STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augusta Nursing & Rehab Center	83 Crossroads Lane Fishersville, VA 22939

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on resident interviews, staff interviews, observations and facility documentation the facility staff failed to allow the residents to exercise their rights as a citizen of the United States for multiple residents residing on 2 of 2 units and failed to treat residents with and provide an environment that promoted respect and dignity for residents on 1 of 2 nursing units. The findings included: 1. The facility staff failed to ensure the resident rights regarding voting was upheld, affecting multiple residents on 2 of 2 units. On 10/15/24 at 11:15 am during the initial tour of the facility nursing units Resident #114 (R114) and Resident #123 (R123) asked the surveyor if they were allowed to vote. R114 and R123 both stated that no one from the facility had talked with them about voting. R114 stated, I want to vote and need to know what to do. R123 stated, I have a voter's card and would like to vote. On 10/15/24 at 11:40 am, an interview was conducted with the social service director. The social service director said she had only been in this position since 9/26/24. The social service director said, If the resident is not registered to vote, then we will get them registered. When asked about the lack of posted voting information, the social service director stated, I will have the information hung up before the end of the day for the residents to see. When questioned further, the social service director said that she had not contacted the register's office but would do so that day. On 10/15/24 at 11:50 a.m., an interview was conducted with the administrator. The administrator said that the preparation for voting should begin the month of September. The administrator stated, Generally social services does the prep for voting but I didn't have anyone in social services for one month. The administrator said, If the residents are not registered, then we would fill out the registration forms so they can vote. When questioned about the lack of observable voting information, the administrator said that the information for the right to vote should be posted. The administrator stated, Residents can do an absentee ballot if they wanted to or go to the polls, we would take them there. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 4:30 p.m., an observation was conducted for voting information. This surveyor observed signs posted that read, if a resident was interested in voting to see the social service director ASAP [as soon as possible]. These signs were posted in common areas on each unit at the bulletin boards at the nurse's station, outside the dining room, and in the vending machine area. On 10/16/24 at 9:00 a.m., a follow-up interview was conducted with R114 and R123. R114 and R123 verbalized that no one from the facility had talked with them about voting and they wanted to vote. On 10/16/24 at 12:10 p.m., an interview was conducted with Resident #103 (R103). R103 stated that over a month ago, I asked the activity assistant about voting and I didn't get a response. R103 said she wanted to vote and was registered in another county to vote so she was not sure how that worked. R103 said no one from the facility had discussed voting with her. R103 stated, if you don't vote, you are part of the problem. When the surveyor asked about being transported to the location where she is registered to vote, R103 stated that it was 2 hours away. On 10/16/24 at 12:20 p.m., an interview was conducted with Resident #106 (R106). R106 stated, I didn't know I could vote but I would like to. On 10/16/24 at 12:25 p.m., an interview was conducted with Resident #111 (R111). R111 said no one had spoken with her about voting from the facility. R111 said that she was registered, wanted to vote, and would like to do absentee ballot. On 10/16/24 at 12:30 p.m. an interview was conducted with Resident #113 (R113). R113 said that she was not registered to vote and does not know how to register. R113 said she would like to vote in this election. On 10/16/24 at 12:35 p.m., an interview was conducted with Resident #108 (R108). R108 said she wanted to vote and was registered to vote in another county. On 10/16/24 at 12:38 p.m., an interview was conducted with Resident #102 (R102). R102 said that no facility staff had spoken with him about voting. R102 said he was registered and wanted to vote. On 10/16/24 at 12:50 p.m., a telephone call was placed to the voter registration office in the locality where the facility was located. The registrar reported that the deadline for non-registered voters to register ended at 5 p.m. on 10/15/24. As for the residents who are registered at other locations, the registrar stated that it would be up to the registrar at each locality as to whether the resident would be able submit an absentee ballot there or not. The registrar reported that the deadline for absentee ballots is that they must be received in the local office by 5pm on Thursday, October 24, 2024. On 10/16/24 at 3:00 p.m., an interview was conducted with the social services director. The social services director said that she called the register's office yesterday and was told if the resident is registered, an absentee ballot can be completed, but must be mailed out by Monday. The social worker director said, If the resident is not registered, then we have missed that deadline. The cutoff date was yesterday. The surveyor asked how the residents would see the notice about voting if they do not come out of their rooms and the social worker director said, We will go room to room and ask each resident about voting. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at approximately 5:00 p.m. the administrator provided a document titled, Center for Clinical Standards and Quality, that was a CMS (Centers for Medicare and Medicaid services) document, and she stated, We have no voting policy. This is all we have. The CMS document read in part, .certified long-term care facilities affirm and support the right of residents to vote. Nursing homes should have a plan to ensure residents can exercise their right to vote, whether in person, by mail, absentee ballot, or other authorized process. Assistance in registering to vote, requesting an absentee ballot or completing a ballot from an agent of the resident's choosing. 2. The facility staff failed to provide residents with an environment that promotes dignity on 1 of 2 units. On 10/15/24 at 2:30 p.m. an interview was conducted with Resident #104 (R104). R104 said she feels safe now and staff is good except some arguing. R104 said this morning that the unit manager was at the door screaming at the aide that was in the room with my roommate. R104 stated, I yelled to get out of here, close the door because it makes me anxious, and it bothers me. On 10/15/24 at 4:30 p.m. an interview was conducted with a licensed practical nurse, unit 3 manager, LPN# 5 (LPN5). When asked about the earlier altercation on the unit, LPN5 said that this morning she had words with certified nursing assistant, CNA #3 (CNA3). LPN#5 said, [CNA3 name redacted] started screaming at me. LPN5 said that she told CNA3 it was her responsibility to chart on residents and CNA3 began arguing and LPN5 stated, I told her to stop, I was not going to argue with her. LPN5 said that she told CNA3 to clock out and leave, then called the director of nursing (DON). LPN5 said that CNA3 was in the resident's room and yelling, You have no control of me! LPN5 said that CNA3 continued to work until her shift was done. On 10/15/24 at 5:00 p.m. an interview was conducted with the director of nursing (DON). The DON said that CNA3 worked until I came in this morning about 7:10 a.m. I had a conversation with CNA3 and CNA# 2 (CNA2), who was a witness to the incident, and we had the conversation with the human resource director. On 10/15/24 at 5:20 p.m. an interview was conducted with the treatment nurse, LPN#7 (LPN7). When asked about the staff altercation that happened that morning, LPN#7 said, At about 6:15 a.m., the aide [indicating CNA2] came up and said I changed the resident and then [LPN#5's name redacted] said you can tell me he had feces on his brief, but did you chart it, if not care has not been done. LPN7 said, Then the other aide [indicating CNA3] said, 'I cannot get in to chart, and we told you a week ago' and then [LPN5's name redacted] said 'advocate for yourself; it looks like you did not do your job. [LPN5's name redacted] said I am not human resources; I cannot help you.' Then [LPN5] said 'I am not going to argue with you and the aide [CNA3) said 'I don't know why you have such an attitude.' The aide [CNA3] went into the resident's room, had the door opened, it wasn't closed all the way, but [LPN5] and the aide [CNA3] were loud. LPN7 said that she had just stepped in, trying to calm the situation. LPN7 said that she had never witnessed other arguments on the floor but had heard that arguments do happen among the staff. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 7:15 p.m. an interview was conducted with CNA#2. CNA2 said that she was getting CNA3 to help her with R122's care. CNA2 reported that CNA3 went to the resident's room, opened the door, and yelled up to the nurse's station asking LPN5 why she was screaming at her. CNA2 said that LPN5 stood up out of her chair and began screaming at CNA3 to clock out. CNA2 reported that R104 had yelled out to CNA3, Close the door! Do that outside the door, not in my room! CNA2 stated that CNA3 closed the door but that she and LPN5 had kept yelling. CNA2 stated that when they finally stopped, CNA3 came into the room with me to help me with Resident #122's name redacted] care. While we were doing incontinence care for R122, LPN5 opened the resident's door and demanded CNA3 to come out of the room. CNA3 said to LPN5 I am providing care for a resident now and LPN5 just kept yelling for CNA3 to come out of the room and was getting louder and louder. When asked about the residents' response, CNA2 said that R104 had been sleeping when this argument started, and after being awakened like that, R104 appeared agitated. CNA2 said that R122 had looked uncomfortable and that all she could do was apologize to both residents. On 10/16/24 at 9:25 a.m. an interview was conducted with R104. When asked about yesterday's disruption, R104 said that she was shocked by all the yelling. When asked how it made her feel, R104 said that it made her feel anxious and agitated. When asked about the frequency of these types of disturbances, R104 stated, An almost fist throwing happened about 2 weeks ago. R104 said, the staff . should be more respectful because it scares us! On 10/16/24 at 9:30 a.m. an interview was conducted with R122. R122 stated, They were talking loudly over me and saying come out here now. I could hear them arguing until [roommate's name redacted] told them to get out and shut the door. R122 said, It was a rough morning! I didn't like it, and it made me uncomfortable! It didn't involve me, so take it elsewhere. On 10/16/24 at 4:45 an interview was conducted with the regional director of clinical services (RDCS). The RDCS said, We interviewed the resident after the incident, and we did not have anyone that stated they were fearful. On 10/16/24 at 5:43 p.m. an end of day meeting was conducted with the administrator, director of nursing and regional director of clinical services. When the above concerns were discussed, the facility administrator stated, We didn't know what was going on until you said something. The RDCS and administrator said that the reason they were not aware of the staff arguing was that the DON was on a medication cart . and then you all [surveyors] walked into the building, and it was forgotten. The RDCS and the administrator said that the altercation had been taken care of and reported, that they had suspended the employees involved, reported the incident as an allegation of abuse, and are investigating. The administrator stated that R104 had been interviewed. When asked about the other resident, R104's roommate, the administrator stated that she wasn't interviewable. The administrator was then made aware that according to R122's clinical record, R122 had a brief interview for mental status (BIMS) score of 15 out of 15 (indicating no cognitive impairments) and that R122 had answered questions when interviewed by the surveyor. The survey team explained that R122 had been the resident staff were providing care to when the altercation had taken place. The facility administrator stated that they would go talk with R122 immediately following the meeting/discussion with the survey team and that they were unaware R122 was involved. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During this same meeting, facility staff reported that they did not have a facility policy with regards to staff interactions in resident care areas. The facility did provide the survey team with a document titled, Employee Guidebook, and on page 16 it read in part, Professional Courtesy and Customer Service . The company is committed in our efforts to provide a high standard of resident/patient care and excellent customer service, and in the communication that takes place during the workday. You are also expected to approach customers, clients, residents, patients and families in a professional, courteous and efficient manner . The facility also provided a document titled, Code of Ethics. Within that document excerpts read, The company will not tolerate: . Any other conduct that creates an intimidating or hostile work environment . The facility provided a policy titled, Resident Rights, read in part .ensure that residents rights are known to staff. Ongoing training on resident rights will be given to staff members as required by state and/or federal regulations. No additional information was provided prior to exit.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 41449 Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure residents were clinically appropriate to self-administer medications, before being permitted to do so for three residents (Resident #111- R111, Resident #114- R114, and Resident #121-R121) in a survey sample of 29 residents. The findings included: 1. For R111, the facility nurse provided the resident with medications and left them at the bedside for the resident to self-administer, when the resident had not been assessed to be appropriate for self-administration of medications. On 10/15/24 at 11:10 a.m., R111 was observed sitting in a wheelchair at the bedside. R111 had an over bed table in front of her and on the table was a cup of medication that contained two round, white tablets. When asked what it was, R111 stated that she didn't know. A visitor in the room, told R111, that's your morning medications, you need to take those. Upon the surveyor exiting the room, licensed practical nurse (LPN #4) was observed in the hallway at the medication cart. When asked about mediation administration and R111 having 2 white tablets in a cup in her room, LPN #4 identified that the medication was sodium bicarbonate. When asked if she normally leaves medications at the bedside for a resident to take, LPN #4 said, I don't normally, I had just given them to her, and came back to the cart to get insulin. When asked what the accepted practice is, LPN #4 stated, To watch, to make sure they take them and don't drop them or whatever. On 10/15/24, a review of R111's clinical record revealed an active physician's order for Sodium Bicarbonate Oral Tablet 325 MG (Sodium Bicarbonate (Antacid)) Give 2 tablet by mouth four times a day for CKD [chronic kidney disease]. There were no orders indicating that R111 could self-administer medications. On 10/15/24, at approximately 1 p.m., the facility administrator provided the survey team with a listing of residents who had been determined safe to self-administer and had an order that they were permitted to self-administer medications. R111 was not on the list. According to R111's assessment tab of the clinical record, there was no assessment of the resident's ability to self-administer medications found. According to R111's care plan, there was no indication of self-administration of medications. 2. For R114, the facility staff permitted the resident to have Vick's vapor rub at the bedside to self-administer, when the resident did not have an order for the medication and had not been determined clinically appropriate to self-administer medications. On 10/15/24 at approximately 10:45 a.m., during a tour of the unit, R114 was observed to have Vicks vapor rub at the bedside. When R114 was asked about the Vicks, the resident stated that she applied it under her nose every night to prevent her nose from getting stopped up. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24, at approximately 1 p.m., the facility administrator provided the survey team with a listing of residents who had been determined safe to self-administer and had an order that they were permitted to self-administer medications. R114 was not on the list. On 10/15/24 at 2:12 p.m., R114's room was observed and again the Vicks vapor rub was noted at the bedside. On 10/15/24 at 2:20 p.m., an interview was conducted with registered nurse (RN #3). RN #3 was asked about R114's medications and stated, We give her her medications. RN #3 went on to say, No medications should be at the patient's bedside. When asked about the Vicks vapor rub, RN #3 said, I can't speak to that. I don't leave medication at the bedside. RN #3 accompanied the surveyor to R114's room, observed the Vicks vapor rub, and removed it. On 10/15/24 at approximately 2:25 p.m., RN #3 took the Vicks vapor rub to the nursing station, where the unit manager/licensed practical nurse #5 (LPN #5) was informed about it. LPN #5 stated, It has to come out, we have to find out where she is using it and if appropriate, there is an assessment that has to be done for her to self-administer, and it has to be done every three months. On 10/15/24, during a clinical record review of R114's chart, it was noted that there was no physician order for the use or administration of Vicks vapor rub. According to R114's assessment listing, no assessment had been conducted to determine if R114 was clinically appropriate to self-administer medications. According to R114's care plan, there was no indication that the interdisciplinary team had determined R114 was appropriate to self-administer medications. 3. For R121, the facility nurse left medications in the room at the bedside for the resident to self-administer, when the resident had not been assessed for the ability to self-administer medications. On 10/15/24, at approximately 1 p.m., the facility administrator provided the survey team with a listing of residents who had been determined to safely self-administer and had an order that they were permitted to self-administer medications. R121 was not on the list. On 10/15/24 at 2:06 p.m., R121 was visited in his room. While talking with R121, it was noted that on the over bed table was a medication cup with two large tablets. When the resident was asked about the medication, R121 stated that it was tums that had been given that morning to take, . since I got the ulcer. On 10/15/24 at 2:11 p.m., an interview was conducted with registered nurse #2 (RN #2). RN #2 confirmed she was R121's nurse. When asked about the pills at the bedside, RN #2 said, I don't recall, I will have to look. On 10/15/24, in the afternoon a clinical record review was conducted. This review revealed that R121 did not have any physician orders in his clinical record, nor any record of any medications being administered. There was also no indication that R121 had been assessed for the ability to self-administer medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at approximately 2:20 p.m., an interview was conducted with the unit manager, who was a licensed practical nurse (LPN #4). LPN #4 confirmed that there had been a problem with R121's physician orders and said she did not give R121 the medications that were observed at the bedside. On 10/15/24 at 2:35 p.m., an interview was conducted with the Director of Nursing (DON). When asked about her expectation when nurses are administering medications, the DON stated, Medications are to be stored in the medication cart. The DON went on to say, During administration, they should pull up the medication administration record (MAR) and follow the five rights of medication administration. They should not leave the patient until the pills are consumed and watch to make sure they take them. According to the facility policy titled, Self-Administration of Medication at Bedside it read in part, Verify physician's order in the resident's chart for self-administration of specific medications under consideration. Complete Self-administration of Medications Evaluation. The interdisciplinary team will review the evaluation and will document Section III. Approval granted must be checked yes or no. Interdisciplinary team member signs the evaluation section . Complete the care plan for approved self-administered drugs . On 10/15/24 at 5:30 p.m., during an end of day meeting, the facility administrator, director of nursing and regional director of clinical services were made aware of the above findings. No additional information was provided.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 47067 Based on resident interviews, staff interviews, observations, and facility documentation, the facility staff failed to ensure multiple residents on 2 of 2 units had the opportunity to exercise autonomy regarding voting interests and preferences. The findings included: 1. The facility staff failed to ensure that multiple residents were able to pursue an activity that was important them. On 10/15/24 at 11:15 am, during the initial tour of the facility, Resident #114 (R114) and Resident #123 (R123) asked the surveyor if they were allowed to vote. R114 and R123 both stated that no one from the facility had talked with them about voting. R114 stated, I want to vote and need to know what to do. R123 stated, I have a voter's card and would like to vote. Also during this tour, no signage with voting information was observed. On 10/15/24 at 11:40 am, an interview was conducted with the social service director. The social service director said she had only been in this position since 9/26/24. The social service director said, If the resident is not registered to vote, then we will get them registered. When asked about the lack of posted voting information, the social service director stated, I will have the information hung up before the end of the day for the residents to see. When questioned further, the social service director said that she had not contacted the register's office but would do so that day. On 10/15/24 at 11:50 a.m., an interview was conducted with the administrator. The administrator said that the preparation for voting should begin the month of September. The administrator stated, Generally social services does the prep for voting but I didn't have anyone in social services for one month. The administrator said, If the residents are not registered, then we would fill out the registration forms so they can vote. When questioned about the lack of observable voting information, the administrator said that the information for the right to vote should be posted. The administrator stated, Residents can do an absentee ballot if they wanted to or go to the polls, we would take them there. On 10/15/24 at 4:30 p.m. an observation was conducted for voting information. This surveyor observed signs posted that read, If a resident was interested in voting to see the social service director ASAP [as soon as possible]. These signs were posted in common areas on each unit at the bulletin boards at the nurse's station, outside the dining room, and in the vending machine area. On 10/16/24 at 9:00 a.m., a follow-up interview was conducted with R114 and R123. R114 and R123 verbalized that no one from the facility had talked with them about voting and that they wanted to vote. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 12:10 p.m. an interview was conducted with Resident #103 (R103). R103 stated that over a month ago, I asked the activity assistant about voting and I didn't get a response. R103 said that she wanted to vote and was registered in another county to vote, so she was not sure how that worked. R103 said no one from the facility had discussed voting with her. R103 stated, If you don't vote, you are part of the problem. When the surveyor asked about being transported to the location where she is registered to vote, R103 stated that it was 2 hours away. On 10/16/24 at 12:20 p.m., an interview was conducted with Resident #106 (R106). R106 stated, I didn't know I could vote but I would like to. On 10/16/24 at 12:25 p.m., an interview was conducted with Resident #111 (R111). R111 said no one had spoken with her about voting from the facility. R111 said that she was registered, wanted to vote, and would like to do an absentee ballot. On 10/16/24 at 12:30 p.m., an interview was conducted with Resident #113 (R113). R113 said that she was not registered to vote and does not know how to register. R113 said she would like to vote in this election. On 10/16/24 at 12:35 p.m. an interview was conducted with Resident #108 (R108). R108 said she wanted to vote and was registered to vote in another county. On 10/16/24 at 12:38 p.m. an interview was conducted with Resident #102 (R102). R102 said that no facility staff had spoken with him about voting. R102 said he was registered and wanted to vote. On 10/16/24 at 12:50 p.m., a telephone call was placed to the voter registration office in the locality where the facility was located. The registrar reported that the deadline for non-registered voters to register ended at 5 p.m. on 10/15/24. As for the residents who are registered at other locations, the registrar stated that it would be up to the registrar at each locality as to whether the resident would be able submit an absentee ballot there or not. The registrar reported that the deadline for absentee ballots is that they must be received in the local office by 5pm on Thursday, October 24, 2024. On 10/16/24 at 3:00 p.m., an interview was conducted with the social services director. The social services director said that she called the register's office yesterday and was told if the resident is registered, an absentee ballot can be completed, but must be mailed out by Monday. The social worker director said, If the resident is not registered, then we have missed that deadline. The cutoff date was yesterday. The surveyor asked how the residents would see the notice about voting if they do not come out of their rooms and the social worker director said, We will go room to room and ask each resident about voting. On 10/16/24 at approximately 5:00 p.m., the administrator provided a document titled, Center for Clinical Standards and Quality, which was a CMS (Centers for Medicare and Medicaid services) guidance for nursing home policies. The administrator stated, We have no voting policy. This is all we have. The CMS document read in part, .certified long-term care facilities affirm and support the right of residents to vote. Nursing homes should have a plan to ensure residents can exercise their right to vote, whether in person, by mail, absentee ballot, or other authorized process. Assistance in registering to vote, requesting an absentee ballot or completing a ballot from an agent of the resident's choosing. (continued on next page)

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Augusta Nursing & Rehab Center	83 Crossroads Lane Fishersville, VA 22939

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No other information was provided prior to survey 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on resident interview, staff interview, clinical record review, and facility document review, the facility failed to implement abuse policies for two of seven residents, Resident #'s 203 and 207. The Findings Include: 1. The facility did not implement facility abuse policy in regards to reporting suspicion of physical abuse/mistreatment for Resident #203 (R203). According to the clinical record, diagnoses for R203 included, Multiple sclerosis, quadriplegia, pulmonary embolism, and depression. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/6/24, which assessed R203 with a cognitive score of 15 out of 15, indicating cognitively intact. Review of R203's clinical record documented a social workers note, dated 12/3/24, that indicated a certified nursing assistant (CNA) had been rude and rough during care (when turning R203) and alluded to R203 not feeling safe during the care provided. On 12/9/24 at 1:50 p.m., R203 was interviewed regarding the incident. R203 verbalized asking for help to turn in bed, CNA #1 came into the room to assist and turned R203 abruptly and roughly. R203 stated that it scared her to the point that it felt like CNA #1 was going to [NAME] her out the bed. When asked if she felt CNA #1 was intending to harm her and if R203 felt safe around CNA #1, R203 verbalized not feeling that CNA #1's intended to harm her but just didn't feel safe while being turned. R203 went onto say that in general CNA #1 seems to be in a hurry, doesn't really speak while providing care, and seems rude. R203 verbalized trying to speak with CNA #1 and thank her for helping but that usually there is no response. A witness statement from R203 was reviewed and indicated CNA #1 was rough when handling R203, grabbed the pad to turn R203 and felt like R203 was being flung on her side. The witness statement documented that R203 goes on to state that CNA #1 is rushing and feels that CNA #1 does not like her (R203). The witness statement also documented that R203 stated that she doesn't feel that CNA #1 would intentionally hurt but doesn't feel safe when CNA #1 works with her (R203). On 12/9/24 at 3:25 p.m., the administrator and the director of nursing (DON) were interviewed regarding not reporting the above allegations to state agency. The DON verbalized that R203 had reported the incident to the wound nurse and the wound nurse had then reported the incident to the DON and administrator. The administrator verbalized that the incident was investigated at the time, along with a skin assessment and talking with R203 (along with the DON), indicated no concerns. The administrator stated that the interview with R203 did not indicate CNA #1 was intentional in her actions and felt that it was more of a customer service concern. The administrator verbalized that education was planned for CNA #1, but that CNA #1 does not work full time and has not worked since the incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/24 at 3:45 p.m., R203 was interviewed again. R203 verbalized, in general CNA #1 seems rude, does not talk, and seems to be in a rush. R203 said that she has tried talking with CNA #1 and thanking her for the help to show kindness but CNA #1 does not converse when providing care. R203 verbalized not feeling that CNA #1 would intentionally harm her, but that particular day felt that CNA #1 would've thrown R203 out of the bed if she thought she (CNA #1) could get away with it. When asked if she (R203) felt that 'CNA #1 would've thrown her out of bed, if CNA #1 could get away with it' sounds intentional, R203 responded, I guess so, I wasn't looking at it like that. R203 then verbalized, This is just how [CNA #1's name redacted] made me feel at the time. On 12/10/24 at 8:45 a.m., an interview was conducted with licensed practical nurse (LPN #1), to whom R203 reported the allegation. LPN #2 verbalized that R203 reported the incident and LPN #1 wrote a witness statement and reported the concern to the DON. LPN #1 said that while talking with R203, it came across that she didn't do anything intentional, but just did not want that particular CNA working with R203. On 12/10/24 at 9:00 a.m., the social worker was interviewed (other staff, OS #1). OS #1 said that after the incident had been reported and the DON and administrator had assessed R203, the OS #1 also assessed and talked with R203. During the conversation with R203, OS #1 verbalized that R203 said this was the first time this had happened. When OS #1 was asked about her notation in the progress notes, OS #1 reviewed the note and agreed that the note does indicate R203 not feeling safe around CNA #1. On 12/10/24 at 10:00 a.m. The DON was interviewed. After reviewing the information, the DON verbalized that it should have been reported, but went onto say, We did do an investigation, which did not yield anything was intentional, and there was no physical evidence to indicate suspicion of abuse. On 12/10/24 at 11:25 a.m., the administrator was interviewed. The administrator verbalized that CNA #1 has not worked since this incident and is currently suspended pending investigation. No other information was presented prior to exit conference on 12/10/24. 2. The facility did not implement facility abuse policy in regards to timely reporting for suspicion of physical abuse/mistreatment for Resident #207 (R207). According to the clinical record, diagnoses for R207 included: Dementia, diabetes, hemiplegia, and anxiety. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 10/3/24 assessed R207 with a cognitive score of 11 out of 15, indicating moderately cognitively intact. Review of facility documentation indicated that the facility had reported an allegation of abuse/mistreatment on 12/9/24, with the incident date of 12/6/24. Review of R207's clinical record documented a social workers note dated 12/6/24 that indicated R207 was upset due to missing drinks and chips were stale after coming back from a leave of absence and was blaming a CNA (identified as CNA #2), and CNA #2 was pointing her finger in R207's face. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 8:30 a.m. R207 was interviewed regarding the incident. R207 verbalized feeling that the CNA #2 did point her fingers in R203's face but is aware that CNA #2 has been noted to talk with her hands. When asked if R207 felt safe, R207 verbalized feeling safe and went onto verbalized knowing how to handle herself. R207 also said that the CNA #2 has not worked with her since. On 12/10/24 at 9:10 a.m. the social worker (OS #1) was interviewed. OS #1 explained that during a conversation with R207, R207 reported CNA #2 had pointed her finger in R207's face. OS #1 said at the time of the discussion with R207 the social worker assistant (OS #2) was present and wrote the note and also talked with CNA #2. OS #1 was asked who reported the incident and who was the incident reported to. OS #1 verbalized she (OS #1 reported the incident on 12/6/24 and it was reported to the regional administrator as the DON was not in the facility that day. OS #1 then left the room and returned a few minutes later and verbalized she was not 100 percent sure that she reported to the regional administrator, but verbalized it was reported on 12/6/24. On 12/10/24 at 10:00 a.m., the DON and regional administrator was interviewed. The DON verbalized not working on the day of the incident. The regional administrator verbalized that she was not aware of anyone reporting the incident to her on 12/6/24, and that she became aware of the incident on 12/9/24, while reviewing progress notes and reports with the DON. The regional administrator also verbalized that on 12/9/24 the DON had found a typed note in her mail box from the social worker reporting an incident, but then realized that was a different incident. The regional administrator verbalized that after reviewing everything, the incident should have been sent within 24 hours of the incident. On 12/10/24 at 11:25 a.m., the administrator was interviewed. The administrator verbalized that this incident was still being investigated, but the CNA in question had been terminated due to unrelated concerns regarding call outs. Review of the facilities abuse policy read in part: [.] Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment [.] is obligated to report such information immediately, but no later that 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator and to other officials [.]. Once the allegation is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that the reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations. No other information was presented prior to exit conference on 12/10/24.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on resident interview, staff interview, clinical record review, and facility document review, the facility failed to report suspicion of physical abuse/mistreatment for one of 7 residents (Resident #203) and failed to report suspicion of physical abuse/mistreatment timely for one of 7 residents (Resident #207) to the state agency. The Findings Include: 1. The facility did not report suspicion of physical abuse/mistreatment for resident #203 (R203). According to the clinical record, diagnoses for R203 included Multiple sclerosis, quadriplegia, pulmonary embolism, and depression. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/6/24. R203 was assessed with a cognitive score of 15 out of 15, indicating cognitively intact. Review of R203's clinical record documented a social workers note dated 12/3/24 that indicated a certified nursing assistant (CNA) had been rude and rough during care (when turning R203) and indicated that R203 was not feeling safe during the provided care. On 12/9/24 at 1:50 p.m., R203 was interviewed regarding the incident. R203 verbalized asking for help to turn in bed, CNA #1 came into the room to assist and turned R203 abruptly and roughly, scaring R203 to the point R203 felt like CNA #1 was going to [NAME] her out the bed. R203 was asked if she felt CNA #1 was intending to harm her and if R203 felt safe around CNA #1. R203 verbalized not feeling that CNA #1's intended to harm her but just didn't feel safe while being turned. R203 went onto say that in general CNA #1 seems to be in a hurry, doesn't really speak while providing care, and seems rude. R203 verbalized trying to speak with CNA #1 and thanking her for helping but usually there is no response. Provided by the facility, a witness statement from R203 was reviewed and indicated that CNA #1 is rough when handling R203, grabbed the pad to turn R203 and felt like being flung on her side. R203 goes on to state that CNA #1 is rushing and feels that CNA #1 does not like her (R203). R203 states that she doesn't feel that CNA #1 would intentionally hurt but doesn't feel safe when CNA #1 works with her (R203). On 12/9/24 at 3:25 p.m., the administrator and the director of nursing (DON) were interviewed regarding not reporting this to state agency. The DON verbalized that R203 had reported the incident to the wound nurse and the wound nurse had then reported the incident to the DON and administrator. The administrator verbalized the incident was investigated at the time and talking with R203 (along with the DON), had done a skin assessment, which indicated no concerns, and interviewed R203 which did not indicate CNA #1 was intentional in her actions and felt that it was more of a customer service concern. The administrator verbalized that education was planned for CNA #1 however, CNA #1 does not work full time and has not worked since the incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/24 at 3:45 p.m. R203 was interviewed again. R203 verbalized, in general CNA #1 seems rude, does not talk, and seems to be in a rush. R203 said that she has tried talking with CNA #1 and thanking her for the help to show kindness but CNA #1 does not converse when providing care. R203 verbalized not feeling that CNA #1 would intentionally harm her, but that particular day felt that CNA #1 would've thrown R203 out of the bed if she thought she (CNA #1) could get away with it. When asked if she (R203) felt that 'CNA #1 would throw her out of bed, if CNA #1 could get away with it' sounds intentional, R203 responded I guess so, I wasn't looking at it like that. R203 again verbalized, This is just how CNA #1 made me feel at the time. On 12/10/24 at 8:45 a.m., an interview was conducted with license practical nurse (LPN #1), to whom R203 reported the allegation. LPN #2 verbalized R203 reported the incident and LPN #1 wrote a witness statement and reported the concern to the DON. LPN #1 said that while talking with R203, it came across that the CNA didn't do anything intentional, but just did not want that particular CNA working with R203. On 12/10/24 at 9:00 a.m. the social worker was interviewed (other staff, OS #1). OS #1 said that after the incident had been reported and the DON and administrator had assessed R203, she also assessed and talked with R203. During the conversation between R203 and OS #1, OS #1 verbalized R203 said this was the first time this had happened. OS #1 was asked about her notation in the progress notes, OS #1 reviewed the note and agreed that the note does indicate R203 not feeling safe around CNA #1. On 12/10/24 at 10:00 a.m. The DON was interviewed. After reviewing the information, the DON verbalized that it should have been reported, but went onto say we did do an investigation which did not yield anything was intentional and there was no physical evidence to indicate suspicion of abuse. On 12/10/24 at 11:25 a.m. the administrator was interviewed. The administrator verbalized CNA #1 has not worked since this incident and is currently suspended pending investigation. No other information was presented prior to exit conference on 12/10/24. The Findings Include: 2. The facility did not report suspicion of physical abuse/mistreatment for resident #207 (R207) timely. Diagnoses for R207 included: Dementia, diabetes, hemiplegia, and anxiety. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 10/3/24. R207 was assessed with a cognitive score of 11 indicating moderately cognitively intact. Review of current Facility Reported Incidents (FRI's) indicated hat the facility had reported an allegation of abuse/mistreatment on 12/9/24. The FRI indicated that the incident date was 12/6/24. Review of R207's clinical record documented a social workers note dated 12/6/24 that indicated R207 was upset due to missing drinks and chips were stale after coming back from a leave of absence and was blaming a CNA (identified as CNA #2), and CNA #2 was pointing her finger in R207's face. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 8:30 a.m. R207 was interviewed regarding the incident. R207 verbalized feeling that the CNA #2 did point her fingers in R203's face but is aware that CNA #2 has been noted to talk with her hands. When asked if R207 felt safe, R207 verbalized feeling safe and went onto verbalized knowing how to handle herself. R207 also said that the CNA #2 has not worked with her since. On 12/10/24 at 9:10 a.m. the social worker (OS #1) was interviewed. OS #1 explained that during a conversation with R207, R207 reported CNA #2 had pointed her finger in R207's face. OS #1 said at the time of the discussion with R207 the social worker assistant (OS #2) was present and wrote the note and also talked with CNA #2. OS #1 was asked who reported the incident and who was the incident reported to. OS #1 verbalized she (OS #1 reported the incident on 12/6/24 and it was reported to the regional administrator as the DON was not in the facility that day. OS #1 then left the room and returned a few minutes later and verbalized she was not a 100 percent sure that she reported to the regional administrator, but verbalized it was reported on 12/6/24. On 12/10/24 at 10:00 a.m. the DON and regional administrator was interviewed. The DON verbalized not working the day of the incident. The regional administrator verbalized she was not aware of anyone reporting the incident to her on 12/6/24 and she became aware of the incident on 12/9/24 after her and the DON were reviewing progress notes and reports. The regional administrator also verbalized that on 12/9/24 the DON had found a typed note in her mail box from the social worker reporting an incident, but then realized that was a different incident. The regional administrator verbalized after reviewing everything, the FRI should have been sent within 24 hours of the incident. On 12/10/24 at 11:25 a.m. the administrator was interviewed. The administrator verbalized this incident is still being investigated but the CNA in question has been terminated due to unrelated concerns regarding call outs. Review of the facilities abuse policy read in part: [.] Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment [.] is obligated to report such information immediately, but no later that 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator and to other officials [.]. Once the allegation is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that the reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations. No other information was presented prior to exit conference on 12/10/24.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on observations, resident interviews, staff interviews, clinical record review, and facility documentation review, the facility staff failed to complete a thorough and accurate investigation of a serious elopement incident involving one resident (Resident #113-R113), in a survey sample of 29 residents. The findings included: On 10/15/24 at 10:50 a.m., an interview was conducted with R113 regarding her 10/2/24 fall outside. R113 said that she walked out to the parking lot and then went on down to the road to smoke a cigarette. R113 said that she stepped in the grass and slid into the mud. R113 said that it took her about half an hour to crawl out of the mud. R113 said that she managed to get out of the mud and to the side of the road, when an employee saw her and picked her up in her vehicle. R113 stated. I go outside whenever I want to go out. No signing out or telling anyone. On 10/16/24 at 10:10 a.m., an interview was conducted with the administrator. The administrator said that education for the wander guards was conducted with the administration staff and the clinical staff. The administrator said that R113 would go out and off the property to smoke, she felt the wanderguard was a restraint. The administrator said that she had physical therapy to evaluate R113 and had the nurse practitioner to see R113 to see if she needed the wanderguard. The administrator said that they were trying to find another facility for R113 to go to so she can smoke because she likes to smoke. The administrator said the day that R113 went out the front door that a receptionist was not working that day. The administrator stated, The receptionist letting resident out was all we could come up with that made sense. Then the administrator said that the receptionist that was there that day was no longer with the company. On 10/16/24, a clinical record review was conducted. On 10/2/24, a nursing progress note written read, Resident had fall outside and was assisted back into facility by [certified nursing assistant #6's name redacted], CNA and no injury noted. Wandergaurd is intact and was let out to set on front porch by receptionist and wanderguard does work. (SIC) On 10/16/24, during a clinical record review, R113's care plan was reviewed. According to R113's care plan, a focus area was initiated on 9/24/24, which remained active at the time of the 10/2/24 elopement and at the time of the survey, that read in part, [R113's name redacted] is an elopement risk & wanderer r/t [related to] dementia and being a smoker. She exit seeks to try to go outside to smoke. On 10/16/24 at 10:30a.m., an interview was conducted with certified nursing assistant #6 (CNA6). CNA6 stated, I did not find her outside and I did not have anything to do with it. I saw her standing outside in the circle and reported it to the social service director. CNA6 verbalized that if residents sign out, they can go outside, off the property to smoke. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 10:55 a.m. an interview was conducted with the regional traveling director of nursing (DON). The regional traveling DON said that R113 fell outside the facility near the circle and was found by an employee that was coming to work and the employee brought R113 back to the building. The regional traveling DON verbalized that she had a statement from the former receptionist, other staff #1 (OS1), that she didn't let R113 out of the facility. The regional traveling DON stated, Someone let her out of the facility. The regional traveling DON was unable to identify who had allowed R113 to leave the facility. On 10/16/24 at 11:25 a.m., an interview was conducted with the social worker assistant (OS1), who was previously the receptionist. OS1 verbalized that she was on unit 2 helping two residents and was not at the receptionist desk when R113 left the building. OS1 verbalized that the staff did not know when the wanderguard was on R113 because sometimes she had it on and other times it had been removed. OS1 verbalized that there were times when R113 came up to the front door and the alarm did not sound off, with the wanderguard on the resident. OS1 verbalized that she had seen R113 sitting in the chair in the lobby, after being brought back inside, and that she went to the unit to get her nurse to come down to the lobby to assess the resident. On 10/16/24 at 1:02 p.m., an interview was conducted with registered nurse #1 (RN #1). RN #1 was the nurse that wrote the progress note dated 10/2/24, regarding R113 having fallen while outside. RN #1 stated that she was told by CNA #6 that she brought her back in. RN #1 also stated that the RDCS (regional director of clinical services) had told her the same thing and reported that the receptionist had let the resident out. RN #1 reported that R113 was . covered in mud, she had a wander guard on, and the receptionist turned the alarm off and let her out. I don't remember who told me that. Corporate said they are allowed to go out and who ever lets them out should go with the resident. On 10/16/24 in the early afternoon, the front door wander guard system was tested with the director of nursing (DON). The DON placed a wander guard into her sock, to mimic the location where the wander guard is placed on resident's ankle. The DON was able to walk through the lobby and open the front door, without the locking mechanism of the wander guard system engaging to lock the door and prevent exit. On 10/16/24 at approximately 2:30 p.m., an interview was conducted with the maintenance assistant. The maintenance assistant reported that he checks the door alarms daily, Monday through Friday, and at times the front door's wander guard system doesn't work and they have to make adjustments. On 10/16/24 at 3:27 p.m., an interview was conducted with maintenance director. The maintenance director reported that in his short tenure of a few months that . once in a while, the receptionist will say that when a resident goes out, it doesn't alarm, and we have to make adjustments. On 10/16/24, in the late afternoon, the front door was again tested using a wander guard by the maintenance director. Initially when the maintenance director had the device pass through the lobby area, the sensor did not pick up the signal, and made no alarm. On the second attempt, the alarm sounded, and the door locked. On the third attempt, the alarm sounded but the door remained unlocked, and a resident with a wanderguard could have exited. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augusta Nursing & Rehab Center	83 Crossroads Lane Fishersville, VA 22939

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 5:21 p.m., a telephone interview was conducted with certified nursing assistant #1 (CNA#1), who had found R113 and assisted her back into the facility on [DATE]. On 10/16/24, CNA #1 stated that she had discovered R113 at 2:45 p.m., while driving to work, lying beside the road, off the facility property, unable to get up. CNA#1 stated that she had assisted Resident #113 up off the ground, into her jeep, and took Resident #113 back to the facility. According to CNA#1, Resident #113 was wet, had mud all over her, and required a shower. CNA#1 stated that upon entering the building with R113 she alerted staff, who had been unaware of R113's absence or how long she was gone. CNA #1 also reported that there was no door alarm sounding when she assisted R113 back into the facility. On 10/16/24 at 5:43 p.m., during an end of day meeting with the facility administrator, director of nursing (DON) and regional director of clinical services (RDCS), the incident on 10/2/24, involving R113 was discussed. The facility administrator reported she was not at the facility and was out of town at the time of the incident. The administrator went on to say that there wasn't a receptionist the day of the incident. When the survey team questioned the accuracy of the nurse's progress note that indicated that the receptionist let the resident out, as well as the facility synopsis of the incident, but that both receptionists had denied doing so, the Administrator and RDCS both acknowledged that they didn't know who had let R113 outside. On 10/17/24 at 8:30 a.m., an interview was conducted with the social service director. The social service director said, I saw [R113's name redacted] standing at the front door, and she was wet. I had her sit down in a chair and had the social worker assistant go up to the unit and get a nurse. The social service director said, No alarm was sounding when the resident came back into the facility and I don't remember an alarm sounding earlier, because we always jump up when the alarm goes off and I don't remember any of us doing that. On 10/17/24 at 9:00 a.m., an interview was conducted with R113. R113 stated, I just went out the front door, the door was unlocked, and people were outside, and no alarm sounded. I would go up sometimes and the alarm would sound, and they would turn it off and I would go out the door. On 10/17/24 at 9:19 a.m., the facility administrator was asked about the functioning of the wander guard system. The administrator said, I am not aware of an issue. The survey team reported to the administrator that during staff interviews multiple staff reported that the wander guard system is inconsistent and doesn't always operate properly. It was also reported that during the testing of the system by the DON and by the maintenance director the day prior, the wander guard system had not functioned properly. The administrator stated, This is the first I've heard of it. I always thought there was a mag [magnetic] lock, that if the door isn't closing enough, they may not latch. We just adjust those sensors on the side regularly. There is some sort of sensitivity, different things can affect it. That's usually what's going on. On 10/17/24 at 11:15 a.m., an interview was conducted with the business office assistant (other staff #2, OS2), who was the back-up receptionist. OS2 verbalized that residents with a wanderguard were able to go out and sit on the front porch without staff going with them, until R113 fell outside. OS2 said, Now, if a resident with a wanderguard wants to go outside, staff or a family member had to be with the resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 3:35 p.m., an interview was conducted with the regional director of clinical services (RDCS). The RDCS verbalized that she took R113 to the receptionist desk earlier on 10/17/24 to identify if CNA#6 was the person that let her out on 10/2/24. The RDCS stated that R113 verbalized that the receptionist was not the one at the desk on 10/2/24. When questioned about R113's prior statements, the RDCS reported that the facility staff had not interviewed R113 prior to 10/17/24 or during the investigation. When this was questioned, the RDCS stated that they had concluded that R113 was not appropriately assessed for elopement risk and had determined that the incident was not an elopement. On 10/18/24 10:50 a.m., an interview was conducted with the administrator. The administrator stated, I feel like [name redacted] business office assistant let her out and won't say that she did. They all have become quiet and only say we were told they could go out and sit on the porch. The administrator also stated that until the incident involving R113 on 10/2/24, the facility staff had permitted residents with a wanderguard to go outside unsupervised. On 10/18/24, a review was conducted of the facility's synopsis of the incident, which read in part, . Through the investigation it was discovered that the receptionist allowed the resident to exit the alarmed door due to the resident stating she wanted to sit on front porch Conclusion: clinical staff has been re-educated on completing elopement assessments accurately and objectively to determine proper use of wander guard. Staff will be educated that residents with wander guards will not be allowed to exit the center unattended . The only statements within this synopsis file were from OS1, whose statement contradicted the synopsis findings, and CNA #1, who had brought R113 back to the facility. The facility's synopsis referenced a receptionist that administration was unable to accurately identify and focused on who allowed the resident to exit the building without interviewing R113 about the incident. The facility's synopsis did not provide any evidence that the wanderguard that R113 had been wearing at the time of her elopement had been tested for appropriate function. The facility synopsis did not reference the wanderguard system as a possible causative factor in the elopement and included no evidence of the facility evaluating if the wander guard system was functioning properly, although it was known to malfunction. On 10/18/24, a facility documentation review was conducted. A policy titled, Elopement/Wandering Risk Guideline, read in part .evaluate and identify patient/residents that are at risk for elopement and develop individualized interventions. A facility document was reviewed titled, Release of Responsibility for Leave of Absence, which indicated that prior to any leave of absence from the facility, residents must first sign out. No other information was provided prior to exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41449 Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to implement the comprehensive care plan interventions for one resident (resident #113- R113) in a survey sample of 29 residents. The findings included: For R113, who had a care plan intervention for staff to monitor location every 30 minutes and prn [as needed], the facility staff failed to implement this intervention. On 10/15/24, in the afternoon, R113 was visited in her room. During the interview, R113 verbalized a desire to leave the facility and return home to live. On 10/15/24 and 10/16/24, at varying times, multiple observations were conducted of R113. There was no indication that facility staff were providing any type of monitoring of the resident every thirty minutes. On 10/16/24, during a clinical record review, R113's care plan was reviewed. According to the care plan, a focus area was initiated on 9/24/24, that read in part, [R113's name redacted] is an elopement risk & wanderer r/t [related to] dementia and being a smoker. She exit seeks to try to go outside to smoke. Interventions for this focus area, included but were not limited to, an intervention entered 9/24/24, read, monitor location every 2 hours and prn. That intervention was resolved on 10/2/24. On 10/8/24, a new intervention was added to R113's care plan which read, monitor location every 30 minutes and prn. On 10/17/24, the facility administration was asked to provide the survey team with evidence of the safety monitoring. On 10/17/24, the facility staff were only able to provide evidence of 15-minute checks being conducted on 10/8/24 from 12:30 p.m. 6:30 p.m. On 10/17/24, attempts were made to interview the care plan nurse that had entered the interventions of monitoring R113's location. However, that employee was no longer employed at the facility and therefore was not available for interview. On 10/17/24, in the afternoon, an interview was conducted with licensed practical nurse (LPN #6), who was also a care plan nurse. LPN #6 was unaware that R113 had a current intervention to monitor the resident's location every 30 minutes. LPN #6 was shown the active care plan. LPN #6 stated she would attempt to find out why this intervention was put into place for R113. LPN #6 was asked by the survey team to provide a copy of the resident's current care plan as well as all resolved items. On 10/17/24, in the afternoon, the survey team was provided a copy of R113's care plan. The care plan provided at that time noted the focus area that indicated R113 was an elopement risk and had every 30-minute safety checks, was resolved on 10/17/24 by the regional director of clinical services. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility policy titled, Plans of Care, it read in part, . The individualized person-centered plan of care may include but is not limited to the following: . individualized interventions that honor the resident's preferences and promote achievement of the resident's goals, interdisciplinary approaches that maintain and/or build upon resident abilities, strengths and desired outcomes . On 10/18/24, during a meeting held with the facility administrator and regional director of clinical services, they were made aware of the above concern that R113's interventions with regards to safety checks had not been implemented. No additional information was provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41449 Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to review and revise the care plan for one resident (resident #113- R113) in a survey sample of 29 residents. The findings included: For R113, who the facility staff identified was no longer an elopement risk, the facility staff failed to review and revise the care plan to indicate this. On 10/15/24, in the afternoon and on multiple occasions on 10/16/24, R113 was visited in her room. During the interviews, R113 verbalized a desire to leave the facility and return home to live. On 10/16/24, during a clinical record review, R113's care plan was reviewed. According to the care plan, a focus area was initiated on 9/24/24, which remained active at the time of survey that read in part, [R113's name redacted] is an elopement risk & wanderer r/t [related to] dementia and being a smoker. She exit seeks to try to go outside to smoke. On 10/2/24, according to a nursing note and facility documentation, it captured that certified nursing assistant #1 (CNA#1) had found Resident #113, who had been wearing a wander guard, lying on the ground and had assisted R#113 back to the building. On 10/16/24, during an interview with CNA #1, CNA #1 stated that she had discovered R113 at 2:45 p.m., while driving in to work, lying on the edge of the road, off the facility property, unable to get up. CNA#1 stated that she had assisted Resident #113 up off the ground, into her jeep, and took Resident #113 back to the facility. According to CNA#1, which had been stated earlier by RN#1 and the regional of clinical services, Resident #113 was wet, had mud all over her, and required a shower. CNA#1 stated that upon entering the building with R113 she alerted staff, who had been unaware of R#113's absence or how long she was gone, and that there had been no audible alarm sounding at that time. On 10/16/24 at 11:20 a.m., the survey team, facility administrator, and regional nurse consultant measured the distance from the facility's front entrance/exit door to the location where the resident was found on 10/2/24, determining that the distance was 465.7 feet. The width of the ditch the resident fell into was measured at 7.2 feet and 0.87 feet in depth. The distance from the hard surface road to the ditch was measured to be 23.5 feet of grass and rough terrain. On 10/16/24, during an interview with the facility administrator and regional director of clinical services (RDCS), the RDCS stated that they determined R113 was not appropriately assessed for elopement. The RDCS stated that another wandering/elopement assessment was conducted and identified that R113 was not an elopement risk. According to the assessment tab of R113's chart on 9/23/24 and 10/7/24, R113 had been assessed to be a risk for elopement. Then on 10/8/24, another assessment was conducted which noted R113 was no longer a risk for elopement. R113's care plan was not reviewed and revised to indicate the change in status as it noted at the time of survey that R113 remained a risk for elopement. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24, in the afternoon, the survey team was provided a copy of R113's care plan. The care plan provided at that time noted the focus area that indicated R113 was an elopement risk, was resolved on 10/17/24 by the regional director of clinical services. According to the facility policy titled, Plans of Care, it read in part, . Review, update and/or revise the comprehensive care plan based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA MDS assessment, and as needed . On 10/18/24, during a meeting held with the facility administrator and regional director of clinical services, they were made aware of the above concern that R113's care plan had not been reviewed and revised. No additional information was provided.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41449 Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to follow professional standards of care during medication administration for two residents (Resident #111- R111 and resident #121- R121) in a survey sample of 29 residents. The findings included: 1. For R111, the facility nurse failed to follow professional standards of practice during medication administration by not observing the resident to take the medications before exiting the room. On 10/15/24 at 11:10 a.m., R111 was observed sitting in a wheelchair at the bedside. R111 had an over bed table in front of her and on the table was a cup of medication that included two round, white tablets. When asked what it was, R111 stated she didn't know. A visitor in the room, told R111, that's your morning medications, you need to take those. Upon the surveyor exiting the room, licensed practical nurse (LPN #4) was in the hallway at the medication cart. When asked about mediation administration and R111 having 2 white tablets in a cup in her room. LPN #4 identified that the medication was sodium bicarbonate. When asked if she normally leaves medications at the bedside for a resident to take, LPN #4 said, I don't normally, I had just given them to her and came back to the cart to get insulin. When asked what the accepted practice is, LPN #4 stated, To watch to make sure they take them and don't drop them or whatever. On 10/15/24, a review of R111's clinical record revealed an active physician's order for Sodium Bicarbonate Oral Tablet 325 MG (Sodium Bicarbonate (Antacid)) Give 2 tablet by mouth four times a day for CKD [chronic kidney disease]. There were no orders indicating the resident could self-administer medications. On 10/15/24, at approximately 1 p.m., the facility administrator provided the survey team with a listing of residents who had been determined and had an order that they were permitted to self-administer medications. R111 was not on the list. 2. For R121, the facility nurse left medications in the room at the bedside for the resident to self-administer versus staying with the resident to ensure and observe the medications being taken. On 10/15/24, at approximately 1 p.m., the facility administrator provided the survey team with a listing of residents who had been determined and had an order that they were permitted to self-administer medications. R121 was not on the list. On 10/15/24 at 2:06 p.m., R121 was visited in his room. While talking with R121, it was noted that on the over bed table was a medication cup with two large tablets. When the resident was asked about the medication, the resident stated, it was tums that had had been given that morning to take since I got the ulcer. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 2:11 p.m., an interview was conducted with registered nurse #2 (RN #2). RN #2 confirmed she was R121's nurse. When asked about the pills at the bedside, RN #2 said, I don't recall, I will have to look. On 10/15/24, in the afternoon a clinical record review was conducted. This review revealed that R121 did not have any physician orders in his clinical record, nor any record of any medications being administered. On 10/15/24 at approximately 2:20 p.m., an interview was conducted with the unit manager, who was a licensed practical nurse (LPN #4). LPN #4 confirmed that there had been a problem with R121's physician orders and said she did not give R121 the medications that were observed at the bedside. On 10/15/24 at 2:35 p.m., an interview was conducted with the Director of Nursing (DON). When asked about her expectation when nurses are administering mediations, the DON stated, during administration they should pull up the medication administration record (MAR) and follow the five rights of medication administration. They should not leave the patient until the pills are consumed and watch to make sure they take them. According to the facility policy titled, Medication- Oral Administration of it read in part, . Chart on nurse's notes: pertinent observations after administration. Education provided to resident or family regarding medication. On 10/15/24 at 5:30 p.m., during an end of day meeting, the facility administrator, director of nursing and regional director of clinical services were made aware of the above findings.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on observations, staff interviews, resident interviews, clinical record review, and facility documentation review, the facility staff failed to provide an environment that was free from accident hazards and provide adequate supervision to prevent an avoidable accident/elopement for one resident (Resident #113-R113) in a survey sample of 29 residents. R113, while wearing a wander guard device, eloped from the facility, left the premises, fell , and was unable to get up, which resulted in complaints of back pain, requiring treatment and new order for x-rays, constituting harm. During the survey, the survey team identified that the wander guard system was not consistently functioning properly, and immediate jeopardy was identified. The findings included: The facility staff failed to provide adequate supervision and have a consistently functioning wander guard system to prevent residents with a known elopement risk from the ability to exit the facility without staff knowledge, which resulted in immediate jeopardy. Resident #113, who was a known elopement risk and had a wander guard in place, exited the facility, left facility grounds, fell into a drainage ditch 465.7 feet away from the buidling, was unable to get herself up, and crawled to the edge of the road. After an unknown amount of time, a staff member driving to work saw R113, assisted her off the ground, and drove her to the facility. R113 subsequently complained of pain in her back, requiring new physician orders to be written, which constituted harm. On 10/15/24 at 10:50 a.m. an interview was conducted with R113. R113 said that she walked out to the parking lot and then went on down to the road to smoke a cigarette. R113 said that she stepped into the grass and slid into the mud. R113 said that it took her about half an hour to crawl out of the mud. R113 said that she managed to get out of the mud and back to the side of the road, when an employee saw her, and picked her up in her vehicle. R113 stated. I go outside whenever I want to go out. No signing out or telling anyone. On 10/15/24 and 10/16/24, a clinical record review was conducted. This review revealed that on 9/19/24, according to Resident #113's (R113) care plan, R113 was identified as being at risk for elopement and as a wanderer. R113's care plan included a focus area, which was initiated on 9/24/24, that read in part, [R113's name redacted] is an elopement risk & wanderer r/t [related to] dementia and being a smoker. She exit seeks to try to go outside to smoke. Interventions for this focus area, included but were not limited to, an intervention entered 9/24/24, which read, monitor location every 2 hours and prn. That intervention was resolved on 10/2/24. On 10/8/24, a new intervention was added to R113's care plan which read, monitor location every 30 minutes and prn. On 10/17/24, the facility staff were only able to provide evidence of 15-minute checks being conducted on 10/8/24 from 12:30 p.m., until 6:30 p.m. R113's hospital discharge summary, dated 8/31/24, noted R113 with confusion, unsteady gait, cognitive decline, and unable to live alone. This summary indicated R113 as being unsafe to live alone because of her poor decision making, and noted an example of her placing a paper plate into a toaster oven to support that assessment. On 9/23/24, an elopement risk assessment was completed by the facility, which determined R113 to be an elopement risk and a wander guard was ordered. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/20/24 at 6:38 p.m., a nursing progress note in R113's chart read in part, Resident noted setting [sic] on porch this evening. When staff was leaving the facility, found resident walking next to stop sign on property. Assisted back to porch and this nurse walked resident to her unit. Resident watching tv at this time. Resident also had two cigarettes and a lighter on her person. Cigarettes placed in med cart until further direction. On 10/17/24 at 11:20 a.m., the regional director of clinical services measured the distance the resident had achieved on 9/20/24, with the surveyor and facility administrator observing. Although there was no stop sign noted in the designated area that the facility indicated R113 had been found on 9/20/24, it was measured as being 244.4 feet from the front door of the facility. The closest stop sign found in the area by the surveyor was approximately 0.25 miles or 1320 feet from the facility. On 9/23/24 at 7:02 p.m., a nursing progress note was entered into R113's record that read, Pt [patient] was seen walking outside upon returning inside facility she requested to speak with the speech therapist she informed her that she wants to leave the facility to go home. ADON [assistant director of nursing] was contacted via phone an instructed the writer to conduct an elopement assessment, this was done and pt is an elopement risk. Grand daughter was contacted and informed and message left on phone for Dr [medical director name redacted]. Wander guard place on pts Lt [left] ankle for safety. SIC On 9/24/24, R113's care plan was revised to add an intervention, which read, Monitor location every 2 hours and prn [as needed]. This intervention was discontinued on 10/2/24. On 10/17/24, the facility administration was asked to provide the survey team with evidence of the safety monitoring. On 10/17/24, the facility staff were only able to provide evidence of 15-minute checks being conducted on 10/8/24 from 12:30 p.m. 6:30 p. m. On 9/25/25 and 9/26/24, nursing note entries in R113's chart both read in part, .Often wonders outside and off sidewalk. Wonderguard in place . SIC On 10/2/24, a nursing progress note in R113's chart read, Resident had fall outside and was assisted back into facility by [certified nursing assistant #6's name redacted], CNA and no injury noted. Wandergaurd is intact and was let out to set on front porch by receptionist and wanderguard does work. On 10/3/24, a progress note from the nurse practitioner was entered into R113's clinical record, which read in part, Patient presented with complaints of lower back pain following a fall. On examination, pain was noted along the spine in the LS [lumbar spine] region. This pain is consistent with a potential injury to the thoracic spine. Plan: Prescribed Tylenol, 1 gram, twice a day for 7 days, with additional doses as needed for pain management. An x-ray will be ordered to rule out a compression fracture. According to facility documents, on 10/2/24, one of the two statements was by certified nursing assistant #1 (CNA#1) who had spotted R113 lying on the ground and had assisted R113 back to the building. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augusta Nursing & Rehab Center	83 Crossroads Lane Fishersville, VA 22939

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/16/24 at 5:21 p.m., an interview was conducted with CNA #1. CNA #1 stated that she had discovered R113 at 2:45 p.m., while driving to work, lying beside the road. CNA#1 stated that R113 had reported that she had fallen into a drainage ditch, off the facility property, and was unable to get up. CNA#1 stated that she had assisted R113 up off the ground, into her jeep, and took R113 back to the facility. According to CNA#1, R113 was wet, had mud all over her, and required a shower. CNA#1 stated that upon entering the building with R113, she had alerted staff, who had been unaware of R113's absence or how long she was gone, and that there had been no audible alarm sounding when they entered the building. On 10/16/24 at 11:20 a.m., the survey team, facility administrator, and regional nurse consultant measured the distance from the facility's front entrance/exit door to the location where R113 was found on 10/2/24, determining that the distance was 465.7 feet. The width of the ditch the resident fell into was measured at 7.2 feet and 0.87 feet in depth. The distance from the hard surface road to the ditch was measured to be 23.5 feet of grass and rough terrain. On 10/16/24 at 11:24 a.m., during an interview, other staff member #1 (OS #1) reported that frequently the front door wander guard system doesn't function properly. OS#1 said, There are times she has it on and it [the door alarm] doesn't go off, they check it and have to make adjustments. It doesn't always go off. Earlier this week [Resident #109's name redacted] went out and it didn't work. OS #1 reported that on 10/2/24, she was helping with answering the phones but was bouncing around and was not at the front desk/lobby when R113 went outside. OS #1 reported that she was on one of the nursing units helping a resident when R113 was brought back to the facility. OS #1 also stated, She [R113] is a difficult one. We never know when she has a wander guard or not, one day she has it and other days she doesn't. On 10/16/24 at 12:28 p.m., an interview was conducted with Other Staff #2 (OS #2), who worked as a back-up receptionist. OS #2 reported that just a few weeks ago she was working on a Sunday and about 1:10 p.m., when she arrived, R113 was in the parking lot. OS #2 said, Since she had a wander guard on, she wasn't supposed to be outside. I told her she needed to come back inside because she had a fall, and I didn't want her to fall again. OS #2 reported this was about 2-3 weeks ago. According to OS #2's timecard, she had worked 9/22/24, which was prior to R113's fall incident and then worked again on Sunday, 10/6/24. OS #2 went on to state that, They [administration] kept changing their minds. At one time they would let her go out on the porch. Another time they said someone had to be with her. When asked about the door alarm and functioning, OS #2 said, Sometimes the things don't go off. It is really sporadic. On 10/16/24 at approximately 2:00 p.m., R124 was observed by the survey team to be in the lobby, beyond the sensor for the wander guard alarm, past the receptionist desk, and only 8 feet from the exit door. Yet, there was no audible alarm triggered by the wander guard system. R124 was redirected back to his room by facility staff, away from the exit doors. On 10/16/24 at approximately 2:30 p.m., an interview was conducted with the maintenance assistant. The maintenance assistant reported that he checks the door alarms daily, Monday through Friday, and at times the front door's wander guard system doesn't work and they have to make adjustments. On 10/16/24 at 3:27 p.m., an interview was conducted with maintenance director. The maintenance director did report that in his short tenure of a few months that . once in a while, the receptionist will say that when a resident goes out, it doesn't alarm, and we have to make adjustments. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/16/24 in the early afternoon, the front door wander guard system was tested with the director of nursing (DON). The DON placed a wander guard into her sock, to mimic the location where the wander guard is placed on resident's ankle. The DON was able to walk through the lobby and open the front door, without the locking mechanism of the wander guard system engaging to lock the door and prevent exit. On 10/16/24, in the late afternoon, the front door was again tested using a wander guard by the maintenance director. Initially when the maintenance director had the device pass through the lobby area, the sensor did not pick up the signal, and made no alarm. On the second attempt, the alarm sounded, and the door locked. On the third attempt, the alarm sounded but the door remained unlocked and a resident could have exited. On 10/16/24 at 5:43 p.m., during an end of day meeting with the facility administrator, director of nursing (DON) and regional director of clinical services (RDCS), the incident on 10/2/24, involving R113 was discussed. The facility administrator reported she was not at the facility and was out of town at the time of the incident. The administrator went on to say that there wasn't a receptionist the day of the incident. When the survey team questioned that the nursing progress note indicated that the receptionist had let the resident out, as well as being noted likewise in the investigation summary, but that both receptionists had denied letting the resident out of the facility on 10/2/24, the Administrator and RDCS both stated they didn't know who had let R113 outside. During the end of day meeting held on 10/16/24, the RDCS provided the survey team with an Action Plan they had implemented following R113's elopement on 10/2/24. According to the action plan residents with a wander guard were reviewed to ensure appropriateness. The RDCS and Administrator stated that they determined R113 was not an elopement risk and was not appropriate to have a wander guard. On 10/17/24 at 9:00 a.m. another interview was conducted with R113. R113 stated, I just went out the front door, the door was unlocked, and people were outside, and no alarm sounded. I would go up sometimes and the alarm would sound, and they would turn it off, and I would go out the door. On 10/17/24 at 9:19 a.m., the facility administrator was asked about the functioning of the wander guard system. The administrator said, I am not aware of an issue. The survey team reported that in staff interviews multiple staff reported that the wander guard system is inconsistent and doesn't always operate properly. It was also reported that during the testing of the system by the DON and by the maintenance director the day prior, the wander guard system had not functioned properly. The administrator stated, This is the first I've heard of it. I always thought there was a mag [magnetic] lock, that if the door isn't closing enough, they may not latch. We just adjust those sensors on the side regularly. There is some sort of sensitivity, different things can affect it. That's usually what's going on. On 10/17/24 at 11:15 a.m. an interview was conducted with the business office assistant (other staff #2, OS2). OS2 verbalized that residents with wander guards were able to go out and sit on the front porch without staff going with them, until R113 fell outside. OS#2 stated, Now, if a resident with a wander guard wants to go outside, staff or a family member had to be with the resident. On 10/17/24 at 9:00 a.m. an interview with R113 was conducted. R113 was complaining of her back hurting from her waist down and that her chest was hurting. The surveyor notified R113's nurse, LPN#6. When notified, the physician ordered an x-ray of R113's lumbar spine on 10/17/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/17/24 at 3:15 p.m., the survey team identified the facility was in immediate jeopardy (IJ) in the care area of Quality of Care, as confirmed by the state agency. Given the findings that the facility failed to provide adequate supervision and failed to have a consistently functioning wander guard system to prevent residents identified as an elopement risk the ability to exit the facility without staff knowledge, the survey team determined that this noncompliance made the occurrence of serious adverse outcome likely and that the facility needed to take immediate corrective action. The survey team met with the facility administrator, director of nursing, and corporate staff and reviewed the IJ findings. On 10/18/24 at 6:20 p.m., the facility administration provided the survey team with an accepted IJ removal plan. The facility's plan to remove IJ read as follows: At approximately 0930 on 10/17/24 a staff member was posted at the front door to monitor entrance and exit and to ensure residents at risk were not allowed to exit without supervision. A staff member was assigned to relieve the scheduled staff when needed. [NAME] Security Services was contacted and on-site at arrived on site 10/17/24 at approximately 3:00 pm to work on functionality of the door alarming and latching when triggered by the Wander guard alarm. A staff person has been scheduled for 1:1 supervision of the front door for next 24 hours and until maintenance has verified door functionality; staff will be educated on responsibility of supervising the front door. All current staff in the building will be educated on their responsibility of preventing resident elopements beginning 10/17 evening shift and additional staff will be educated at their assigned shift. The facility alleged they would have the IJ removal plan completed on 10/17/24 at 6:30 p.m. On 10/17/24 at 6:20 p.m. the front receptionist was interviewed. The receptionist was able to verbalize that she was not able to leave the desk for any reason, unless someone came to relieve her. The receptionist was able to verbalize that residents with wander guards are not able to exit the front door unless a staff member was with them and also showed the surveyor an elopement book which identified the residents with wander guards. On 10/18/24 at 8:15 am the survey team returned on-site to verify the removal of IJ. A receptionist was sitting at the front desk in the lobby. The receptionist was interviewed and was able to verbalize that residents with wander guards are not permitted to go outside unless accompanied by staff or family. The receptionist also stated that she was not able to leave from monitoring the front desk/door unless someone was present to relieve her. Sign off sheets were verified that since 5 p.m. on 10/17 staff signed every 15 minutes that they were watching the front door, and it was continuously monitored. A statement from the maintenance director indicated that he had worked on the front door on 10/17 and had called a contractor in to work on it. The contractor bill dated 10/17/24 was provided which showed that the lever trim function of the front exterior door had been changed. The facility reported that the front door wander guard system was now operating properly. The survey team verified this with the Director of Nursing, noting that the system alarmed and locked the door when a wander guard approached the door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A copy of the schedule for all departments on 10/17 and 10/18 was received. Staff education sign-in sheets were also received, and a comparison was made to ensure that all staff working in the facility at 6:30 p.m., on 10/17 signed that they were educated on elopement, how to manage elopement risks, etc. Several staff were identified that had worked the evening/night shift that had not signed as having received education. Also identified was a certified nursing assistant (CNA #4) who was currently working who had not signed as having received education. CNA #4 was interviewed and confirmed she had not received any education. A sample of staff across all departments to include therapy, housekeeping, laundry, nursing and dietary were interviewed to ensure that they received training and understood elopement risk, how to respond in the event of a missing resident, and how to respond if the wander guard alarm sounds, etc. On 10/18/24 at 10 a.m., the administrator was asked to come to the conference room. When shown the staff that that had not signed as being educated, the administrator provided additional sign-in sheets that the survey team had not been given. The survey team was able to identify that all staff currently working and who had worked since 6:30 pm on 10/17/24 had received training except for CNA #4. On 10/18/24 at 10:10 a.m., the facility administrator was made aware the survey team had found that a staff member had not been educated. The administrator was notified that the survey team could not verify abatement of IJ until CNA #4 was trained. On 10/18/24 at 10:20 a.m., the facility administrator provided evidence that CNA #4 had been educated. On 10/18/24 at 10:20 a.m., the survey team was able to confirm that the immediacy had been removed. Following the removal of immediate jeopardy the scope and severity was lowered to a level three, isolated, as R113 suffered pain following the elopement incident and fall. No more information was provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on resident interviews, staff interviews, observations and facility documentation the facility staff failed to allow the residents to exercise their rights as a citizen of the United States for multiple residents residing on 2 of 2 units and failed to treat residents with and provide an environment that promoted respect and dignity for residents on 1 of 2 nursing units. The findings included: 1. The facility staff failed to ensure the resident right regarding voting was upheld, affecting multiple residents on 2 of 2 units. On 10/15/24 at 11:15 am during the initial tour of the facility nursing units Resident #114 (R114) and Resident #123 (R123) asked the surveyor if they were allowed to vote. R114 and R123 both stated that no one from the facility had talked with them about voting. R114 stated, I want to vote and need to know what to do. R123 stated, I have a voter's card and would like to vote. On 10/15/24 at 11:40 am an interview was conducted with the social service director. The social service director said she had only been in this position since 9/26/24. She stated that if the resident is not registered to vote, then we will get them registered. The social service director stated, I will have the information hung up before the end of the day for the residents to see. The social service director said that she had not contacted the register's office but would do that today. On 10/15/24 at 11:50 a.m. an interview was conducted with the administrator. The administrator said that the preparation for voting should begin the month of September. The administrator stated, generally social services does the prep for voting but I didn't have anyone in social services for one month. The administrator said if the residents were not registered, then we would fill out the registration forms so they can vote. The administrator said the information for the right to vote should be posted. She stated, do an absentee ballot if they wanted to or go to the polls, we would take them there. On 10/15/24 at 4:30 p.m. an observation was conducted. This surveyor observed signs posted that read, if a resident was interesting in voting to see the social service director ASAP [as soon as possible]. The signs were posted only in common areas on each unit at the bulletin boards at the nurse's station, outside the dining room and in the vending machine area. On 10/16/24 at 9:00 a.m. a follow-up interview was conducted with R114 and R123. R114 and R123 verbalized that no one from the facility had talked with them about voting and they wanted to vote. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 12:10 p.m. an interview was conducted with Resident #103 (R103). R103 stated that over a month ago, I asked the activity assistant about voting and I didn't get a response. R103 said she wanted to vote and was registered in another county to vote so she was not sure how that worked. R103 said no one from the facility had discussed voting with her. R103 stated, if you don't vote, you are part of the problem. When the surveyor asked about being transported to the location where she is registered to vote, R103 stated that it was 2 hours away. On 10/16/24 at 12:20 p.m. an interview was conducted with Resident #106 (R106). R106 stated, I didn't know I could vote but would like to vote. On 10/16/24 at 12:25 p.m. an interview was conducted with Resident #111 (R111). R111 said no one had spoken with her about voting from the facility. She said she was registered, wanted to vote and would like to do absentee ballot. On 10/16/24 at 12:30 p.m. an interview was conducted with Resident #113 (R113). R113 said that she was not registered to vote and does not know how to register. R113 said she would like to vote in this election. On 10/16/24 at 12:35 p.m. an interview was conducted with Resident #108 (R108). R108 said she wanted to vote and was registered to vote in another county. On 10/16/24 at 12:38 p.m. an interview was conducted with Resident #102 (R102). R102 said that no facility staff had spoken with him about voting. R102 said he was registered and wanted to vote. On 10/16/24 at 12:50 p.m., a telephone call was placed to the voter registration office in the locality where the facility was located. The registrar reported that the deadline for non-registered voters to register was yesterday by 5 p.m. As for residents who are registered at other locations, it would be up to the registrar at that locality as to if the resident can do an absentee ballot there or not. The registrar reported that the deadline for absentee ballots is that they must be received in their office by 5pm on Thursday, October 24, 2024, at 5 pm. On 10/16/24 at 3:00 p.m. an interview was conducted with the social service director. The social service director said she called the register's office yesterday and if the resident is registered that an absentee ballot can be completed and must be mailed out by Monday. The social worker director stated, that if the resident is not registered that we have missed that deadline, and the cutoff date was yesterday. The surveyor asked how the residents would see the notice about voting if they do not come out of their rooms and the social worker director said, we will go room to room and ask each resident about voting. On 10/16/24 at approximately 5:00 p.m. the administrator provided a document titled, Center for Clinical Standards and Quality, that was a CMS (Centers for Medicare and Medicaid services) document, and she stated, we have no voting policy this is all we have. The CMS document read in part, .certified long-term care facilities affirm and support the right of residents to vote. Nursing homes should have a plan to ensure residents can exercise their right to vote, whether in person, by mail, absentee ballot, or other authorized process. Assistance in registering to vote, requesting an absentee ballot or completing a ballot from an agent of the resident's choosing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The facility staff failed to provide residents with an environment to promote dignity on 1 of 2 units. On 10/15/24 at 2:30 p.m. an interview was conducted with Resident #104 (R104). R104 said she feels safe now and staff is good except some arguing. R104 said this morning that the unit manager was at the door screaming at the aide that was in the room with my roommate. R104 stated, I yelled to get out of here, close the door because it makes me anxious, and it bothers me. On 10/15/24 at 4:30 p.m. an interview was conducted with a licensed practical nurse, unit 3 manager, LPN# 5 (LPN5). LPN5 said that this morning she had words with certified nursing assistant, CNA #3 (CNA3). LPN#5 said that CNA3 started screaming at me. LPN5 said she told CNA3 it was her responsibility to chart on residents and CNA3 began arguing and LPN5 stated, I told her to stop I was not going to argue with her. LPN5 said she told CNA3 to clock out, leave and called the director of nursing (DON). LPN5 said CNA3 was in the resident's room and yelling, you have no control of me. LPN5 said CNA3 continued to work until her shift was done. On 10/16/24 at 4:45 an interview was conducted with the regional director of clinical services (RDCS). The RDCS said that they interviewed the resident after the incident, and we did not have anyone that stated they were fearful. On 10/15/24 at 5:00 p.m. an interview was conducted with the director of nursing (DON). The DON said that CNA3 worked until I came in this morning about 7:10 a.m. I had a conversation with CNA3 and CNA# 2 (CNA2), because she was a witness to the incident, and we had the conversation with the human resource director. On 10/15/24 at 5:20 p.m. an interview was conducted with the treatment nurse, LPN#7 (LPN7). LPN#7 said, at about 6:15 a.m. I don't know the aides name, but aide (CNA2) came up said I changed the resident and LPN#5 said you can tell me he had feces on his brief, but did you chart it, if not care has not been done. LPN7 said, then the other aide (CNA3) said I cannot get in to chart, and we told you a week ago and [LPN5's name redacted] said advocate for yourself, and it looks like you did not do your job. [LPN5's name redacted] said I am not human resources I cannot help you. Then, LPN5 said I am not going to argue with you and the aide (CNA3) said I don't know why you have such an attitude. The aide CNA3) went to the resident's room, had the door opened, was not closed all the way, and LPN5 and the aide (CNA3) were loud. LPN7 said she was just stepping in trying to calm the situation and support another manager. LPN7 said she had never witnessed other arguments on the floor but had heard that it happens. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 7:15 p.m. an interview was conducted with CNA#2. CNA2 said that she was getting CNA3 to help her with a resident's care. CNA2 reported that CNA3 went to the resident's room and opened the door and CNA3 yelled up to the nurse's station asking LPN5 why she was screaming at her. CNA2 said that LPN5 stood up out of her chair and began screaming at CNA3 to clock out. CNA2 reported that R104 yelled out for CNA3 to close the door and do that outside the door not in my room. CNA3 closed the door and she and LPN5 kept yelling and then finally they stopped and CNA3 came into the room with me to help me with Resident #122's (R122) care. While we were doing incontinence care for R122, LPN5 opened the resident's door and demanded CNA3 to come out of the room. CNA3 said to LPN5 I am providing care for a resident now and LPN5 just kept yelling for CNA3 to come out of the room and was getting louder and louder. CNA2 said R104 was sleeping when this argument started, and the resident appeared agitated. CNA2 said that R122 looked uncomfortable and all she could do was apologize to both residents. On 10/16/24 at 9:25 a.m. an interview was conducted with R104. R104 said that she was shocked by all the yelling. She said it made her anxious and agitated. R104 stated, an almost fist throwing happened about 2 weeks ago. R104 said the staff should be more respectful because it scares us! On 10/16/24 at 9:30 a.m. an interview was conducted with R122. R122 stated, they were talking loudly over me and saying come out here now. I could hear them arguing until [roommate's name redacted] told them to get out and shut the door. R122 said, It was a rough morning. I didn't like it, and it made me uncomfortable. It didn't involve me, so take it elsewhere. On 10/16/24 at 5:43 p.m. an end of day meeting was conducted with the administrator, director of nursing and regional director of clinical services. The above concerns were discussed. The facility administrator stated, we didn't know what was going on until you said something. The RDCS and administrator said that the reason they were not aware of the staff arguing, was that the DON was on a medication cart and then you all (surveyors) walked into the building, and it was forgotten. The RDCS and the administrator said it had been taken care of and reported they had suspended the employees involved, reported the incident as an allegation of abuse and are investigating. The administrator stated that R104 had been interviewed. When asked about the other resident, R104's roommate, the administrator stated, she wasn't interviewable. The facility administrator was made aware that according to R122's clinical record, she had a brief interview for mental status (BIMS) score of 15 out of 15 and had been able to communicate and answer questions with the surveyor. The survey team explained that R122 had been the resident staff were providing care to when the altercation had taken place. The facility administrator stated they would go talk with her immediately following the meeting/discussion with the survey team and that they were unaware R122 was involved. The facility reported that they did not have a facility policy with regards to staff interactions in resident care areas. The facility did provide the survey team with a document titled, Employee Guidebook, and on page 16 it read in part, Professional Courtesy and Customer Service . The company is committed in our efforts to provide a high standard of resident/patient care and excellent customer service, and in the communication that takes place during the workday. You are also expected to approach customers, clients, residents, patients and families in a professional, courteous and efficient manner . The facility also provided a document titled, Code of Ethics. Within that document excerpts read, The company will not tolerate: . Any other conduct that creates an intimidating or hostile work environment . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augusta Nursing & Rehab Center	83 Crossroads Lane Fishersville, VA 22939

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility provided a policy titled, Resident Rights, read in part .ensure that residents right are known to staff. Ongoing training on resident rights will be given to staff members as required by state and/or federal regulations. No additional information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41449 Based on observation, resident and staff interviews, clinical record review and facility documentation review, the facility staff failed to ensure medications were stored in a secure manner for two residents (Resident #114-R114 and Resident #126-R126) in a survey sample of 29 residents. The findings included: 1. For R114, the facility staff failed to ensure Vicks vapor rub, which was at the bedside unsecured, was stored appropriately. On 10/15/24 at approximately 10:45 a.m., during a tour of the resident, R114 was observed to have Vicks vapor rub at the bedside. When R114 was asked about the Vicks, the resident stated she applied it under her nose every night to prevent her nose from getting stopped up. On 10/15/24 at 2:20 p.m., an interview was conducted with registered nurse (RN #3). RN #3 was asked about R114's medications and stated, we give her, her medications. RN #3 went on to say that no medications should be at the patient's bedside. When asked about the Vicks vapor rub, RN #3 said, I can't speak to that, I don't leave medication at the bedside. RN #3 accompanied the surveyor to R114's room, observed the Vicks vapor rub and removed it. On 10/15/24 at approximately 2:25 p.m., RN #3 took the Vicks vapor rub to the nursing station, where the unit manager/licensed practical nurse #5 (LPN #5) was, told LPN #5 about it and LPN #5 stated, it has to come out, we have to find out where she is using it and if appropriate there is an assessment that has to be done for her to self-administer and it has to be done every three months. On 10/15/24, during a clinical record review of R114's chart, it was noted that there was no physician order for the use or administration of Vicks vapor rub. On 10/15/24, in the afternoon, during an interview with the director of nursing, when asked about medication storage, the DON stated that all medications should be stored securely in the medication cart. According to the facility policy titled, Medication Storage Guidance, provided to the survey team, it read in part on page 11, . safe and secure storage includes abiding by proper temperature controls as well as maintaining appropriate light and humidity exposure . On 10/15/24, during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided. 2. For R126, who had medication at the bedside, the facility staff failed to remove the medication and/or provide the resident with a means to securely store medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 4:43 p.m., R126's room was observed, noting that a 120 ml bottle of Ketoconazole Shampoo 2%, which had a pharmacy label, was on the bedside table On 10/17/24 at approximately 4:50 p.m., the director of nursing (DON), facility administrator, and a regional director of clinical services accompanied the surveyors to R126's room. The facility administration confirmed the medication at the bedside and stated that it should not be stored at the bedside, which could be accessible to anyone entering the room and they removed it. On 10/15/24, in the afternoon, during an interview with the director of nursing, when asked about medication storage, the DON stated that all medications should be stored securely in the medication cart. According to the facility policy titled, Medication Storage Guidance, provided to the survey team, it read in part on page 11, . safe and secure storage includes abiding by proper temperature controls as well as maintaining appropriate light and humidity exposure . On 10/18/24, during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41449 Based on observation, resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to administer the facility in a manner to effectively maintain the highest practicable well-being of each resident, having the potential to affect many residents on 2 of 2 nursing units. The findings included: 1. The facility administration failed to effectively administer/manage the facility to provide adequate supervision and a consistently functioning wander management system, to prevent residents with a known elopement risk the ability to exit the facility and facility grounds. According to multiple staff interviews, the facility administration was aware and had permitted residents identified as a wandering risk to exit the facility routinely. The administrator failed to ensure adequate supervision although it was known that the wander guard system didn't operate properly, which also permitted residents at risk for wandering to exit the facility without staff knowledge. On 10/15/24 and 10/16/24, an interview was conducted with R113. R113 reported to the surveyor that she used to go outside, sit on the porch and would at times walk off the facility premises to smoke. R113 also verbalized during the interview that she wanted to leave the facility and return home to live. On 10/15/24 and 10/16/24, a clinical record review was conducted. This review revealed several nursing note entries related to R113 going outside unassisted and unsupervised. The entries were on the following dates: 9/20/24, 9/23/24, 9/25/24, 9/26/24, and 10/2/24. On 10/2/24, R113 exited the facility, left the facility premises, fell into a drainage ditch, and crawled out of the ditch to the side of the road, where she was seen by a staff member who was driving to work, assisted off the ground, and driven back to the facility. On 10/16/24 at 12:24 p.m., an interview was conducted with licensed practical nurse #9 (LPN #9) who had written the nursing note dated 9/20/24, referenced above. LPN #9 was asked about the incident on 9/20/24 with R113. LPN #9 said, The CNA told me they thought she was out, as I was going down, the business office manager said, I just got [R113's name redacted] from the stop sign. They also handed me 2 cigarettes they had taken away. LPN #9 reported she was not sure how far R113 had gotten or the specific location she was retrieved from but had been told that R113 was at the end of the driveway. LPN #9 reported that at that time, R113 did not have a wander guard in place. On 10/16/24 at 11:19 a.m., an interview was conducted with registered nurse #3 (RN #3) who was the author of the nursing note dated 9/23/24. During the interview, RN #3 stated, I was in my car getting my blood pressure equipment and she [R113] was in the parking lot. I raised the concern, as I had heard she was an elopement risk, and I asked the other nurse when I came back in with her, since I am only part-time. She [R113] had told the nutrition lady she wanted to leave, she told her not to tell me, she wanted to go home and wanted to leave without permission. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 11:24 a.m., during an interview with other staff member #1 (OS #1), she reported that frequently the front door wander guard system doesn't function properly. OS #1 said, There are times she [R113] has it on and it [the door] doesn't go off, they check it, and have to make adjustments. It doesn't always go off. Earlier this week [resident #109's name redacted] went out and it didn't work. OS #1 reported that on 10/2/24, she was helping with answering the phones but was bouncing around and was not at the front desk/lobby when R113 went outside. OS #1 reported that she was on one of the nursing units helping a resident when R113 was brought back. OS #1 also stated, She [R113] is a difficult one, we never know when she has a wander guard or not. One day she has it and other days she doesn't. When asked if the administrator was aware that the wander guard was not functioning properly, OS #1 stated that the administrator was aware. On 10/16/24 at 12:28 p.m., an interview was conducted with Other Staff #2 (OS #2), who worked as a back-up receptionist. OS #2 reported that just a few weeks ago she was arriving about 1:10pm on a Sunday and saw R113 in the parking lot. OS #2 said, Since she [R113] had a wander guard on, she wasn't supposed to be outside. I told her she needed to come back inside because she had a fall, and I didn't want her to fall again. OS #2 reported that this was about 2-3 weeks ago. According to OS #2's timecard, she had worked 9/22/24, which was prior to R113's fall incident, and then worked again on Sunday, 10/6/24. OS #2 went on to state, They [administration] kept changing their minds, at one time they would let her go out on the porch, another time they said someone had to be with her. When asked about the door alarm and functioning OS #2 said, Sometimes the things don't go off; it is really sporadic. On 10/16/24 at 1:02 p.m., an interview was conducted with registered nurse #1 (RN #1). RN #1 was the nurse that wrote the progress note dated 10/2/24, regarding R113's fall while outside. RN #1 stated that she was told by CNA #6 that she brought her back in. RN #1 also stated that the RDCS had told her the same thing and reported that the receptionist had let the resident out. RN #1 reported that the resident was covered in mud, she had a wander guard on, and the receptionist turned the alarm off and let her out. I don't remember who told me that. Corporate said they are allowed to go out and whoever lets them out should go with the resident. On 10/16/24 at approximately 2:30 p.m., an interview was conducted with the maintenance assistant about the wander guard system. The maintenance assistant reported that he checks the door alarms daily and at times the front door's wander guard system doesn't work and they must make adjustments. On 10/16/24 at 3:27 p.m., an interview was conducted with the maintenance director about issues with the wander guard system. The maintenance director reported that in his short tenure of a few months that .once in a while the receptionist will say that when a resident goes out it doesn't alarm, and we have to make adjustments. On 10/16/24, the front door wander system was tested with the director of nursing (DON). The DON placed a wander guard into her sock, to mimic the location where the wander guard is placed on resident's ankle. The DON was able to walk through the lobby and open the front door, without the locking mechanism engaging to lock the door and prevent exit. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24, in the late afternoon, the front door was again tested using a wander guard by the maintenance director. Initially when the maintenance director had the device pass through the area, the sensor did not pick up the signal and made no alarm. On the second attempt, the alarm sounded, and the door locked. On the third attempt, the alarm sounded but the door remained unlocked, and a resident could have exited. On 10/16/24 at 5:43 p.m., during an end of day meeting with the facility administrator, director of nursing (DON), and regional director of clinical services (RDCS), the incident on 10/2/24, involving R113 was discussed. The facility administrator reported that she was not at the facility and was out of town at the time of the incident. When questioned further, the administrator went on to say that there wasn't a receptionist the day of the incident. When the survey team questioned that the nurse progress note indicated that the receptionist let the resident out, as well as the investigation summary, but both receptionists denied having done so, the Administrator and RDCS stated that they didn't know who had let R113 outside. On 10/17/24 at 9:19 a.m., the facility administrator was asked about the wander guard system. The administrator said, I am not aware of an issue. The survey team informed the administrator that multiple staff had reported that the wander guard system is inconsistent and doesn't always operate properly. The administrator was also informed that during the testing by the DON and maintenance director the day prior, the wander guard system had not functioned properly. The administrator then said, This is the first I've heard of it. I always thought there was a mag [magnetic] lock, if the door isn't closing enough, they may not latch. We just adjust those sensors on the side regularly. There is some sort of sensitivity, different things can affect it. That's usually what's going on. 2. The facility administration failed to ensure the resident's right to vote was being upheld, knowing a presidential election was upcoming. On 10/15/24 at 11:15 am, during the initial tour of the facility nursing units, Resident #114 (R114) and Resident #123 (R123) asked the surveyor if they were allowed to vote. R114 and R123 both stated that no one from the facility had talked with them about voting. R114 said, I want to vote and need to know what to do. R123 stated, I have a voter's card and would like to vote. On 10/15/24 at 11:40 am, an interview was conducted with the social service director. The social service director said she had only been in this position since 9/26/24. The social service director stated, If the resident is not registered to vote, then we will get them registered. When questioned about the lack of posted voting information, the social service director said, I will have the information hung up before the end of the day for the residents to see. When questioned about voting eligibility, the social service director stated that she had not contacted the register's office but would do so that day. On 10/15/24 at 11:50 a.m. an interview was conducted with the administrator. The administrator stated that the preparation for voting should begin the month of September. The administrator stated, Generally social services does the prep for voting but I didn't have anyone in social services for one month. The administrator stated if the residents were not registered, then we would fill out the registration forms so they can vote. The administrator stated the information for the right to vote should be posted. The administrator said, The residents can do an absentee ballot if they wanted to or go to the polls, we would take them there. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 4:30 p.m. an observation of the common areas was conducted. The survey team observed signs posted that read, If a resident was interesting in voting to see the social service director ASAP [as soon as possible]. The signs were posted in common areas on each unit at the bulletin boards at the nurse's station, outside the dining room, and in the vending machine area. On 10/16/24 at 9:00 a.m. a follow-up interview was conducted with R114 and R123. R114 and R123 verbalized that no one from the facility had talked with them about voting and that they wanted to vote. On 10/16/24 at 12:10 p.m. an interview was conducted with Resident #103 (R103). R103 stated that over a month ago, I asked the activity assistant about voting and I didn't get a response. R103 said that she wanted to vote and was registered in another county to vote, so she was not sure how that worked. R103 said no one from the facility had discussed voting with her. R103 stated, If you don't vote, you are part of the problem. When the surveyor asked about being transported to the location where she is registered to vote, R103 stated that it was 2 hours away. On 10/16/24 at 12:20 p.m. an interview was conducted with Resident #106 (R106). R106 stated, I didn't know I could vote but would like to vote. On 10/16/24 at 12:25 p.m. an interview was conducted with Resident #111 (R111). R111 said that no one had spoken with her about voting from the facility. R111 said that she was registered, wanted to vote, and would like to do absentee ballot. On 10/16/24 at 12:30 p.m. an interview was conducted with Resident #113 (R113). R113 said that she was not registered to vote and does not know how to register. R113 said that she would like to vote in this election. On 10/16/24 at 12:35 p.m. an interview was conducted with Resident #108 (R108). R108 said she wanted to vote and was registered to vote in another county. On 10/16/24 at 12:38 p.m. an interview was conducted with Resident #102 (R102). R102 said that no facility staff had spoken with him about voting. R102 said that he was registered and wanted to vote. On 10/16/24 at 12:50 p.m., a telephone call was placed to the voter registration office in the locality where the facility was located. The registrar reported to the surveyor that the deadline for non-registered voters to register was 5 p.m. yesterday, 10/15/24. As for residents who are registered at other locations, it would be up to the registrar at that locality as to whether the resident could do an absentee ballot there or not. The registrar reported that the deadline for absentee ballots is that they must be received in the local office by 5pm on Thursday, October 24, 2024, On 10/16/24 at approximately 5:00 p.m. the administrator provided a document titled, Center for Clinical Standards and Quality, that was a CMS (Centers for Medicare and Medicaid services) guidance for nursing home policies, and stated, We have no voting policy. This is all we have. This CMS document read in part, . certified long-term care facilities affirm and support the right of residents to vote. Nursing homes should have a plan to ensure residents can exercise their right to vote, whether in person, by mail, absentee ballot, or other authorized process. Assistance in registering to vote, requesting an absentee ballot or completing a ballot from an agent of the resident's choosing. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The facility administrator denied being aware of a disruptive staff argument that took place on the nursing unit, that continued into the room of two residents, with yelling and raised voices that awoke one resident and alarmed them both, until being notified by the survey team. On 10/15/24 at approximately 11 a.m., during an interview with Resident #104 (R104), the resident reported to the surveyor that she had been awakened by yelling that morning. I told them [the staff] to get out of my room, shut the door, and take it elsewhere! When questioned how the incident had made her feel, R104 reported that she had gotten anxious and didn't like it. On 10/15/24, during an end of day meeting, the facility administrator, director of nursing, and regional director of clinical services were made aware of Resident #104 reporting that staff had an argument that morning, which took place out on the unit and then continued into the resident's room. The facility administrator stated that was the first she was hearing of the incident. On 10/15/24 at 7:20 p.m., staff interviews were conducted with certified nursing assistants #2 and #3 (CNA #2 and CNA #3). Both CNA #2 and CNA #3 confirmed that on the morning of 10/15/24 at approximately 6:30-6:45 a.m., a disagreement had taken place at the nursing station between them and the unit manager/licensed practical nurse #5 (LPN #5). CNA #3 reported that she walked away and went to provide care to Resident #122 and that LPN #5 came to the room and started calling her to come out of the room with a raised voice. CNA #2 confirmed that LPN #5 had come to the resident's room and in a loud voice kept yelling for CNA #3 to exit the room. CNA #2 went on to report that R104 was awakened by the incident and shouted for them to get out & shut the door. CNA#2 stated that R#122 had looked very uncomfortable and that she had apologized to both residents. On the morning of 10/16/24 at approximately 8:40 a.m., an interview was conducted with R122. R122 reported that the CNA#2 and CNA#3 were providing care for her, when another staff member [LPN #5] had come to the room door and was yelling at CNA #3. On 10/16/24 at 5:43 p.m., during an end of day meeting, the facility administrator, director of nursing, and regional director of clinical services were asked what they had done with regards to the staff conflict. The facility administrator stated, We didn't know what was going on until you said something. We have suspended the employees involved, reported the incident as an allegation of abuse, and are conducting an investigation. The administrator stated that R104 had been interviewed. When asked about the other resident, R104's roommate, the administrator stated, she wasn't interviewable. When asked why she felt that R#122 was not interviewable, the administrator did not respond. The facility administrator was made aware that according to R122's clinical record, she had a brief interview for mental status (BIMS) score of 15 out of 15, indicating intact cognition, and had been able to communicate and answer questions appropriately with the surveyor. The survey team also informed the administrator that R122 was the resident to whom staff were providing care when the altercation had taken place. The facility administrator stated that they would go talk with her immediately following the meeting with the survey team and that they were unaware the roommate was involved. According to the facility job description of the Executive Director 1 (Administrator), which read in part, . The primary purpose of the Executive Director is to direct the day-to-day functioning of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to ensure that the highest degree of quality care can be provided to our residents at all times . You will also provide leadership to all facility staff in meeting the goal of providing quality resident care . (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No other information was provided prior to exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for two residents (resident #121- R121 and resident #113-R113) in a survey sample of 29 residents. The findings included: 1. For R121, who had been readmitted to the facility on [DATE], the facility staff failed to enter the resident's physician orders, nursing assessment and documentation of administration of medications into the correct clinical record, therefore leaving R121's record incomplete. On 10/15/24 at 2:06 p.m., R121 was visited in his room. R121 reported that he had just recently been readmitted to the facility following hospitalization for an ulcer in his esophagus that was bleeding. The surveyor noted that R121 had at the bedside an IV (intravenous) pole with an antibiotic of Zosyn 4.5 grams hanging. The antibiotic line set was dated 10/14 23:45 [10/14/24 at 11:45 p.m.]. On 10/15/24 at 2:11 p.m., an interview was conducted with the registered nurse #2 (RN #2), who confirmed she was R121's assigned nurse. When asked about R121, RN #2 stated the resident had returned last night. When asked about his IV antibiotic, RN #2 said, he got a dose at 6 this morning, night shift hung it. When asked how often it is scheduled, RN #2 stated, I don't know, every 6 hours, I think. He didn't get a noon dose, something has happened to his orders, and they just disappeared, and we have to resend everything, we already resubmitted them, my manager knows. On 10/15/24 at 2:13 p.m., an interview was conducted with the unit manager/licensed practical nurse #4 (LPN #4). When the unit manager was asked about R121, she said, they have been straightened out. When asked what the problem was, LPN #4 stated, I had to confirm the dosage of the two antibiotics, I had spoken with the pharmacy. On 10/15/24 at approximately 2:30 p.m., a clinical record review was conducted of R121's chart. This review revealed according to the census tab, R121 had been readmitted on [DATE]. According to the nursing progress notes the most recent entry was dated 10/11/24 at 1:46 p.m., that noted the resident was sent to the emergency room for not feeling well and abdominal pain and vomiting. There had been no notes indicating the resident had returned, his condition, etc. According to the assessment tab of the clinical record, there was no nursing assessment noted. The only assessments present since the resident's readmission was a therapy payer verification and a psychosocial evaluation, which was in progress. According to the physician orders, there were no orders for any medications and the only orders present were noted as incomplete and read as follows, Residents plan of care, drug regimen & specific orders have been reviewed and approved for 45 days and admit to facility skilled nursing facility. According to the medication administration record, there was no evidence of any medications, to include the Zosyn, having been administered since the resident's readmission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augusta Nursing & Rehab Center	83 Crossroads Lane Fishersville, VA 22939

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 2:35 p.m., an interview was conducted with the director of nursing (DON). The DON was asked about R121 and notified that the surveyor had been IV antibiotics hanging at the bedside and according to the clinical record there was not any physician orders for this medication, or any other medications or care. The DON stated that he [R121] was entered under the wrong person in the computer. The DON went on to explain that there was another resident with the same name who had only one letter difference in the spelling of the name and I noticed it when I came in this morning. I delegated this to anther nurse to be fixed. According to the facility policy titled, Content of the Clinical Records' it read in part, . Resident's medical record to contain the following information including but not limited to: record of the resident assessments ., pre-admission screening and resident reviews, evaluations, and determinations, physician, nurse and other licensed professionals' progress notes . current physician's orders are obtained from the attending physician on admission ., medication and treatment records, including records of oxygen administration, alcoholic beverages, and nutritional supplements will be documented . On 10/15/24 at 5:30 p.m., during an end of day meeting, the facility administrator, director of nursing and regional director of clinical services (RDCS) were made aware of the above findings. The RDCS reported that R121 had not missed any doses of the IV antibiotics, they [the facility staff] changed the administration times to ensure he received all required doses. On 10/16/24 at 12:09 p.m., R121's clinical record was again reviewed. It was noted that the facility staff had still not corrected R121's chart to reflect the medications administered to include the dose of Zosyn administered on 10/14/24 at 11:45 p.m. No additional information was provided. 2. For R113, the facility staff failed to document within the clinical record the assessment of the resident upon return to the facility following an elopement and sustaining a fall. On 10/15/24 and 10/16/24, during a review of R113's clinical record, it was noted that there was a nursing note entry on 10/2/24, that read, Resident had fall outside and was assisted back into facility by [staff name redacted], CNA and no injury noted. Wander guard is intact and was let out to set on front porch by receptionist and wander guard does work. On 10/16/24 and 10/17/24, the survey team conducted telephone interviews with certified nursing assistant #1 (CNA#1) who had found Resident #113, who had been wearing a wander guard, lying on the ground and had assisted R#113 back to the building on 10/2/24. On 10/16/24, CNA #1 stated that she had discovered R113 at 2:45 p.m., while driving to work, lying beside the road, off the facility property, unable to get up. CNA#1 stated that she had assisted Resident #113 up off the ground, into her jeep, and took Resident #113 back to the facility. According to CNA#1, Resident #113 was wet, had mud all over her, and required a shower. CNA#1 stated that upon entering the building with R113 she alerted staff, who had been unaware of R#113's absence or how long she was gone, and that there had been no audible alarm sounding at that time. On 10/16/24, the regional director of clinical services (RDCS), reported she was at the facility on 10/2/24, and upon the resident's return into the facility had advised the nurse to complete an assessment of R113. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation within the clinical record of an assessment being conducted other than a fall risk evaluation. On 10/18/24, during an end of day meeting, the facility administrator and regional director of clinical services were made aware of the above findings. On 10/18/24, following an end of day meeting, the RDCS provided the survey team with a copy of the incident report, which was not part of R113's clinical record which recorded some vital signs, that the resident reported no pain, etc. When asked if the expectation would have been for the assessment of the resident to be included in the chart, the facility administration stated yes. No further information was provided.