STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Ridge Rehab Center	5872 Hanks Street Dublin, VA 24084

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 - Few	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, staff interview, resident interview and facility document review the facility staff failed to provide a reasonable accommodation of needs for 1 of 16 residents, Resident #15.The findings included:For Resident #15 the facility staff failed to answer the resident's call bell in a timely manner. Resident #15's clinical record listed diagnoses which included but not limited to chronic obstructive pulmonary disease, dysphagia, and major depressive disorder.Resident #15's most recent minimum data set with an assessment reference date of 07/17/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.Surveyor spoke with Resident #15 on 09/05/25 at 11:05 am regarding call bell response times. Resident stated that call bell response has been addressed at resident council meetings, but times never get any better, and they have waited up to an hour after ringing call bell. Resident stated that their call bell is currently on, and they thought surveyor was facility staff coming in to answer the call bell. Surveyor asked resident how long their call bell had been on, and resident stated, about 5 minutes. Surveyor thanked resident and exited room. Surveyor observed light over resident's door for call bell on. Surveyor walked to end of hallway and observed several staff at nurse's station and could hear call bell from behind nurse's station. Surveyor waited until 11:20 am, observing multiple staff members walking by Resident #15's room without acknowledging call bell. At 11:20 am, surveyor spoke with assistant director of nursing (ADON) regarding call bell response times, and what their expectations are for response time. ADON stated their expectation would be 5ish minutes or so. Surveyor informed ADON of resident's call bell being on for at least 20 minutes. ADON exited their office, walked by Resident #15's room, and went to the nurse's station and asked which certified nurse's aide was responsible for Resident #15.Surveyor spoke with the director of nursing (DON)/interim administrator on 09/05/25 at 12:20 pm regarding call bell response times. DON stated their expectations would be 20 minutes or less. Surveyor asked DON who can answer call bells and DON stated anyone who sees the light on can answer, because resident's needs are not always clinical. DON stated that resident's light should not be turned off until resident's needs are met. Surveyor informed DON of observing several staff walking by Resident #15's room without acknowledging call bell.Surveyor requested and was provided with a facility policy entitled, Answering the Call Light which read in part, The facility will maintain a functional call light system and will make all reasonable efforts to ensure timely response to the resident's requests and needs. DEFINATIONS: 'Timely Response': is not defined by a 'pre-set' measure of minutes but rather is defined that the response time was appropriate t situation and/or need. Response time varies based on each situation and is impacted from the resident's need and perception/understanding of the urgency and time lapse. General Guidelines-1. Call lights may be answered by any staff member; if the resident needs assistance that cannot be provided by the staff member answering the light, the staff member will promptly notify a staff member who can assist the resident.The concern of not answering the resident's call bell in a timely manner was discussed with DON, ADON, regional director of clinical services, UM/LPN #1, UM/LPN #3, and UM/LPN #4 on 09/05/25 at 3:35 pm. 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on staff interview and clinical record review, the facility staff failed to follow the medical provider orders for medication administration for 1 of 16 sampled residents (Resident #6). The findings included:For Resident #6, the facility staff failed to administer the oral medication, Cyclobenzaprine as ordered by the medical provider. Cyclobenzaprine is a muscle relaxant used to treat skeletal muscle conditions such as pain and injury. Resident #6's diagnosis list indicated diagnoses, which included, but not limited to Encephalopathy, Hemiplegia and Hemiparesis, Congestive Heart Failure, Epilepsy, Multiple Rib Fractures Left Side, Fracture of Nasal Bones, Fracture of Left Thumb, and Fracture of Shaft of Left Clavicle. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/23/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #6's clinical record included a medical provider order for Cyclobenzaprine HCL 10 mg by mouth three times a day for muscle spasms. A review of Resident #6's September 2024 Medication Administration Record (MAR) revealed an omission for the administration of Cyclobenzaprine on 9/08/24 at 6:00 AM. On 9/05/25 at 12:25 PM, surveyor spoke with the Interim Administrator concerning the Cyclobenzaprine omission. She stated the medication was not signed off and she would assume that meant it was not given. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/05/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, resident interview, clinical record review and facility document review the facility staff failed to follow and established infection control program for 3 of 10 residents, Resident #15, Resident #12, and Resident #16.The findings included:1.For Resident #15 the facility staff failed to provide and don personal protective equipment (PPE) while providing incontinence care. Resident #15's clinical record listed diagnoses which included but not limited to personal history of urinary (tract) infections and resistance to multiple antimicrobial drugs. Resident #15's most recent minimum data set with an assessment reference date 07/17/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #15's comprehensive care plan was reviewed and contained a plan for ISOLATION: the resident requires Enhanced Barrier precautions (EBP) due to colonization of MDRO (multi drug-resistant organism). Interventions for this plan include appropriate PPE (personal protective equipment) per policy. Resident #15's clinical record was reviewed and contained a physician's order summary which read in part, Enhanced Barrier precautions due to MDRO colonization. Surveyor observed Resident #15's room from hallway on 09/05/25 at 1:15 pm and no EBP signage was seen, nor was any PPE observed to be in the general area of resident's room. Surveyor went to speak with Resident #15 on 09/05/25 at 1:20 pm and observed certified nurse's aide (CNA) #4 and CNA #5 providing incontinence care for resident. Both CNAs were wearing gloves, but neither one was wearing a gown. Surveyor spoke with CNA #4 and CNA #5 on 09/05/25 at 1:55 pm. Surveyor asked CNAs what type of PPE they were wearing while caring for Resident #15, and both stated they were wearing gloves. Surveyor asked both CNA's if they had been wearing a gown, and both stated they were not. CNA #4 stated, Nobody told me I was supposed to. Surveyor asked CNA's if they knew that resident was on enhanced barrier precautions, and both stated they did not. CNA #5 stated, I always dress out when I know someone is on precautions, I have a baby at home and then asked if there is a sign for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and was provided with a facility policy entitled Enhanced Barrier Precautions (EBP) Process which read in part, To ensure proper implementation of Enhanced Barrier Precautions (EBP) to prevent the spread of multidrug-resistant organisms (MDROs) while maintaining resident dignity. Procedure: 1. Identification of Resident on EBP: *When a resident is determined to require EBP, the designated staff member (e.g., nurse or infection preventionist) will initiate the protocol. 2. Visual Identification: *A colored dot sticker will be placed on the nameplate outside the resident's door to discretely indicate EBP status. *This ensures staff awareness without compromising resident privacy. 3. Resident Room Signage: *An EBP sign will be hung over the resident's bed rather than on the door to protect their dignity while ensuring compliance. 4. EBP Supply Storage: *Gowns and other necessary EBP supplies with be stored on the linen carts located on the unit. *Staff must ensure adequate supply availability and replenish as needed .5. *All staff must follow EBP guidelines, including donning appropriate PPE (gowns and gloves) before performing high-contact resident care activities .7. Education and Reinforcement: *Staff will receive ongoing education on EBP, including when and how to implement precautions . Surveyor observed Resident #15's room on 09/05/25 at 2:05 pm. Surveyor observed a green dot sticker on the resident's nameplate and EBP sign above the resident's bed. Surveyor observed two linen carts on the unit on 09/05/25 at 2:10 pm. Neither linen cart contained PPE. Surveyor spoke with Resident #15 on 09/05/25 at 2:15 pm. Surveyor asked Resident #15 is staff were wearing gowns while providing care for them, and resident stated, No, why would they? Surveyor observed the two linen carts along with unit manager, licensed practical nurse (LPN) #1 on 09/05/25 at 2:40 pm. LPN#1 confirmed there was no PPE on either cart. The concern of not following and established infection control plan was discussed with the DON/interim administrator, assistant director of nursing, regional director of clinical services, LPN #1, LPN #3, and LPN #4 on 09/05/25 at 3:35 pm. No further information was provided prior to exit. 2. For Resident #12 the facility staff failed to follow the facility established Enhanced Barrier Precautions (EBP) process. Resident #12's clinical record included diagnoses which included but not limited to urinary tract infection, site not specified. Resident #12's most recent minimum data set with an assessment reference date of 08/29/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #12's comprehensive care plan was reviewed and contained a care plan for Catheter: .Catheter for post op urinary retention until follow up. Interventions for this care plan included enhanced barrier precautions. (continued on next page)

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	495333	A. Building B. Wing	09/05/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12's clinical record was reviewed and contained a physician's order summary which read in part, Enhanced Barrier Precautions secondary to Foley Catheter. Resident #12's room was observed on 09/05/25 at 2:10 pm. There was no sticker on the nameplate, nor any signage in the room to indicate that resident is on EBP. Surveyor requested and was provided with a facility policy entitled Enhanced Barrier Precautions (EBP) Process which read in part, To ensure proper implementation of Enhanced Barrier Precautions (EBP) to prevent the spread of multidrug-resistant organisms (MDROs) while maintaining resident dignity. Procedure: 1. Identification of Resident on EBP: *When a resident is determined to require EBP, the designated staff member (e.g., nurse or infection preventionist) will initiate the protocol. 2. Visual Identification: *A colored dot sticker will be placed on the nameplate outside the resident's door to discretely indicate EBP status. *This ensures staff awareness without compromising resident privacy. 3. Resident Room Signage: *An EBP sign will be hung over the resident's bed rather than on the door to protect their dignity while ensuring compliance. 4. EBP Supply Storage: *Gowns and other necessary EBP supplies with be stored on the linen carts located on the unit. *Staff must ensure adequate supply availability and replenish as needed .5. *All staff must follow EBP guidelines, including donning appropriate PPE (gowns and gloves) before performing high-contact resident care activities .7. Education and Reinforcement: *Staff will receive ongoing education on EBP, including when and how to implement precautions . Surveyor observed two linen carts on the unit on 09/05/25 at 2:10 pm. Neither linen cart contained PPE. Surveyor observed the two linen carts along with unit manager, licensed practical nurse (LPN) #1 on 09/05/25 at 2:40 pm. LPN #1 confirmed there was no PPE on either cart. The concern of not following the facility established Enhanced Barrier Precautions (EBP) process was discussed with the DON/interim administrator, assistant director of nursing, regional director of clinical services, LPN #1, LPN #3, and LPN #4 on 09/05/25 at 3:35 pm. No further information was provided prior to exit. 3. For Resident #16 the facility staff failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases and infection by failing to follow the facility Transmission-Based Precautions (TBP) process for the resident due to an active infection of Acinetobacter (a common environmental bacterium that can cause various infections, including UTIs, and can pose a serious health threat, especially in healthcare settings due to its increasing antibiotic resistance) in the urine. Resident #16's diagnosis list indicated diagnoses, which included, but not limited to Venous Thrombosis and Embolism, Edema, Overactive Bladder, Hypertension, Chronic Pain, Metabolic Encephalopathy, Atrial Fibrillation, Urinary Tract Infection, and Weakness. The most recent MDS (minimum data set) with an assessment reference date (ARD) of 8/19/25 assigned the resident a brief interview for mental status (BIMS) summary score of 11 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record disclosed a medical provider order with a start date of 8/8/25 which read in part, “…Contact isolation for positive Acinetobacter in the urine…” A review of the person-centered comprehensive care plan revealed a focus which read in part, “…ISOLATION…Contact isolation precautions due to VRE (Vancomycin-Resistant Enterococci-a type of antibiotic-resistant infection enterococcus bacteria that can cause infections in healthcare settings)…” An intervention related to the focus read in part, “…appropriate PPE (personal protective equipment) per policy…” On 9/5/25 at 1:42 PM, surveyor observed Resident #16 and did not observe the resident's room to have any signage or PPE available outside the room. On 9/5/25 at 2:12 PM, surveyor observed certified nursing assistant #3 (CNA#3) enter and exit Resident #16's room without donning or doffing appropriate PPE. On 9/5/25 at 2:15 PM, surveyor spoke with licensed practical nurse #5 (LPN#5) and inquired if Resident #16 was on precautions and she informed surveyor she believed the resident to be on EBP (enhanced barrier precautions) because the resident had a catheter. Surveyor and LPN#5 reviewed Resident #16's medical provider orders together and the orders disclosed Resident #16 was on contact isolation (TBP) with an order start date of 8/8/25. Surveyor asked LPN#5 the protocol for someone on TBP and she stated an isolation cart should be placed outside of door, PPE should be available, and a sign should be placed on the door for residents on TBP. On 9/5/25 at 2:18 PM, surveyor observed a male nursing staff member sitting at Resident #16's bedside without PPE and surveyor observed licensed practical nurse #3 (LPN#3) enter Resident #16's room without donning PPE. Surveyor spoke with LPN#3 and informed her Resident #16 is on contact precautions, she stated she would take care of this right away. This concern was discussed on 9/5/25 at 2:54 PM in a meeting with interim administrator, interim director of nursing, regional director of clinical services, and licensed practical nurse #1. Regional director of clinical services informed the survey team that the issues are corrected now and there are signs and PPE carts available outside the resident rooms. Surveyor requested and received a facility policy titled, “Transmission-Based Precautions” which read in part, “…The facility will ensure systems and processes are in place for the prevention and spread of infectious diseases…Contact Precautions may be implemented for resident's known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment…1. Signs will be placed outside to each resident's room requiring transmission-based precautions…the signs will identify the type of PPE and special instructions…2. An adequate supply of PPE will be accessible and maintained outside of each resident room for staff and visitor use…” No further information was provided to the survey team prior to exit on 9/5/25.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on observations, staff interview, and facility document review, the facility staff failed to employ an infection preventionist with the required training prior to assumption of the role.The findings included:On 9/5/25, members of the survey team made multiple observations of residents requiring EBP (enhanced barrier precautions) and/or TBP (transmission-based precautions) without proper notification/signage and PPE available to staff, residents and/or visitors. On 9/5/25 at 2:54 PM-surveyors met with interim administrator (ADM), interim director of nursing (DON), regional director of clinical services and licensed practical nurse #1 (LPN#1). This surveyor inquired about the facility IP (infection preventionist) and the DON informed surveyor the previous IP left employment at the facility on 7/4/25 and she and the ADM are acting IPs and both agreed neither of them has an IP certification. LPN#1 has an IP certification from 2022 and she agreed that she does not perform the IP role at the facility. Surveyor requested evidence of staff education on infection control procedures for EBP/TBP and was provided evidence of staff education. Surveyor requested and received a facility job description for Infection Preventionist which read in part, .Infection Prevention Responsibilities.Education.Be able to obtain certification in Infection Control. No further information was provided to the survey team prior to exit on 9/5/25.