STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, resident interviews, staff interviews, clinical record reviews, and facility documentation review, the facility failed to ensure that the accommodation of resident needs and preferences was provided for six of 76 residents in the survey sample, Residents #5, #101, #118, #81, #40 and #117. The findings include:1. For Resident #5 (R 5) Facility staff failed to accommodate resident needs by failing to ensure the resident had access to a call bell. R5 was originally admitted to the facility 09/26/2022. Diagnoses included but are not limited to, chronic kidney disease, type 2 diabetes mellitus, morbid (severe) obesity, primary osteoarthritis, hemiplegia unspecified affecting left nondominant side, other lack of coordination, muscle weakness, contracture of muscle left hand, cognitive communication deficit, unsteadiness on feet, unsteadiness on feet, pain unspecified, anxiety disorder, and essential hypertension. R 5's most recent MDS (minimum data set) and quarterly assessment with an ARD (assessment reference date) of 05/16/2026, coded R 5 as scoring a 15 out of 15 on the brief interview for mental status (BIMS) score, indicating the resident is oriented to person, place and time and has unimpaired immediate recall. Observation on 06/22/2026 at 12:50 p.m., 06/23/2026 at 9:25 a.m., 06/23/2026 at 4:05 p.m., and 06/24/2026 at 9:45 a.m. revealed R 5's call bell was intertwined with his roommate's call bell and was lying on the floor under the left side of the head of R 5's bed. On 06/24/2026 at 9:45 a.m., Certified Nursing Assistant (CNA) #7 was asked the purpose of a call bell, and she stated it is so a resident can call the nurse or CNA for assistance. When asked if she uses the call bell to know a resident needs assistance, she said Yes, I use it to know the residents need help. At the time of speaking with CNA #7, the call bells were still intertwined on the floor under the left side of the head of R 5's bed and the call well was still not illuminating outside the room. Review of facility policy titled Call Light: Accessibility did not include information on a call bell being within reach for residents. The Administrator, Director of Nursing and Regional Director of Clinical Services were made aware of the concern on 06/24/2026 at 5:15 p.m. No additional information was provided prior to exit. 2. For Resident #101 (R 101) Facility staff failed to accommodate resident needs by failing to ensure the resident had access to a call bell. R101 was originally admitted to the facility 02/26/2026. Diagnoses include but are not limited to (continued on next page)

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
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	autistic disorder. Observation on 06/22/2026 at 12:50 p.m., 06/23/2026 at 9:25 a.m., 06/23/2026 at 4:05 p.m., and 06/24/2026 at 9:45 a.m. revealed R 101's call bell was intertwined with his roommate's call bell and was lying on the floor under the left side of the head of his roommate's bed. On 06/22/206 at 3:24 p.m. R101 was asked how he would call for help if he fell out of bed and he stated his call bell was Right over there, and pointed toward the middle of the room, and attempted to get the call bell and was unable to. R 5 said it is all crisscrossed. On 06/24/2026 at 9:45 a.m., CNA #7 was asked the purpose of a call bell and she stated it is so a resident can call the nurse or CNA for assistance. When asked if she uses the call bell to know a resident needs assistance, she said Yes, I use it to know the residents need help. At the time of speaking with CNA #7, the call bells were still intertwined on the floor under the left side of the head of R 5's bed and the call well was still not illuminating outside the room. CNA #22 was asked if R101 had been in his bed, on the floor by his bed, or anywhere on his side of the room, would he have been able to call for help. CNA #22 confirmed the resident would not have been able to use his call light to call for help and said R101 would not have had access to his bell because it was tangled up under his roommate's bed. The Administrator, Director of Nursing and Regional Director of Clinical Services were made aware of the concern on 06/24/2026 at 5:15 p.m. No additional information was provided prior to exit. 3. For Resident #118 (R118), the facility staff failed to provide a bathroom call bell that would be accessible from the floor. On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 5/4/2026, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) indicated they were cognitively intact for orientation to year, month, day and short-term recall. Section GG coded R118 utilizing a manual wheelchair, requiring substantial/maximal assistance for toileting and toilet transfers. The comprehensive care plan for R118 documented in part, I have physical functioning deficit related to: Some assistance required from staff with ADLs, episodes of weakness, Dx of Dementia with behavioral disturbance, HTN (hypertension), DM (diabetes mellitus), Glaucoma. Date Initiated: 1/18/2011. On 6/22/2026 at approximately 2:18 PM, an observation was made of the bathroom in R118's room. The bathroom was observed to contain a call bell which contained a button that could be activated by pulling a lever down, however there was no pull cord to activate the call bell from the floor if the resident were to have a fall while in the bathroom. The call bell button was observed to be above the toilet paper dispenser to the right side of the toilet and at the level of the top of the grab bar on the wall approximately six feet from the bathroom entrance. At that time, an interview was conducted with R118 who stated that she used the bathroom when needed and pressed the call button when she needed staff assistance. R118 stated that she had not had any falls in the bathroom but thought she may be able to reach the button if she tried but was not sure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional observations of R118's bathroom were made on 6/23/2026 at 8:11 AM, 5:28 PM, 6/24/2026 at 8:25 AM, and 10:30 AM. The observations remained as described above. On 6/24/2026 at 10:45 AM, an interview was conducted with licensed practical nurse (LPN) #3 who stated that if a resident was in the bathroom and needed staff they pulled the call bell. She stated that they should all have a string to pull if they fell in the floor and if they could not reach it they could scream for staff. On 6/24/2026 at 11:05 AM, an interview was conducted with certified nursing assistant (CNA) #17 who stated that residents rang their call bell if they needed assistance in the bathroom. She stated that they activated the call bell by pulling the string attached to the call bell and it should be long enough for them to reach it if they were to fall in the floor. On 6/24/2026 at 5:00 PM, the Administrator, Director of Nursing and Regional Director of Clinical Services were made aware of the concern. No further information was provided prior to exit. 4. For Resident #81 (R81), the facility failed to ensure the resident's call bell was within reach at all times. Diagnoses for R81 include malignant neoplasm of the mouth, acute and chronic respiratory failure with hypoxia, pneumonitis due to inhalation of food and vomit, repeated falls, contracture of muscles multiple sites, dysphagia, disorder of teeth and supporting structures, cognitive communication deficit, and unspecified traumatic total brain injury. On the most recent Minimum Data Set (MDS), a significant change assessment with an assessment reference date (ARD) of 4/29/2026, R81 scored a nine out of 15 on the Brief Interview for Mental Status (BIMS) indicating that R81 has moderate cognitive impairment. On the same MDS, R81 was noted to have functional impairment to both lower extremities and utilizes a wheelchair. R81 was noted to be dependent on staff for all Activities of Daily Living (ADLs) except eating. A care plan for R81 was created on 2/1/2019 for physician functioning impairment with an intervention stating to keep the call bell within reach. On 6/23/26 at 9:11 AM, R81 was observed sitting in their wheelchair on the right side of the bed facing the wall. An overbed table was in front of R81 containing breakfast and R81 was feeding themselves. The call light was observed to be clipped to the left corner of the bed by the wall out of the reach of R81. During an interview with certified nursing assistant (CNA) #6 on 6/23/26 at 9:29 AM, CNA #6 stated that call bells should be kept in reach of the residents. Review of the facility policy titled Call Light: Accessibility dated 2/1/2026 revealed that with each interaction in the resident's room or bathroom, employees will ensure the call light is within reach of the resident and secure, as needed. The above information was provided to facility leadership on 6/24/26 at 4:30 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No addition information was provided prior to exit. 5. The facility staff failed to ensure Resident #40's (R40) call bell was in reach of the resident. On 6/25/26 at 10:50 AM, an observation was made of R40 trying to reach her call bell that was out of reach and lying on the floor under her bed. R40 was observed reaching down trying to find her call bell to be able to call for staff assistance. R40 stated that she was blind and was not able to find the call bell, but she liked it to be clipped to her pillow, so she would be able to reach the call bell to call for staff assistance. On 6/25/26 at 10:55 AM, an interview was conducted with a licensed practical nurse, LPN2, the unit manager of C Wing. LPN2 came into R40's room and observed the call bell lying on the floor under her bed. LPN2 stated that the call bell should not be on the floor or under the bed. She stated that the call bell should be clipped to or in reach of the resident to be able to call for assistance. On 6/25/26 at 5:34 PM, an end of the day meeting was held with the Administrator and Director of Nursing. They were informed of the above concerns. No additional information was provided prior to the end of the survey. 6. The facility failed to ensure Resident #117's (R117) call bell was accessible for use if he needed assistance. On 6/25/2026 at 10:37 AM, an observation was made of R117's call bell behind the headboard of the bed and was tied around a fall mat that was between the headboard and the wall. On 6/25/26 at 10:40 AM, an interview was conducted with LPN8. LPN8 answered the call bell that was activated when she entered R117's room, she observed the call bell tied around the fall mat and it was all behind the headboard. She stated she did not know why it was like that and it should not be tied around the fall mat or behind the headboard. She stated the call bell should be in reach of the resident. On 6/25/26 at 5:34 PM, an end of the day meeting was held with the Administrator and Director of Nursing. They were informed of the above concerns. No additional information was provided prior to the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **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 notify the physician and/or responsible party for a change in condition for two of 76 residents in the survey sample, Residents #174 and 175.The findings include: 1. For Resident #174 (R174) the facility staff failed to notify the physician and the responsible party for a medication not available for administration at the scheduled time. R174 was admitted to the facility on [DATE] with diagnoses that included but were not limited to: hypothyroidism. The physician order dated 9/10/2024 documented, Levothyroxine Sodium Oral Tablet (1) 50 MCG (micrograms); Give 1 tablet by mouth in the morning related to hypothyroidism. The MAR (medication administration record) for September 2024, documented the above order. For 9/10/204 at 6:00 a.m. a 14 was documented. A 14 indicates, Medication not available. The nurse's note dated 9/10/2024 at 5:26 a.m. documented, New admit waiting on pharmacy. Review of the backup pharmacy contents for 2024 was provided by the pharmacy. Levothyroxine is not listed. An interview was conducted with LPN (licensed practical nurse) #1 on 6/24/26 at 1:50 p.m. When asked what the process is when a medication is not available for the scheduled time of administration, LPN #1 stated first you call the pharmacy, then call the physician to see if they want to order something else or if they want to change the time of administration for that day. LPN #1 stated the facility receives three deliveries of medications each day. LPN #1 stated all of the actions you take should be documented in a nurse's note. The facility policy, Notification of Change of Condition documented in part, The purpose of this policy is to ensure the Facility promptly informs the resident, consults the resident's physician/physician extender, and notified the resident's legal representative when there is The Administrator and Director of Nursing were made aware of the above findings on 6/24/2026 at approximately 5:00 p.m. No further information was provided prior to exit. 2) For Resident #175 (R175), the facility staff failed to notify the physician of a change in condition on 9/14/2024. R175 was admitted to the facility with diagnoses that included but were not limited to end stage renal disease (1), diabetes mellitus (2), peripheral vascular disease (3), and gout (4). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/19/2024, the resident scored 13 out of 15 on the BIMS (brief interview for mental (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status) assessment, indicated they cognitively intact for orientation of year, month and date and short-term recall. The assessment documented no skin concerns. A skin assessment for R175 dated 9/13/2024 documented Skin clear, no change of condition assessed. The progress notes for R175 documented in part, - 9/14/2024 18:30 (6:30 PM) Situation: Res (resident) c/o (complains of) left great toe pain and small amount of bloody drainage. Background: Res has a h/o (history of) gout. Assessment: Writer observed small amount of drainage from left great toe nail bed. Response: Note placed in MD (medical doctor) communication book for further assessment. Standing order treatment initiated. - 9/15/2024 18:28 (6:28 PM) Note Text: Dry dsg applied to left great toe, small amount of drainage noted. Res cont to c/o toe pain and discomfort. Minimal relief from scheduled pain meds. Will cont to monitor. - 9/16/2024 11:09 (AM) Situation: Left great toe swelling and painful. Background: history of gout and pain. Assessment: left great toe painful still after being treated for gout. Response: NP [Name of nurse practitioner] gave orders to start Keflex (5) 500mg (milligram) bid (twice a day) for 10 days for cellulitis (6). Resident aware and agrees with orders. - 9/16/2024 11:17 (AM) Physician note . Asked to see patient for evaluation due to complaints of pain. Staff reports patient is complaining of great toe pain. Patient is seen, sitting up in a wheelchair prior to leaving for hemodialysis (7). She notes that she has pain to her left great toe. She notes that the pain is constant and unalleviated with any current measures . SKIN: Warm and dry, normal color for ethnicity **Left great toe noted with bloody drainage and tenderness to palpate to the entire toe. Mild warmth to palpation . ASSESSMENT/PLAN (reviewed w/ patient): 1) Pain - I suspect she has some underlying cellulitis. There is some erythema and tenderness to the site. Will continue with supportive measures and treat underlying infection. 2) Cellulitis - ? Ingrown toenail versus superficial laceration. Will treat with antibiotics and monitor closely . The dialysis communication record for R175 dated 9/16/2024 documented under the section Dialysis Center to Complete for the Facility in part, .Any issues during treatment? Lt (left) foot infection & pain . The eTAR (electronic treatment administration record) for R175 dated 9/1/2024-9/30/2024 documented in part, Cleanse left great toe with NS (normal saline) or wound cleanser, apply dry dsg (dressing) qd (every day) until healed. one time a day for Pain. It documented the treatment completed 9/15/2024 and 9/16/2024 at 9:00 AM. On 6/24/2026 at 11:28 AM, an interview was conducted with LPN (licensed practical nurse) #2, unit manager, who stated that they remembered R175 when they resided at the facility. She stated that the nurses who wrote the progress notes documented above no longer worked at the facility and the nurse practitioner who examined R175 on 9/16/2024 was on vacation and not available. LPN #2 stated that she was unsure about standing treatment orders but thought that they were to clean the wound and notify the physician if the nurse felt that they needed to go further than that. She stated that she never saw R175's toe but normally the staff would clean and dress a wound, write it in the physician communication book and notify the facility wound nurse to assess the area. LPN #2 stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the physician or nurse practitioner came in every day except the weekends and then there was a provider on call. She stated that if there was no change or if there was no relief then she would have contacted the on-call physician for guidance when R175 was continuing to complain of pain in the toe with the drainage present. On 6/25/2026 at approximately 2:35 PM, the Administrator stated that they did not have any standing treatment orders during 9/14/2024 timeframe. The facility policy Notification of Change of Condition effective 2/1/2026, documented in part, The purpose of this policy is to ensure the Facility promptly informs the resident, consults the resident's physician/physician extender; and notified the resident's legal representative when there is a change requiring notification . On 6/25/2026 at approximately 5:30 PM, the Administrator, the Director of Nursing and the Regional Director of Clinical Services were made aware of the concern. No further information was provided prior to exit. Reference: (1) End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD) . This information was obtained from the website: End-stage kidney disease: MedlinePlus Medical Encyclopedia (2) Diabetes, also known as diabetes mellitus, is a disease in which your blood glucose, or blood sugar, levels are too high. Glucose is your body's main source of energy. Your body can make glucose, but it also comes from the food you eat. Insulin is a hormone made by your pancreas. Insulin helps move glucose from your bloodstream into your cells, where it can be used for energy . This information was obtained from the website: Diabetes | Type 1 Diabetes | Type 2 Diabetes | MedlinePlus (3) Your peripheral arteries and veins carry blood to and from your arm and leg muscles and the organs in and below your stomach area. PVD may also affect the arteries leading to your head (see Carotid Artery Disease). When PVD affects only the arteries and not the veins, it is called peripheral arterial disease (PAD). The main forms that PVD may take include blood clots (for example, deep vein thrombosis or DVT), swelling (inflammation), or narrowing and blockage of the blood vessels . This information was obtained from the website: Peripheral Vascular Disease | The Texas Heart Institute (4) Gout is a common type of inflammatory arthritis. It causes pain, swelling, and redness in one or more joints. It usually happens as a flare, which can last for a week or two and then gets better. The flares often begin in your big toe or a lower limb . This information was obtained from the website: Gout | [NAME] Arthritis | MedlinePlus (5) Cephalexin is used to treat certain infections caused by bacteria. Cephalexin is in a class of medications called cephalosporin antibiotics. It works by killing bacteria. Antibiotics such as cephalexin will not work for colds, flu, or other viral infections. Using antibiotics when they are not needed increases your risk of getting an infection later that resists antibiotic treatment . This information was obtained from the website: Cephalexin: MedlinePlus Drug Information (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(6) Cellulitis is an infection of the skin and deep underlying tissues. Group A strep (streptococcal) bacteria are the most common cause. The bacteria enter your body when you get an injury such as a bruise, burn, surgical cut, or wound. Symptoms include: Fever and chills; Swollen glands or lymph nodes; A rash with painful, red, tender skin. The skin may blister and scab over. Your health care provider may take a sample or culture from your skin or do a blood test to identify the bacteria causing infection. Treatment is with antibiotics. They may be oral in mild cases, or intravenous (by IV) for more severe cases . This information was obtained from the website: Cellulitis | Cellulitis Treatment | MedlinePlus (7) Dialysis treats end-stage kidney disease (also called kidney failure). It removes waste from your blood when your kidneys can no longer do their job. There are different types of kidney dialysis. This article focuses on hemodialysis . This information was obtained from the website: Dialysis - hemodialysis: MedlinePlus Medical Encyclopedia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **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 provide a clean, comfortable, homelike environment for eleven of seventy-six residents in the survey sample, on one of three units and in one of sixty-five rooms (Residents #45, #81, #5, #101, #118, #181, #55, #73, #76, #74, #156, C-wing, room A-4). The findings include 1. The sink in Resident #45's room leaked and the cold-water faucet handle would not turn. Resident #45 (R45) was admitted to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease), dementia, dysphagia, psychosis, hypertension and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed R45 with severely impaired cognitive skills. On 6/23/26 at 8:30 a.m., R45 was observed in the foyer area to her room at the installed sink. R45 stated the sink leaked underneath when the water was running and that she was unable to turn on the cold water. R45 turned on the water and water was observed leaking from the drain pipes underneath the sink. The resident had a trash can placed under the sink to catch the leaking water. Cold water was not accessible at the sink as the faucet handle did not turn in either direction. R45 stated the sink had been in disrepair for a long time. On 6/23/26 at 8:50 a.m., the director of plant operations was shown the sink and interviewed about the leak and dysfunctional handle. The director of plant operations stated the sink should not be leaking and that the cold-water knob would have to be replaced. On 6/25/26 at 7:54 a.m., the maintenance director was interviewed about R45's sink. The maintenance director stated he was not sure what was wrong with the sink or how long it had been in disrepair. The maintenance director stated there had been no work order entered for the sink. The maintenance director stated rounding was performed weekly to identify items in need of repair. The maintenance director stated staff members were supposed to enter work orders for items in need of repair. The facility's policy titled Maintenance Request Policy (revised 11/2020) documented the policy was, To ensure that all maintenance problems identified within the facility are reviewed and addressed in a timely fashion and on a priority basis. The Maintenance Director will act with due diligence in addressing facility requests for maintenance; and will ensure that all appropriate building and safety codes are adhered to . All facility requests for maintenance, regardless of complaint/request type, building or affected area, must be submitted to the Maintenance Director via TELS work order by entering information in the maintenance log book stored at the nurses station . The request will be reviewed and a determination will be made as to the scope of work, priority, required trade(s), and whether or not the request requires an immediate response . This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 6/24/26 at 4:35 p.m. with no further information presented prior to the end of the survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For Resident #81 (R81), the facility failed to provide a safe, homelike, environment in the resident's bathroom. Diagnoses for R81 include malignant neoplasm of the mouth, acute and chronic respiratory failure with hypoxia, pneumonitis due to inhalation of food and vomit, repeated falls, contracture of muscles multiple sites, dysphagia, disorder of teeth and supporting structures, cognitive communication deficit, and unspecified traumatic total brain injury. On the most recent Minimum Data Set (MDS), a significant change assessment with an assessment reference date (ARD) of 4/29/26, R81 scored a nine out of 15 on the Brief Interview for Mental Status (BIMS) indicating that R81 has moderate cognitive impairment. On 6/23/26 at 12:45 PM, the sink in R81's restroom was observed to have water running freely from the faucet to the basin. There were no residents or staff present in the bathroom or in R81's room. Attempts to shut the water off at the faucet were not successful. On 6/23/26 at 3:53 PM the water in R81's bathroom sink was again observed running freely with no residents or staff present. On 6/23/26 at 5:30 PM, the facility leadership was asked to provide a work order for the running water in R81's bathroom sink. The facility provided a work order dated 6/23/26 at 6:27 PM to the survey team on 6/24/26 at 9:00 AM. On 6/24/26 at 9:11 AM, R81 was observed in their wheelchair in their room. The bathroom sink was again observed to be running freely. There were no residents or staff present. During an interview with R81 that occurred on the same date at the same time, R81 stated that the water in the bathroom sink had been running like that for a couple of months and nothing has been done for it. On 6/25/26 at 9:07 AM, the water in R81's bathroom sink was observed to still be running freely. This information was provided to facility leadership on 6/25/26 at 4:30 PM. No additional information was provided prior to exit. 3. For Resident #5 (R 5), the facility staff failed to maintain a functional bed. R 5's most recent MDS (minimum data set) and quarterly assessment with an ARD (assessment reference date) of 05/16/2026, coded R 5 as scoring a 15 out of 15 on the brief interview for mental status (BIMS) score, indicating the resident is oriented to person, place and time and has unimpaired immediate recall. On 06/22/2026 at 12:50 p.m., 06/23/2026 at 9:25 a.m., and 06/23/2026 at 4:05 p.m., R 5's bed was also observed to be broken. The foot board edges were coming apart, a metal mattress securing device was lying in the window and at one time, the mattress would not lower to be flat and remained at about a 45-degree incline. On 06/24/2026 at 10:15 AM, the Maintenance Director observed the broken bed and stated he would have to get the bed fixed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator, Director of Nursing and Regional Director of Clinical Services were made aware of the concern on 06/24/2026 at 5:15 p.m. No additional information was provided prior to exit. 4. For Resident #101 (R 101), the facility staff failed to maintain a home-like bathroom. R 101's most recent MDS (minimum data set) and quarterly assessment with an ARD (assessment reference date) of 05/25/2026, coded R 101 as scoring a 12 out of 15 on the brief interview for mental status (BIMS). On 06/22/2026 at 12:50 p.m., 06/23/2026 at 9:25 a.m., 06/23/2026 at 4:05 p.m., observation was made of the bathroom in R 101's room. The bathroom was observed to have significant visible damage to the wall exposing the sheetrock, including where the toilet connected to the wall, and around the sink. Other visible discoloration was also observed around the fixtures in the bathroom. On 06/24/2026 at 10:15 AM, an interview was conducted with the Maintenance Director who stated that any repairs that were needed were put into the maintenance work order system on the computer by the staff and were sent directly to him. He stated that he was able to see all the repairs that were needed and complete them and there had been some issues in the past that had been fixed but several rooms still had issues that required renovation. He stated that rooms that did not have holes in the walls were lower on the priority list. The Maintenance Director observed the bathroom in R 101's room and stated he inherited an old building, they are working on repairs, and there are only three maintenance staff for two buildings. He added that R 101's bathroom used to have holes in the wall and there is still work that needs to be done and was not homelike. The Administrator, Director of Nursing and Regional Director of Clinical Services were made aware of the concern on 06/24/2026 at 5:15 p.m. No additional information was provided prior to exit. 5. For Resident #118 (R118), the facility staff failed to maintain a homelike bathroom. On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 5/4/2026, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) indicated they were cognitively intact for orientation to year, month, day and short-term recall. Section GG coded R118 utilizing a manual wheelchair, requiring substantial/maximal assistance for toileting and toilet transfers. On 6/22/2026 at approximately 2:18 PM, an observation was made of the bathroom in R118's room. The bathroom was observed to have visible wall damage to the wall exposing the sheetrock where the toilet connected to the wall. The baseboard behind the commode was observed to be missing with caulking along the border between the wall and the floor. The sink area was observed to have visible wall damage between the mirror and the top of the sink exposing peeling wall, and a green colored wall surface. The sides and underneath the sink were observed to have visible wall damage including the appearance of water damage, exposed sub wall surface, with a pink wash basin (approximately 7 quart sized) observed underneath the exposed piping of the sink with approximately one-quarter filled with water inside. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, an interview was conducted with R118 who stated that she used the bathroom when needed and the basin was there to catch the water that leaked from the sink. Additional observations of R118's bathroom were made on 6/23/2026 at 8:11 AM, 5:28 PM, and 6/24/2026 at 8:25 AM. The observations remained as described above. On 6/24/2026 at 10:13 AM, an interview was conducted with the Maintenance Director who stated that any repairs that were needed were put into the maintenance work order system on the computer by the staff and were sent directly to him. He stated that he was able to see all the repairs that were needed and complete them and there had been some plumbing issues in the past and several rooms had issues that required renovation. He stated that rooms that did not have holes in the walls were lower on the priority list. The Maintenance Director observed the bathroom in R118's room and stated that it needed some attention and was not homelike. On 6/24/2026 at 5:00 PM, the Administrator, Director of Nursing and Regional Director of Clinical Services were made aware of the concern. No further information was provided prior to exit. 6. For Resident #181 (R181), the facility staff failed to maintain a homelike bathroom environment. The MDS (minimum data set) assessment was not due at the time of the survey. The admission nursing assessment for R181 dated 6/21/2026 documented the resident being alert and moderately impaired for short- and long-term recall. On 6/22/2026 at 1:27 PM, an observation was made of the bathroom in R181's room. The bathroom was observed to have a baseboard heater along the right wall. The heater was observed with visible rust on top along the length approximately four feet. All baseboards were missing with visible wall damage along the wall at the floor level except for a single baseboard along the left wall which showed visible buckling and wall damage above it. Wall damage appearing to be water damage was observed approximately 20 inches from the floor up the wall on the wall where the toilet was attached to the wall. Beneath the sink and toilet, the wall was observed with visible wall damage and cracked and peeling paint exposing brown/black/grey colored wall exposing the sub wall. Portions of the flooring were missing exposing the flooring underneath near the toilet. At that time, an interview was conducted with R181 who stated that she had just arrived at the facility a few days before and was set to start therapy that day. She stated that she previously used the bathroom before her recent hospital stay and planned to have therapy to get her strength back and go back home. She stated that she was using the bedpan until therapy got her up later today and planned to start using the restroom in the room. Additional observations of R181's bathroom were made on 6/23/2026 at 8:13 AM, 5:27 PM, and 6/24/2026 at 8:28 AM. The observations remained as described above. On 6/24/2026 at 10:13 AM, an interview was conducted with the Maintenance Director who stated that any repairs that were needed were put into the maintenance work order system on the computer by the staff and were sent directly to him. He stated that he was able to see all the repairs that were needed and complete them and there had been some plumbing issues in the past and several rooms had issues that required renovation. He stated that rooms that did not have holes in the walls were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lower on the priority list. The Maintenance Director observed the bathroom in R181's room and stated that it was one that needed a total renovation and they needed the money to do it. He stated that it was not homelike. On 6/24/2026 at 5:00 PM, the Administrator, Director of Nursing and Regional Director of Clinical Services were made aware of the concern. No further information was provided prior to exit. 7. For Resident #55 (R55), the facility staff failed to maintain a homelike bathroom. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/18/2026, the resident was assessed as scoring 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for orientation to year, month and day and short-term recall. On 6/22/2026 at 2:18 PM, an interview was conducted with R55 in their room. R55 stated that they had no care concerns but stated Look at my bathroom, it is a mess. R55 stated that the bathroom had been leaking for a long time and wanted to have it fixed. She stated that she used the bathroom as needed. Observation of R55's bathroom revealed visible wall damage underneath the sink and two pink basins (approximately 7 quart sized) underneath the sink under the visible pipes with visible dripping observed from the sink pipe into the pan on the right side. The basin on the right was observed to be approximately one-half filled with water. Additional observations of R55's bathroom were made on 6/23/2026 at 8:14 AM, 5:26 PM, and 6/24/2026 at 8:22 AM. The observations remained as described above. On 6/24/2026 at 10:13 AM, an interview was conducted with the Maintenance Director who stated that any repairs that were needed were put into the maintenance work order system on the computer by the staff and were sent directly to him. He stated that he was able to see all the repairs that were needed and complete them and there had been some plumbing issues in the past. The Maintenance Director observed the bathroom in R55's room and stated that it was not homelike. On 6/24/2026 at 5:00 PM, the Administrator, Director of Nursing and Regional Director of Clinical Services were made aware of the concern. No further information was provided prior to exit. 8. For Resident #73 (R73), the facility staff failed to provide a comfortable environment free from excessive heat. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 4/13/26, R73 was coded as being mildly cognitively impaired for immediate recall and orientation to person, place, and situation. His diagnoses included heart failure and lung dysfunction. On 6/22/26 at 1:31 p.m., R73 was observed sitting up on the side of his bed. The room felt hot and stuffy. R73 stated that the air conditioning on his entire hallway had been out for at least two weeks, and that it was too hot in his room. He stated he had not been able to sleep well at night due to the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	heat. R73 had two portable fans blowing air directly on him. On 6/22/26 at 5:36 p.m., R73 was observed sitting up on the side of the bed eating dinner. The room temperature was unchanged from the observation earlier in the afternoon. He stated: I'm still hot. I've been hot since before the weekend. On 6/23/26 at 8:26 a.m., R73 was observed sitting up in bed watching television. He stated he did not sleep well the previous evening due to the heat. On 6/23/26 at 9:59 a.m., the Maintenance Director was asked to take the temperatures in R73's room. The Maintenance Director measured the temperatures with a laser thermometer. The ceiling temperature was 82.8 degrees and the floor temperature was 82.9 degrees. The Maintenance Director stated he was unaware of a maximum allowable temperature in the facility. He stated he is a relatively new employee, and the air conditioner on this unit (Unit C) had been broken since he began work in April 2026. He stated he has attempted to get multiple contractors to the facility to fix the air conditioner but so far has been unsuccessful. He stated he was not aware of anything other than repair orders that could be done to keep residents cool until the unit could be repaired. He stated that portable units cost money and they are out of my realm. He stated the Administrator was aware of the broken air conditioner, but she had not offered portable units as a solution. On 6/25/26 at 1:38 p.m., the Director of Plant Operations was interviewed. He stated he is corporate employee who is responsible for the building and grounds of several buildings. He stated he visits this building approximately once a week and that when he was in the building last week, the air conditioner was functioning fine. He stated when he arrived at the building this week, the air conditioner was broken and he ordered three portable units. He admitted that the residents complained to him last week that the air conditioning chillers were not working correctly. He stated that the maintenance staff does not take room temperatures every day but only do this when the temperatures seem higher than normal. He stated he did not have records of the temperatures when he arrived at the building on 6/23/26. On 6/25/26 at 5:34 p.m., the Administrator and Director of Nursing were informed of these concerns. On 6/26/26 at 9:30 a.m., the Administrator was interviewed. She stated that in June 2025, the air conditioner broke. She explained that the resident rooms on Unit C are directly above the kitchen and laundry room and that these rooms get especially hot when the air conditioner is not working. She stated the unit is old and it takes vendors a while to get replacement parts for it. She stated last June when the facility put portable air conditioners on the unit, It was still hot on Unit C just because of the location of the rooms. She stated she received one report from a resident last week about the excessive temperatures and added: We corrected it. She stated she had identified on Monday morning, 6/22/26, before the survey team's arrival, that Unit C was hot again. However, no portable units were put into place until 6/23/26 in the late afternoon. She stated that when the facility is unable to repair the air conditioner right away, she offers residents the options to move to another unit temporarily. She added that most residents refuse this offer. The Administrator was asked to provide evidence of interventions offered to residents on 6/22/26 and 6/23/26 prior to the portable units being put into place. No additional information was provided prior to exit. 9. For Resident #76 (R76), the facility staff failed to provide an environment with clean floors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/22/26 at 2:20 p.m., R76 was observed sitting up in bed. The floor around his bed had scattered loose debris and dirt. Several areas of smeared brown material were observed on the floor near the foot of the bed. The floor between the resident's bed and the wall contained three large clumps of fuzzy, black debris. On 6/22/26 at 5:39 p.m., 6/23/23 at 8:34 a.m., 1:29 p.m. and 2:47 p.m., and 6/24/26 at 9:14 a.m. and 10:24 a.m., the floor conditions remained unchanged from the initial observation on 6/22/26. On 6/25/26 at 3:58 p.m., the District Environmental Services Manager was interviewed. He stated that all resident rooms are touched daily, including sweeping and mopping the floors. He stated floors are both dust mopped and wet mopped each day. He stated that if a resident's floor becomes soiled after the housekeepers leave for the day, the nurses have access to brooms and mops in the basement housekeeping supplies area. He explained, After hours, it is up to the nursing staff. He stated a resident's room is not home like or clean if the floor is soiled with the same debris and smears for three days. He stated he would not leave his own floor at home soiled like that for three days. On 6/25/26 at 5:34 p.m., the Administrator and Director of Nursing were informed of these concerns. No additional information was provided prior to exit. 10. For Resident #74 (R74), the facility failed to maintain a comfortable environment free from excessive heat. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/1/26, R74 was coded as having no cognitive impairment for immediate recall or orientation to person, place, or situation. On 6/22/26 at 1:51 p.m., R74 was observed sitting up in bed. He stated he had not slept for many nights because of the excessive temperatures in his room. He stated the nursing staff told him the air conditioner had been broken on and off since last year, and there was nothing they could do about the heat. At that time, the room felt hot and humid. On 6/22 26 at 5:37 p.m., the room temperature felt warmer than at the 1:51 p.m. observation and R74 stated, I cannot sleep in this. On 6/23/26 at 8:32 a.m., R74 was observed sitting up in bed eating breakfast. He stated that it was so hot last night, he could not sleep. On 6/23/26 at 10:04 a.m., the Maintenance Director was asked to take the temperatures in R74's room. The Maintenance Director measured the temperatures with a laser thermometer. The ceiling temperature was 84.9 degrees and the floor temperature was 82.9 degrees. The Maintenance Director stated he was unaware of a maximum allowable temperature in the facility. He stated he is a relatively new employee, and the air conditioner on this unit (Unit C) had been broken since he began work in April 2026. He stated he has attempted to get multiple contractors to the facility to fix the air conditioner but so far has been unsuccessful. He stated he was not aware of anything other than repair orders that could be done to keep residents cool until the unit could be repaired. He stated that portable units cost money and they are out of my realm. He stated the Administrator was aware of the broken air conditioner, but she had not offered portable units as a solution. On 6/25/26 at 1:38 p.m., the Director of Plant Operations was interviewed. He stated he is corporate (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	employee who is responsible for the building and grounds of several buildings. He stated he visits this building approximately once a week and that when he was in the building last week, the air conditioner was functioning fine. He stated when he arrived at the building this week, the air conditioner was broken and he ordered three portable units. He admitted that the residents complained to him last week that the air conditioning chillers were not working correctly. He stated that the maintenance staff does not take room temperatures every day but only do this when the temperatures seem higher than normal. He stated he did not have records of the temperatures when he arrived at the building on 6/23/26. On 6/25/26 at 5:34 p.m., the Administrator and Director of Nursing were informed of these concerns. On 6/26/26 at 9:30 a.m., the Administrator was interviewed. She stated that in June 2025, the air conditioner broke. She explained that the resident rooms on Unit C are directly above the kitchen and laundry room and that these rooms get especially hot when the air conditioner is not working. She stated the unit is old and it takes vendors a while to get replacement parts for it. She stated last June when the facility put portable air conditioners on the unit, It was still hot on Unit C just because of the location of the rooms. She stated she received one report from a resident last week about the excessive temperatures and added: We corrected it. She stated she had identified on Monday morning, 6/22/26, before the survey team's arrival, that Unit C was hot again. However, no portable units were put into place until 6/23/26 in the late afternoon. She stated that when the facility is unable to repair the air conditioner right away, she offers residents the options to move to another unit temporarily. She added that most residents refuse this offer. The Administrator was asked to provide evidence of interventions offered to residents on 6/22/26 and 6/23/26 prior to the portable units being put into place. No additional information was provided prior to exit. 11. For Resident #156 (R156), the facility staff failed to provide an environment with clean floors. On 6/22/26 at 2:22 p.m., R156 was observed sitting up in a wheelchair in his room. The floor on R156's side of the room had scattered loose dirt, debris, clumps of fuzzy black material, and a partially eaten mandarin orange. On 6/22/26 at 5:41 p.m. and 6/23/23 at 9:01 a.m., and 6/24/26 at 8:06 a.m., the floor conditions remained unchanged from the initial observation on 6/22/26. On 6/25/26 at 3:58 p.m., the District Environmental Services Manager was interviewed. He stated that all resident rooms are touched daily, including sweeping and mopping the floors. He stated floors are both dust mopped and wet mopped each day. He stated that if a resident's floor becomes soiled after the housekeepers leave for the day, the nurses have access to brooms and mops in the basement housekeeping supplies area. He explained, After hours, it is up to the nursing staff. He stated a resident's room is not home like or clean if the floor is soiled with the same debris and smears for three days. He stated he would not leave his own floor at home soiled like that for three days. On 6/25/26 at 5:34 p.m., the Administrator and Director of Nursing were informed of these concerns. No additional information was provided prior to exit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. On Unit C, the facility staff failed to maintain common areas at a comfortable temperature. On 6/23/26 at 9:58 a.m., the Maintenance Director was asked to take the temperatures in the hallway and dining room of Unit C. The Maintenance Director measured the temperatures with a laser thermometer. At 9:58 a.m., the temperatures in the hallway outside of room [ROOM NUMBER] were measured. The floor temperature was 82 degrees; the ceiling temperature was 84 degrees. At 10:10 a.m., the temperatures in the dining room were measured. The floor temperature was 82.4 degrees; the ceiling temperature was 89.9 degrees. At this time, six residents were seated in the dining room eating breakfast. The Maintenance Director stated he was unaware of a maximum allowable temperature in the facility. He stated he is a relatively new employee, and the air conditioner on this unit (Unit C) had been broken since he began work in April 2026. He stated he has attempted to get multiple contractors to the facility to fix the air conditioner but so far has been unsuccessful. He stated he was not aware of anything other than repair orders that could be done to keep residents cool until the unit could be repaired. He stated that portable units cost money and they are out of my realm. He stated the Administrator was aware of the broken air conditioner, but she had not offered portable units as a solution. On 6/25/26 at 1:38 p.m., the Director of Plant Operations was interviewed. He stated he is corporate employee who is responsible for the building and grounds of several buildings. He stated he visits this building approximately once a week and that when he was in the building last week, the air conditioner was functioning fine. He stated when he arrived at the building this week, the air conditioner was broken and he ordered three portable units. He admitted that the residents complained to him last week that the air conditioning chillers were not working correctly. He stated that the maintenance staff does not take room temperatures every day but only do this when the temperatures seem higher than normal. He stated he did not have records of the temperatures when he arrived at the building on 6/23/26. On 6/25/26 at 5:34 p.m., the Administrator and Director of Nursing were informed of these concerns. On 6/26/26 at 9:30 a.m., the Administrator was interviewed. She stated that in June 2025, the air conditioner broke. She explained that the resident rooms on Unit C are directly above the kitchen and laundry room and that these rooms get especially hot when the air conditioner is not working. She stated the unit is old and it takes vendors a while to get replacement parts for it. She stated last June when the facility put portable air conditioners on the unit, It was still hot on Unit C just because of the location of the rooms. She stated she received one report from a resident last week about the excessive temperatures and added: We corrected it. She stated she had identified on Monday morning, 6/22/26, before the survey team's arrival, that Unit C was hot again. However, no portable units were put into place until 6/23/26 in the late afternoon. She stated that when the facility is unable to repair the air conditioner right away, she offers residents the options to move to another unit temporarily. She added that most residents refuse this offer. The Administrator was asked to provide evidence of interventions offered to residents on 6/22/26 and 6/23/26 prior to the portable units being put into place. No additional information was provided prior to exit. 13. Facility staff failed to maintain a bathroom in a clean and sanitary manner. During observation of room #A4's bathroom on 6/22/26 at approximately 3:45pm, revealed a dry, crusty, brownish-black substance was observed accumulated, covering the bottom surface of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bathtub. An odor consistent with sewage was also present in the bathroom area. An interview was conducted with the Maintenance Director on 6/22/26 at approximately 3:50. The Maintenance Director was shown the brownish-black substance observed in the bathtub and was asked about the odor present in the bathroom. The Maintenance Director stated he did not know what the substance was. During an interview with an CNA#4 (Certified Nursing Assistant) on 6/24/26 at approximately 1:43pm, CNA#4 stated Bedroom bathtubs are not in use, she doesn't think they are suitable for use. Everyone uses shower room. During

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide ADL (activities of daily living) care to dependent residents for three of 76 residents in the survey sample, Residents #173, #76 and #6.The findings include: 1. For Resident #173 (R173), the facility staff failed to provide showers during January, February and March of 2025. R173 was admitted to the facility with diagnoses that included but were not limited to morbid obesity, congestive heart failure (1) and diabetes mellitus (2). On the most recent minimum data set (MDS), an annual assessment with an assessment reference date (ARD) of 9/15/2025, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for short-term recall and oriented to month/day/year. The assessment documented no refusals of care and R173 being dependent for bathing/showering. The comprehensive care plan for R173 documented in part, I sometimes have behaviors which include- Refusal of skin checks/showers/ADL Care/meds. keeps bed in high position. I throw my soiled briefs/linen on the floor. Date Initiated: 03/31/2025. Review of the ADL documentation for R173 failed to evidence a shower provided during January, February and March of 2025. The documentation showed a bed bath completed five times in January, six times in February and four times in March of 2025. One refusal was documented on 3/21/2025. Review of the progress notes for R173 failed to evidence documentation of refusals for showers during January, February and March of 2025. On 6/24/2026 at 10:45 AM, an interview was conducted with licensed practical nurse (LPN) #3 who stated that they remembered working with R173. She stated that showers were offered twice a week according to a schedule and documented if the resident refused. On 6/24/2026 at 11:05 AM, an interview was conducted with certified nursing assistant (CNA) #17 who stated that she did not remember R173, but showers were given twice a week at a minimum and more if requested. She stated that if a resident refused they reapproached them later and documented it if they still refused. CNA #17 stated that they also reported this to the nurse so they could attempt to speak with the resident. The facility policy ADL care effective 2/1/2026 documented in part, It is the policy of this Facility to provide ADL care for residents to ensure all ADL needs are met daily . Residents will receive a tub/shower bath as often as needed, but not less than twice weekly . On 6/25/2026 at approximately 5:30 PM, the Administrator, the Director of Nursing and the Regional Director of Clinical Services were made aware of the concern. No further information was provided prior to exit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: (1) Heart failure means that your heart can't pump enough oxygen-rich blood to meet your body's needs. Heart failure doesn't mean that your heart has stopped or is about to stop beating. But without enough blood flow, your organs may not work well, which can cause serious problems . This information was obtained from the website: Heart Failure | Congestive Heart Failure | CHF | MedlinePlus (2) Diabetes, also known as diabetes mellitus, is a disease in which your blood glucose, or blood sugar, levels are too high. Glucose is your body's main source of energy. Your body can make glucose, but it also comes from the food you eat. Insulin is a hormone made by your pancreas. Insulin helps move glucose from your bloodstream into your cells, where it can be used for energy . This information was obtained from the website: Diabetes | Type 1 Diabetes | Type 2 Diabetes | MedlinePlus 2. For Resident #76 (R76), the facility staff failed to provide assistance with bathing, dressing and incontinence care. 06/25/26 at 11:05 AM, an observation was conducted with R76. R76 was lying on his bed with his legs hanging off the bed and his hand was hanging off the bed and appeared to be reaching down tor the call bell. The call bell was lying on the floor underneath his bed. R76 appeared to be trying to call for assistance and could not find the call bell. During the observation he was pointing down and was asked if he needed assistance and he shook his head. During the observation, R76 was visibly soiled, his incontinent brief appeared full and saturated with yellowish and brownish material that had leaked out of his incontinent brief on to the sheets. His legs and arms were hanging off the bed and he was only wearing a white shirt. R76 was not covered by a sheet or blanket at the time of the observation. On 6/25/26 at 11:10 AM, an observation was made by the Director of Education and Clinical Services. She came to the room to answer the activated call bell, and she observed the call bell on the floor, the resident visibly soiled and stated the call bell should not be there it should be within the resident's reach. She said, the resident should not be in this way and I will get it taken care of right away. On 6/25/26, a clinical record review was conducted. R76's care plan had that he requires assistance with all activities of daily living, dependent on staff for care, and is incontinent of bowel and bladder. On 6/25/25, a review of the facility documentation was conducted. The facility policy titled, ADL [activities of daily living] Care, read in part, .It is the policy of this facility to provide ADL care for residents to ensure all ADL needs are met daily. 1. Each resident will be provided with daily personal attention and care, including skin, nail, hair, and oral hygiene, in addition to any specific care ordered by the physician/physician extender. Daily personal care provided will be documented in the resident's medical record. On 6/25/26 at 5:34 PM, a end of day meeting was held with the Administrator and Director of Nursing. They were informed of the above concerns. No additional information was provided prior to the exit of the survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. For Resident #6 (R6), the facility failed to ensure the resident received personal hygiene in regard to showers and/or baths. Diagnoses for R6 include cerebral infarction, hemiplegia and hemiparesis, heart failure, diabetes mellitus, autistic disorder, anxiety disorder, and PTSD. On the most recent Minimum Data Set (MDS), a significant change assessment with an assessment reference date (ARD) of 6/5/26, R6 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating that R6 was cognitively intact. In section GG of this MDS, R6 was noted to be dependent on staff for showering/bathing. Review of R6's clinical record showed that R6 did not receive a shower or bath between the dates of 5/6/26-5/15/26, 5/20/26-5/26/26, 5/31/26-6/6/26, and 6/6/26-6/17/26. The clinical record was marked not-applicable for shower/bath. On 6/24/26 at 9:17 AM, R6 was observed in their bed. R6's hair was dull, dingy, and oily. R6 stated that her hair was dirty as the staff had not given her a shower in a long time. R6 stated that she was frightened to be transferred out of bed by staff for showers because she had been dropped a while back during a transfer, and she suffered from Post Traumatic Stress Disorder (PTSD). During an interview with Certified Nursing Assistant (CNA) #7 on 6/23/26 at 12:24 PM, CNA #7 stated that R6 utilizes a shower lift for showering. CNA #7 was unsure when the last time R6 had received a shower. CNA #7 stated that if a resident refuses a shower it is documented in the clinical record. CNA #7 referred to a shower schedule that showed that R6 was to receive a shower or bath twice a week. During an interview with Licensed Practical Nurse (LPN) #3 on 6/24/26 at 12:29 PM, LPN #3 stated that it had been over a week since R6 had been out of bed. LPN #3 was unsure why R6 refused to transfer out of bed, and that the staff encourages her to get up, but do not inquire as to the reason why she is refusing. Review of the facility policy titled ADL Care with a date of 2/1/2026 revealed residents will receive a tub/shower bath as often as needed, but not less than twice weekly. The above information was presented to facility leadership on 6/24/26 at 4:30 PM. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495299	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabeth Adam Crump Health and Rehab	3600 Mountain Road Glen Allen, VA 23060

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure pressure relieving device was in place to prevent pressure ulcers for one resident, Resident #112 (R112) out of a survey sample of 76 residents. The findings included:For resident R112, the facility staff failed to provide ear protectors on R112's oxygen tubing to prevent pressure ulcers. 06/22/2026 at 3:51 PM, an observation was conducted. R112 was lying on her bed with her oxygen tubing around her ears and no ear protectors in place on the tubing. 06/23/2026 at 12:47 PM, a second observation was conducted. R112 was lying on her bed with her oxygen tubing around her ears and no ear protectors in place on the tubing. 06/24/2026 at 12:48 PM, a third observation was conducted. R112 was lying on her bed with her oxygen tubing around her ears and no ear protectors in place on the tubing. 06/24/2026 at 12:49 PM, an interview was conducted with a licensed practical nurse, LPN12. LPN12 entered R112's room and she observed that R112 was not wearing ear protectors on the oxygen tubing. LPN12 went to the nurses station and looked up the orders for R112. She stated that R112 should have the ear protectors and said, I will see if we have the protectors and correct these things. 06/25/26 at 11:00 AM, an observation was made of R112 lying in bed with her oxygen setting corrected and being administered per physician's orders. R112 remained without the ear protectors behind her ears after bringing it to the attention of her nurse, LPN12 yesterday. On 6/25/26, a facility documentation was reviewed. The facility document titled, Pressure Injury Prevention Guidelines, read in part, .to prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this Facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury, and in accordance with physician/physician extender. 3. Interventions will be documented in the care plan and communicated to all relevant employees. 06/25/26 at 4:15 PM, a meeting was held with the Administrator. She was given an update on concerns with R112's ear protectors were still not being provided even after being brought to the attention of her nurse yesterday. The Administrator stated she would check into this situation and get this corrected. On 6/26/26 at 9:00 AM, R112 was observed with her ear protectors being provided to prevent pressure ulcers. No additional information was provided prior to the end of the survey.