ASM #1 stated at times, there is a difference in a staff member actually yelling and in what a resident perceives as yelling but this is also dependent on the staff member's verbalizations such as saying shut up and cursing. In regard to the verbal abuse incident involving R4 and R5 on 6/12/25, ASM #1 stated LPN #1 denied the allegations but both residents' BIMS were 13 or greater, both residents were interviewed separately and their statements aligned so he substantiated the allegation of verbal abuse because he did not want to jeopardize anyone else. On 7/29/25 at 1:07 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for three of five residents in the survey sample, Residents #3, #4, and #5. The findings include: 1. For Resident #3 (R3), the facility staff failed to review and revise the comprehensive care plan after a staff member verbally abused the resident. The comprehensive care plan dated 2/5/25 was reviewed. It failed to evidence any documentation related to the resident being verbally abused by a staff member. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/6/25, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. The facility synopsis of events dated 6/13/25, documented the incident occurred on 6/3/25, documented in part, On 6/13/25 the Administrator was notified by patient (#3) of an allegation of verbal abuse that occurred on 6/3/25 by dietary cook, (other staff member) (OSM) #4. During dinner. Patient BIMS is 14. NP (nurse practitioner), RP (responsible party) and (name of local) police department notified. (OSM #4) suspended. Facility investigation initiated. The resident statement dated 6/13/25 documented in part, I was asking for a sandwich and (OSM #4) started yelling and arguing with me. She slammed the door on me and got very mad and was rude and told me to (explicative) off. I want her to apologize. She did not need to do all that. An interview was conducted with OSM (other staff member) #2, the director of discharge planning/social services, on 7/28/25 at 4:39 p.m. OSM #2 stated she did not review and revise the care plan after a resident has been verbally abused. An interview was conducted with LPN (licensed practical nurse) #5, the unit manager on 7/28/25 at 4:56 p.m. When asked if the care plan should be reviewed and revised if a resident was verbally abused, LPN #5 stated, yes, so that everyone is aware of the incident and what interventions were put in place, such as care needs and need for counseling. The facility policy titled, Care Planning documented, 5. Care plans will be updated on an ongoing basis as changes in the patient occur . ASM (Administrative staff member) #1, ASM #2, the director of nursing, and ASM #4, regional director of clinical services, were made aware of the above concern on 7/29/25 at 1:04 p.m. No further information was provided prior to exit. 2. For Resident #4 (R4), the facility staff failed to review and revise the resident's comprehensive care plan regarding verbal abuse. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of written statements obtained from R4 and another resident by facility staff on 6/18/25 revealed documentation that LPN (licensed practical nurse) #1 yelled at the residents and told R4 to shut up (on 6/12/25). A review of R4's comprehensive care plan (dated 5/16/25) failed to reveal the care plan was reviewed and revised after the verbal abuse incident on 6/12/25. On 7/28/25 at 4:40 p.m., an interview was conducted with OSM (other staff member) #2 (the director of discharge planning/social services). OSM #2 stated she does not review and revise residents' care plans after residents have been verbally abused. On 7/28/25 at 4:56 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated residents' care plans should be reviewed and revised after an incident of verbal abuse, so everyone is aware of the situation and aware of the interventions that have been put into place. On 7/29/25 at 1:07 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 3. For Resident #5 (R5), the facility staff failed to review and revise the resident's comprehensive care plan regarding verbal abuse. A review of written statements obtained from R5 and another resident by facility staff on 6/18/25 revealed documentation that LPN (licensed practical nurse) #1 yelled at the residents (on 6/12/25). A review of R5's comprehensive care plan (dated 11/17/22) failed to reveal the care plan was reviewed and revised after the verbal abuse incident on 6/12/25. On 7/28/25 at 4:40 p.m., an interview was conducted with OSM (other staff member) #2 (the director of discharge planning/social services). OSM #2 stated she does not review and revise residents' care plans after residents have been verbally abused. On 7/28/25 at 4:56 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated residents' care plans should be reviewed and revised after an incident of verbal abuse, so everyone is aware of the situation and aware of the interventions that have been put into place. On 7/29/25 at 1:07 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on resident interview, facility document review and clinical record review, it was determined the facility staff failed to provided medical related social services for three of five residents in the survey sample, Residents #3, #4 and #5. The findings include: 1. For Resident #3 (R3), the facility staff failed to provide medically related social services after an incident of verbal abuse by a staff member. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/6/25, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. The facility synopsis of events dated 6/13/25, documented the incident occurred on 6/3/25, documented in part, On 6/13/25 the Administrator was notified by patient (#3) of an allegation of verbal abuse that occurred on 6/3/25 by dietary cook, (other staff member) (OSM) #4. During dinner. Patient BIMS is 14. NP (nurse practitioner), RP (responsible party) and (name of local) police department notified. (OSM #4) suspended. Facility investigation initiated. The resident statement dated 6/13/25 documented in part, I was asking for a sandwich and (OSM #4) started yelling and arguing with me. She slammed the door on me and got very mad and was rude and told me to (explicative) off. I want her to apologize. She did not need to do all that. An interview was conducted with R3 on 7/28/25 at 4:00 p.m. R3's statement was reviewed with him. He stated he had never had that happen to him before. It affected him for quite a while. When asked how the incident made him feel, R3 stated he felt disrespected. R3 stated no one had asked him before how it made him feel. An interview was conducted with OSM (other staff member) 2, the director of discharge planning/social services, on 7/28/25 at 4:49 p.m. OSM #2 stated if a resident comes to her and alleges abuse by a staff member, she files a complaint and informs the administrator. She further stated if a resident doesn't come to her and goes straight to the administrator, she does not get involved. When asked if she does any psychosocial assessment to determine if the resident needs anything, OSM #2 stated she will go talk to the resident to see if they need to see the psychiatric nurse practitioner or the clinical psychologist. She speaks to the residents about the incident, if the resident feels safe in the building and what the resident wants to do about the concern/incident. Most of the time, she stated, the residents are already seeing psych (psychological) services. OSM #2 further explained that she does a trauma informed screen on the resident. When asked where she documents the conversation or informed trauma screen completed on the resident, OSM #2 stated, she honestly doesn't. OSM #2 stated she was not aware of the incident between the kitchen staff member and R3 and did not complete an assessment at that time. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 7/29/25 at 9:15 a.m. When asked if a psychosocial assessment be completed on a resident who was verbally abused by a staff member, ASM #2 stated she could not recall which assessment it is, but social services go around for anyone who has had an allegation of abuse to determine the severity of where the resident is at. They should complete the assessment to see how the resident is doing mentally and emotionally. The facility policy titled, Medically Related Social Services documented, In conjunction with medical and clinical staff, Social Work and Discharge Planning Staff will identify and provide assistance in meeting patients' psychosocial and medically related social service needs . (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM #1, ASM #2, the director of nursing, and ASM #4, regional director of clinical services, were made aware of the above concern on 7/29/25 at 1:04 p.m.No further information was provided prior to exit. 2. For Resident #4 (R4), the facility staff failed to assess the resident's psychosocial status and implement psychosocial interventions to address verbal abuse on 6/12/25. A review of written statements obtained from R4 and another resident by facility staff on 6/18/25 revealed documentation that LPN (licensed practical nurse) #1 yelled at the residents and told R4 to shut up (on 6/12/25). Further review of R4's clinical record failed to reveal the resident's psychosocial status related to the verbal abuse was assessed or psychosocial interventions were implemented. On 7/28/25 at 4:40 p.m., an interview was conducted with OSM (other staff member) #2 (the director of discharge planning/social services). OSM #2 stated she does not complete a formal assessment after a resident reports an allegation of abuse, but she talks to the resident, asks about a visit with the psychiatric nurse practitioner or psychologist, and would complete a trauma informed screening if the resident felt something more was needed. OSM #2 stated she did not complete an assessment or follow-up regarding R4's verbal abuse incident on 6/12/25. On 7/28/25 at 4:56 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that after a resident has reported an allegation of abuse, staff should frequently check on the resident, and a follow-up with the psychiatric nurse practitioner and/or the psychologist should occur. On 7/29/25 at 1:07 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 3. For Resident #5 (R5), the facility staff failed to assess the resident's psychosocial status and implement psychosocial interventions to address verbal abuse on 6/12/25. A review of written statements obtained from R5 and another resident by facility staff on 6/18/25 revealed documentation that LPN (licensed practical nurse) #1 yelled at the residents (on 6/12/25). Further review of R5's clinical record failed to reveal the resident's psychosocial status related to the verbal abuse was assessed or psychosocial interventions were implemented. On 7/28/25 at 4:40 p.m., an interview was conducted with OSM (other staff member) #2 (the director of discharge planning/social services). OSM #2 stated she does not complete a formal assessment after a resident reports an allegation of abuse, but she talks to the resident, asks about a visit with the psychiatric nurse practitioner or psychologist, and would complete a trauma informed screening if the resident felt something more was needed. OSM #2 stated she did not complete an assessment or follow-up regarding R5's verbal abuse incident on 6/12/25. (continued on next page)

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/28/25 at 4:56 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that after a resident has reported an allegation of abuse, staff should frequently check on the resident, and a follow-up with the psychiatric nurse practitioner and/or the psychologist should occur. On 7/29/25 at 1:07 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495279	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Culpeper Health & Rehabilitation Center	602 Madison Road Culpeper, VA 22701

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interview, facility document review and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for three of five residents, Resident #3, #4, and #5. The findings include: 1. For Resident #3 (R3), the facility staff failed to document in the clinical record, an incident between the resident and a staff member. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/6/25, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. The facility synopsis of events dated 6/13/25, documented the incident occurred on 6/3/25, documented in part, On 6/13/25 the Administrator was notified by patient (#3) of an allegation of verbal abuse that occurred on 6/3/25 by dietary cook, (other staff member) (OSM) #4. During dinner. Patient BIMS is 14. NP (nurse practitioner), RP (responsible party) and (name of local) police department notified. (OSM #4) suspended. Facility investigation initiated. The resident statement dated 6/13/25 documented in part, I was asking for a sandwich and (OSM #4) started yelling and arguing with me. She slammed the door on me and got very mad and was rude and told me to (explicative) off. I want her to apologize. She did not need to do all that. Review of the clinical record failed to evidence any documentation related to the incident above. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 7/29/25 at 9:15 a.m. When asked if a note should be entered into the resident's clinical record when there is a substantiated allegation of abuse, ASM #2 stated, yes, it is dependent upon whose patient it is, she didn't recall but felt the IDT (interdisciplinary team) would put a note regarding the incident happening. An interview was conducted with ASM #1, the administrator, on 7/29/25 at 10:40 a.m. ASM #1 stated, when there is an allegation of verbal abuse, he typically does the (facility synopsis of event) and obtains statements, he does not document in the clinical record. The facility policy, Medical Records – Duties, documented in part, 1. An accurate and complete clinical record is to be maintained for each patient. ASM (Administrative staff member) #1, ASM #2, the director of nursing, and ASM #4, regional director of clinical services were made aware of the above concern on 7/29/25 at 1:04 p.m. No further information was provided prior to exit. 2. For Resident #4 (R4), the facility staff failed to document an incident regarding verbal abuse on 6/12/25 in the resident's clinical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of written statements obtained from R4 and another resident by facility staff on 6/18/25 revealed documentation that LPN (licensed practical nurse) #1 yelled at the residents and told R4 to shut up (on 6/12/25). A review of R4's clinical record failed to reveal documentation regarding the incident on 6/12/25. On 7/28/25 at 4:56 p.m., an interview was conducted with LPN #5. LPN #5 stated the staff do not document allegations of abuse in residents' clinical records and she did not know why. On 7/29/25 at 9:23 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated allegations of abuse should be documented in residents' clinical records. On 7/29/25 at 1:07 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. No further information was presented prior to exit. 3. For Resident #5 (R5), the facility staff failed to document an incident regarding verbal abuse on 6/12/25 in the resident's clinical record. A review of written statements obtained from R5 and another resident by facility staff on 6/18/25 revealed documentation that LPN (licensed practical nurse) #1 yelled at the residents (on 6/12/25). A review of R5's clinical record failed to reveal documentation regarding the incident on 6/12/25. On 7/28/25 at 4:56 p.m., an interview was conducted with LPN #5. LPN #5 stated the staff do not document allegations of abuse in residents' clinical records and she did not know why. On 7/29/25 at 9:23 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated allegations of abuse should be documented in residents' clinical records. On 7/29/25 at 1:07 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. No further information was presented prior to exit.