| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495336 | A. Building<br>B. Wing | 05/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Augusta Nursing and Rehabilitation | 83 Crossroad Lane<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident/staff interview facility, document review and clinical record review, it was determined the facility staff failed to implement the care plan for two of five residents in the survey sample, Residents #2 and #5.The findings include: 1.The facility staff failed to implement the comprehensive care plan providing snacks and monitoring meal intake for Resident #2 (R2).R8 was admitted to the facility on [DATE] with diagnosis that included but were not limited to Alzheimer's Disease, dementia and rheumatoid arthritisThe most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/14/26, coded the resident as scoring a 07 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for hygiene/bathing; requiring maximal assistance for locomotion/transfer/dressing and independent for eating.A review of the comprehensive care plan dated 12/10/25 revealed, FOCUS: Resident is at risk of altered nutritional status related to ulcer of esophagus with bleeding, hypothyroidism, hiatal hernia and protein calorie malnutrition. INTERVENTIONS: Provide and serve supplements as ordered. Provide, serve diet as ordered. Monitor intake and record every meal.A review of R2's ADL (activities of daily living record) for March 2026 to May 2026 revealed no evidence of snacks being provided or percent (%) of meal intake on the following days: 3/2, 3/5, 3/9, 3/10, 3/13, 3/16, 3/19, 3/20, 3/23, 3/24, 3/28, 3/29, 3/31, 4/7, 4/10, 4/11, 4/14, 4/22, 4/24, 4/25, 5/26, 4/30, 5/1, 5/4, 5/5 and 5/6. An interview was conducted on 5/6/26 at 11:00 AM with R2. Asked if she is provided with snacks between meals and at bedtime, R2 stated, once in a while the staff bring some food in.An interview was conducted on 5/6/26 at 2:45 PM with RN (registered nurse) #1. RN #1 described the care plan purpose, as identifying the specific needs and interventions to meet those needs for each resident. Asked if interventions are not followed, has the care plan been implemented, RN #1 stated, no, it was not implemented.On 5/7/26 at 2:30 PM, the Executive Director and the Director of Clinical Services were made aware of the findings. A review of the facility's Comprehensive Care Plan policy revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.No further information was provided prior to exit. 2. The facility staff failed to implement the comprehensive care plan providing snacks and monitoring meal intake for Resident #5 (R5).R5 was admitted to the facility on [DATE] with diagnosis that included but were not limited to DM (diabetes mellitus) and pneumonitis due to inhalation of food or vomit.The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/13/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being independent for locomotion/transfer/dressing/toileting/bathing/eating and<br>(continued on next page) |

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

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

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | hygiene.A review of the comprehensive care plan dated 12/28/23 revealed, FOCUS: Resident has is at nutritional risk related to Type 2 DM (diabetes mellitus), CKD (chronic kidney disease) and GERD (gastro-esophageal disease). INTERVENTIONS: Provide, serve diet as ordered. Monitor intake and record every meal. Offer substitutes for foods not eaten.A review of R5's ADL (activities of daily living record) for March 2026 to May 2026 revealed no evidence of snacks being provided or percent (%) of meal intake on the following days: 3/2, 3/5, 3/9, 3/10, 3/13, 3/14, 3/16, 3/19, 3/20, 3/24, 3/27, 3/28, 3/29, 3/30, 3/31, 4k/7, 4/10, 4/11, 4/16, 4/20, 4/22, 4/24, 4/25, 4/26, 4/30 and 5/5.An interview was conducted on 5/6/26 at 11:45 AM with R5. Asked if he is provided snacks between meals and at bedtime, R5 stated, No, there are no snacks provided; with diabetes, I should have a bedtime snack, and they do not bring it into me. They may have one half peanut butter sandwich, but no other snacks.An interview was conducted on 5/6/26 at 2:45 PM with RN (registered nurse) #1. RN #1 described the care plan purpose, as identifying the specific needs and interventions to meet those needs for each resident. Asked if interventions are not followed, has the care plan been implemented, RN #1 stated, no, it was not implemented.On 5/7/26 at 2:30 PM, the Executive Director and the Director of Clinical Services were made aware of the findings. No further information was provided prior to exit. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>Based on clinical record review and staff interview, facility staff failed to provide ADL (activites of daily living) care for one of five residents in the survey sample, Resident #3.The findings include:For Resident #3 (R3), facility staff failed to ensure independent feeding skills did not dimmish by documenting level of assistance and percentage of food consumed during breakfast, lunch or dinner.R3 was admitted to the facility with a diagnosis that included but not limited to depression.On the most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 05/03/2026, R3 scored 15 of 15 on the BIMS (brief interview for mental status), indicating R3 was cognitively intact for making daily decisions. Section GG Functional Abilities coded R4 as requiring Setup or Clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following activity.The ADL sheet dated May 2026 for R3 documented in part, Eating. 0900, 1300 and 1800. Further review of the ADL sheet for eating failed to evidence documentation regarding R3's level of assistance, and the percentage of the meal consumed in nine of 19 opportunities.On 05/06/2026 at approximately 3:31 p.m. an interview was conducted with CNA (certified nursing assistant) #1. When asked how they evidence the resident's level of assistance during a meal and the percentage of the meal consumed she stated that it is documented on the ADL record.On 05/07/2026 at approximately 8:00 a.m. an interview was conducted with CNA #5. When asked how they evidence the resident's level of assistance during a meal and the percentage of the meal consumed she stated that it is documented on the ADL record.On 05/07/2026 at approximately 8:20 a.m. an interview was conducted with CNA#6. When asked how they evidence the resident's level of assistance during a meal and the percentage of the meal consumed she stated that it is documented on the ADL record.The facility's policy Activities of Daily Living (ADLs) documented in part, Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.On 05/07/2026 at approximately 12:47 p.m. the facility Executive Director and Director of Clinical Services were made aware of the above findings.No further information was provided prior to exit. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview and clinical record review, facility staff failed to provide ADL (activities of daily living) for dependent residents for two of five residents in the survey sample, Resident #4 and #1.The finding include:1. For Resident #4 (R4), facility staff failed to ensure independent feeding skills did not dimmish by documenting level of assistance and percentage of food consumed during breakfast, lunch or dinner.<br><br>R4 was admitted to the facility with a diagnosis that included but not limited to chronic obstructive pulmonary disease (1) and dysphagia (2).<br><br>On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/06/2026, R4 scored 2 (two) of 15 on the BIMS (brief interview for mental status), indicating R4 was severely impaired of cognition for making daily decisions. Section GG Functional Abilities coded R4 as requiring Setup or Clean-up assistance – Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following activity.<br><br>The ADL (activities of daily living) sheet dated February 2026 for R4 documented in part, Eating. 0900 (9:00 a.m.), 1300 (1:00 p.m.) and 1800 (6:00 p.m.). Further review of the ADL sheet for eating failed to evidence documentation regarding R4's level of assistance, and the percentage of the meal consumed in 40 of 84 opportunities.<br><br>The ADL sheet dated March 2026 for R4 documented in part, Eating. 0900, 1300 and 1800. Further review of the ADL sheet for eating failed to evidence documentation regarding R4's level of assistance, and the percentage of the meal consumed in 48 of 93 opportunities.<br><br>The ADL sheet dated April 2026 for R4 documented in part, Eating. 0900, 1300 and 1800. Further review of the ADL sheet for eating failed to evidence documentation regarding R4's level of assistance, and the percentage of the meal consumed in 25 of 39 opportunities.<br><br>On 05/06/2026 at approximately 3:31 p.m. an interview was conducted with CNA (certified nursing assistant) #1 regarding R4. CNA #1 stated she worked two times a week and every other weekend and had frequently provided care to R4. When asked about R4's ability to eat she stated R4 usually required verbal prompts to feed herself during breakfast and sometimes required total assistance and would sometimes feed R4. When asked how they evidence the resident's level of assistance during a meal and the percentage of the meal consumed she stated that it is documented on the ADL record.<br><br>On 05/07/2026 at approximately 8:00 a.m. an interview was conducted with CNA #5 regarding R4. CNA #5 stated she took care of R4 a few times. When asked about R4's ability to eat she stated R4 was dependent on staff to feed R4 but was independent with finger foods (i.e. small sandwiches. The daughter would come in at lunchtime, and the son would come in at dinner time, feed R4 and when they finished feeding R4 they give the tray back after the meal was completed and we (CNAs) would document the level of assistance, and the percentage R4 ate. When asked how they evidence the resident's level of assistance during a meal and the percentage of the meal consumed she stated that it is documented on the ADL record.<br><br>On 05/07/2026 at approximately 8:20 a.m. an interview was conducted with CNA#6 regarding R4. She stated she provided care on regular bases to R4 during 7:00 a.m. to 7:00 p.m. shift. She stated R4 (continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | could eat independently given some prompting and sometimes R4 was dependent on staff to feed her. When asked how they evidence the resident's level of assistance during a meal and the percentage of the meal consumed she stated that it is documented on the ADL record.<br><br>On 05/07/2026 at approximately 8:38 a.m. an interview was conducted with the ADON (assistant director of nursing) regarding R4. She stated she assist R4 with a few meals and R4 could feed herself with minimal assistance, her food needed to be cut up into bite size piece, assistance with loading the food on a fork or spoon, place it in R4's hand and she would bring it to her mouth to feed self. She stated R4 was independent with finger foods (i.e. sandwiches, cookies, etc ). She stated the family would come in and feed R4 for lunch and dinner every day (seven days a week). When asked how they evidence the resident's level of assistance during a meal and the percentage of the meal consumed she stated that it is documented on the ADL record.<br><br>The facility's policy Activities of Daily Living (ADLs) documented in part, Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.<br><br>On 05/07/2026 at approximately 12:47 p.m. the facility Executive Director and Director of Clinical Services were made aware of the above findings.<br><br>No further information was provided prior to exit.<br><br>Reference:<br><br>(1) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.<br><br>(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.<br><br>2. The facility staff failed to provide ADL (activities of daily living) specifically feeding assistance for a dependent resident, Resident #1 (R1).<br><br>R1 was admitted to the facility on [DATE] with diagnosis that included but were not limited fracture of left ulna, neuropathy and hepatic encephalopathy.<br><br>The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 4/21/26, coded the resident as scoring an 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for locomotion/transfer/dressing/toileting and hygiene; assistance with meals.<br><br>A review of the comprehensive care plan dated 4/28/26 revealed, FOCUS: Resident has nutritional problem or potential nutritional problem related to diagnosis of hepatic encephalopathy, metabolic encephalopathy, cirrhosis of liver, fatty liver and significant weight loss. INTERVENTIONS: Provide, serve diet as ordered. Monitor intake and record every meal.<br><br>A review of the 5/5/26 diet order revealed, Regular diet, Mechanical Soft texture, Regular/Thin liquids consistency.<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of R1's ADL (activities of daily living) record reveals missing evidence of percent eating on following dates: 3/5, 3/7, 3/8, 3/13, 3/15, 3/17, 3/18, 3/26, 3/30, 4/1, 4/2, 4/5, 4/6, 4/8, 4/9, 4/10, 4/12, 4/22, 4/23, 4/24, 4/25, 4/27, 4/28, 4/29, 5/1, 5/3, 5/4, 5/5 and 5/6.<br><br>A review of the mini nutrition progress note dated 1/23/26 at 8:09 AM revealed, Resident has no decrease in food intake in the last 3 months. Mini Nutrition Score: The score is:11.0 (8 - 11 points: At risk of malnutrition).<br><br>A review of the mini nutrition progress note dated 4/20/26 at 3:47 PM revealed, Resident has no decrease in food intake in the last 3 months. Weight loss greater than 3kg (6.6 pounds) in the last 3 months. Mini Nutrition Score: The score is:7.0 (0 - 7 points: Malnourished).<br><br>A review of the progress note dated 5/5/26 at 7:10 PM revealed, Residents' sister POA (power of attorney) in facility and requested residents' diet be changed to mechanical soft- due to risk of aspiration. New order noted, POA made aware, diet slip updated and taken to dietary manager.<br><br>A review of the LPN (licensed practical nurse) progress note dated 5/6/26 at 9:00 AM revealed, This writer offered resident her breakfast tray, resident refused. This writer offered to feed resident, resident continued to refuse.<br><br>A review of the LPN progress note dated 5/6/26 at 1:58 PM revealed, This writer offered resident her lunch tray, resident refused. This writer offered to feed resident, resident continued to refuse.<br><br>On 5/6/26 at approximately 12:00 PM, lunch trays were being passed. R1 was in bed sleeping with no lunch tray on bedside table. The 200-unit nursing station included CNA (certified nursing assistant) #4 and LPN (licensed practical nurse) #1. When asked about R1's lunch tray, LPN #1 stated, the family asked us not to feed the resident, there was a note about it last evening. When asked if there was a physician order, LPN #1 stated, no, the resident is in hospice. When asked who had asked the resident if she wanted to eat, CNA #4 stated, she said no, no, no. She did not want to eat.<br><br>On 5/7/26 at 8:00 AM, an interview was conducted with CNA #5 who stated, there is a lack of communication about what residents are feeders. It is not clear from nursing staff or in documentation.<br><br>On 5/7/26 at 9:00 AM, an interview was conducted with R1's sister-POA who stated, My sister cannot use a knife and a fork, that is why I requested a soft diet and for her to be fed.<br><br>On 5/7/26 at 9:05 AM, an interview was conducted with Assistant Director of Clinical Services, who stated, if a resident refuses a meal, the CNA is to document it as a refusal and tell the nurses who then write a progress note. CNA #4 is on light duty. She would absolutely have access to document a resident meal refusal. In PCC (point click care) there is a section for eating, there are multiple questions, so they will select answer if they what assistance is needed and should be documented for every meal; that is the evidence that they were assisted in some way.<br><br>On 5/7/26 at 9:55 AM, an interview was conducted with CNA #4 who stated, Meal trays are passed to residents and documentation is in PCC. If the resident refuses a meal tray I deliver, then I document in PCC. Yesterday, R1 stated, no, no, I do not want that when I offered her the lunch tray.<br><br>On 5/7/26 at 2:30 PM, the Executive Director and the Director of Clinical Services were made aware<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | of the findings.<br><br>No further information was provided prior to exit. |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to provide snacks at bedtime to diabetic residents and snacks to general residents for four of five residents in the survey sample, Residents #2, #5, #3 and #4. The findings include: 1.The facility staff failed to provide snacks for Resident #2 (R2).<br><br>5/6/26 at 2:00 PM observation of unit nourishment pantries: Hall 400-no snacks, Hall 300-seven Peanut butter (PB) sandwiches, seven mighty shakes, two vanilla ice cream, Hall 200-four chocolate cakes.<br><br>5/7/26 at 7:50 AM, observation of unit nourishment pantries: Hall 400-no snacks, Hall 300- eight packs chocolate cakes, two vanilla ice cream, ten mighty shakes, three one-half peanut butter (PB) sandwiches, Hall 200- eight packs chocolate cakes, seven mighty shakes, five one-half PF sandwiches.<br><br>R2 was admitted to the facility on [DATE] with diagnosis that included but were not limited to Alzheimer's Disease, dementia and rheumatoid arthritis<br><br>The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/14/26, coded the resident as scoring a 07 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for hygiene/bathing; requiring maximal assistance for locomotion/transfer/dressing and independent for eating.<br><br>A review of the comprehensive care plan dated 12/10/25 revealed, FOCUS: Resident is at risk of altered nutritional status related to ulcer of esophagus with bleeding, hypothyroidism, hiatal hernia and protein calorie malnutrition. INTERVENTIONS: Provide and serve supplements as ordered. Provide, serve diet as ordered. Monitor intake and record every meal.<br><br>A review of R2's ADL (activities of daily living record) for March 2026 to May 2026 revealed no evidence of snacks being provided or percent (%) of meal intake on the following days: 3/2, 3/5, 3/9, 3/10, 3/13, 3/16, 3/19, 3/20, 3/23, 3/24, 3/28, 3/29, 3/31, 4/7, 4/10, 4/11, 4/14, 4/22, 4/24, 4/25, 5/26, 4/30, 5/1, 5/4, 5/5 and 5/6.<br><br>An interview was conducted on 5/6/26 at 11:00 AM with R2. Asked if she is provided with snacks between meals and at bedtime, R2 stated, once in a while the staff bring some food in.<br><br>An interview was conducted on 5/6/26 at 2:35 PM with CNA (certified nursing assistant) #3, who stated snacks are kept in the nourishment pantry. If they are not on the unit, snacks are in the kitchen and are obtained there. Dietary is to stock the pantries with snacks. If there were no snacks, she would pay for something for the resident out of the vending machine. The residents should be getting snacks between meals.<br><br>An interview was conducted on 5/6/26 at 3:00 PM with the dietary manager. Asked about resident<br>(continued on next page) |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | snacks, the dietary manager stated, snacks come from the kitchen twice a day, a tray of snacks is put at the nursing station, and the nursing staff distributes them to the residents. Snacks are mainly PBJ (peanut butter jelly), some turkey/cheese, ham/cheese if I have it on hand, oatmeal cream cookies. This is just for the diabetic residents. The kitchen does not provide snacks for the whole building.<br><br>An interview was conducted on 5/6/26 at 3:30 PM with CNA #1, asked about resident snacks, CNA #1 stated, residents are offered snacks if they are stocked. The kitchen stocks the nutrition rooms on their units. On night shifts 7PM-7AM, if there were no snacks, and a resident wanted a snack, and there was not any, she would pay for the snack from the vending machine out of money that is hers. In the kitchen, the snacks would be in dry storage area.<br><br>On 5/6/26 at 3:45 PM, a review of the dry storage area of the kitchen revealed no snack crackers, cookies or any other variation.<br><br>On 5/7/26 at 8:20 AM, Resident #2 stated, there was no snack last evening.<br><br>On 5/7/26 at 2:30 PM, the Executive Director and the Director of Clinical Services were made aware of the findings.<br><br>A review of the facility's Snack policy revealed, Snacks and beverages will be provided as identified in the individual plans of care. Bedtime snacks will be provided for all residents. Additional snacks and beverages will be available upon request for all residents who want to eat at non-traditional times. The Dining Services Department assembles on a daily basis, snack items (food and beverages) for delivery to each resident/patient care area. The Dining Services Department will assemble and deliver to each unit the individually planned snack items and bulk snack items to be offered at bedtime.<br><br>No further information was provided prior to exit.<br><br>2. The facility staff failed to provide snacks for Resident #5 (R5).<br><br>5/6/26 at 2:00 PM observation of unit nourishment pantries: Hall 400-no snacks, Hall 300-seven Peanut butter (PB) sandwiches, seven mighty shakes, two vanilla ice cream Hall 200-four chocolate cakes.<br><br>5/7/26 at 5/7/26 7:50 AM, observation of unit nourishment pantries: Hall 400-no snacks, Hall 300-eight packs chocolate cakes, two vanilla ice cream, ten mighty shakes, three one-half peanut butter (PB) sandwiches, Hall 200- eight packs chocolate cakes, seven mighty shakes, five one-half PB sandwiches.<br><br>R5 was admitted to the facility on [DATE] with diagnosis that included but were not limited to DM (diabetes mellitus) and pneumonitis due to inhalation of food or vomit.<br><br>The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/13/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being independent for locomotion/transfer/dressing/toileting/bathing/eating and hygiene.<br>(continued on next page) |

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|---|---|---|---|
| | 495336 | A. Building<br>B. Wing | 05/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Augusta Nursing and Rehabilitation | 83 Crossroad Lane<br>Fishersville, VA 22939 |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A review of the comprehensive care plan dated 12/28/23 revealed, FOCUS: Resident has is at nutritional risk related to Type 2 DM (diabetes mellitus), CKD (chronic kidney disease) and GERD (gastro-esophageal disease). INTERVENTIONS: Provide, serve diet as ordered. Monitor intake and record every meal. Offer substitutes for foods not eaten.<br><br>A review of R5's ADL (activities of daily living record) for March 2026 to May 2026 revealed no evidence of snacks being provided or percent (%) of meal intake on the following days: 3/2, 3/5, 3/9, 3/10, 3/13, 3/14, 3/16, 3/19, 3/20, 3/24, 3/27, 3/28, 3/29, 3/30, 3/31, 4k/7, 4/10, 4/11, 4/16, 4/20, 4/22, 4/24, 4/25, 4/26, 4/30 and 5/5.<br><br>An interview was conducted on 5/6/26 at 11:45 AM with R5. Asked if he is provided snacks between meals and at bedtime, R5 stated, No, there are no snacks provided; with diabetes, I should have a bedtime snack, they do not bring it and even if I ask for it, they often do not have snacks. Only snack provided is one half peanut butter sandwich, but no other snacks.<br><br>An interview was conducted on 5/6/26 at 2:35 PM with CNA (certified nursing assistant) #3, who stated snacks are kept in nourishment pantry. If they are not on the unit, snacks are obtained from the kitchen. Dietary is to stock the pantries with snacks. If there were no snacks, she would pay for something for the resident out of the vending machine. The residents should be getting snacks between meals.<br><br>An interview was conducted on 5/6/26 at 3:00 PM with the dietary manager. Asked about resident snacks, the dietary manager stated, snacks come from the kitchen twice a day, a tray of snacks is put at the nursing station, and the nursing staff distributes them to the residents. Snacks are mainly PBJ (peanut butter jelly), some turkey/cheese, ham/cheese if I have it on hand, oatmeal cream cookies. This is just for the diabetic residents. Snacks are not provided for the whole building.<br><br>An interview was conducted on 5/6/26 at 3:30 PM with CNA #1, asked about resident snacks, CNA #1 stated, residents are offered snacks if they are stocked. The kitchen stocks the nutrition rooms on their units. On night shifts 7PM-7AM, there are often no snacks, and a resident wanted a snack, and there was not any, she would pay for the snack from the vending machine. In the kitchen, the snacks would be in dry storage area.<br><br>On 5/6/26 at 3:45 PM, a review of the dry storage area of the kitchen revealed, no snack crackers, cookies or any other variation.<br><br>On 5/7/26 at 8:45 AM, Resident #5 stated, there was no snack last evening.<br><br>On 5/7/26 at 2:30 PM, the Executive Director and the Director of Clinical Services were made aware of the findings.<br><br>No further information was provided prior to exit.<br><br>4. For Resident #3 (R3), facility staff failed to offer snacks.<br><br>R3 was admitted to the facility with a diagnosis that included but not limited to depression.<br><br>On the most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 05/03/2026, R3 scored 15 of 15 on the BIMS (brief interview for<br>(continued on next page) |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | mental status), indicating R3 was cognitively intact for making daily decisions.<br><br>The ADL (activities of daily living) sheet dated May 2026 for R3 documented in part, HS (at hours of sleep) Snack 1900 to 0700 (7:00 p.m-7:00 a.m.). Further review revealed that R3 was not offered a snack during 7:00 p.m-7:00 a.m. in two of six opportunities.<br><br>On 05/06/2026 at approximately 1:40 p.m. an interview was conducted with R3 regarding snacks. She stated she is not always offered a snack during the day or in the evening.<br><br>On 05/06/2026 at approximately 2:00 p.m. an observation of the facility's nourishment rooms revealed the following: Unit 200 – four small chocolate snack cakes; Unit 300 - seven peanut butter sandwiches, seven mighty shakes, two vanilla ice cream cups and Unit 400 – no evidence of any snacks.<br><br>On 05/06/2026 at approximately 3:40 p.m. an observation of the facility's dry storage room failed to evidence a supply of snacks, such as chips, crackers, cookies, etc, for residents.<br><br>On 05/07/2026 at approximately 7:50 a.m. observation of the facility's nourishment rooms revealed the following: Unit 200 - eight small packs of chocolate snack cakes; Unit 300 - eight small packs of chocolate snack cakes, two vanilla ice cream cups, ten mighty shakes, three one-half peanut butter sandwiches.<br><br>On 05/06/2026 at approximately 2:58 p.m. interview was conducted with the facility's Dietary Manager regarding the availability of snacks for the facility's residents. He stated that a tray of snacks such as sandwiches, peanut butter and jelly and /or cold cuts, and oatmeal cream cookies, are taken to the nurse's stations at approximately 2:00 and 7:00 p.m. and the nurses distribute them to the diabetic residents. When asked about other types of snacks for the rest of the facility's residents he stated he does not provide snacks for the whole building.<br><br>On 05/06/2026 at approximately 3:31 p.m. an interview was conducted with CNA (certified nursing assistant) #1 regarding snacks. When asked about snacks for residents who were not diabetics, she stated that residents would receive snacks only if the facility had any snacks and they were kept in nutrition rooms on the hallways. She stated that the facility did not always have snacks for the residents. When asked who stocked the nutrition rooms, she stated the kitchen staff were responsible for stocking the nutrition rooms. She further stated that on the weekends when she worked on during the 7:00 p.m. to 7:00 a.m. shift on Saturdays and Sundays, if a resident wanted a snack and if the nourishment room did not have any and she would check the dry storage room in the kitchen and if there were no snacks there she would get the resident something from the vending machine using her own money. When asked how they evidence a resident is offered a snack she stated that it is documented on the ADL record.<br><br>On 05/07/2026 at approximately 8:00 a.m. an interview was conducted with CNA #5 regarding snacks. She stated that she works the 7:00 a.m.- 3:00 p.m. shift and had not seen any snacks given out or supplied in the nutrition room on the unit. She further stated if a resident asked for a snack she would go to the kitchen and ask for something or if they had their own snacks in their room she would provide those snacks to the resident. When asked how they evidence a resident is offered a snack she stated that it is documented on the ADL record.<br><br>On 05/07/2026 at approximately 8:45 a.m. an interview was conducted with the facility's ADCS<br>(continued on next page) |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | (Assistant Director of Clinical Services) regarding snacks for residents who are not diabetic. She stated snacks are offered to the residents by the nursing staff twice daily, in the afternoon and evening, around the residents' bedtime usually around 8:00 p.m.to 9:00 p.m. She stated snacks were stocked in the nourishment rooms on each unit by the dietary staff. She further stated if the nourishment room run out of snacks, the staff can access additional snacks in the facility's dry storage room and freezer in the kitchen. At approximately 8:50 a.m. an observation of the inside of the cabinets, drawers, refrigerator and freezer inside the facility's nourishment room on Unit 400 was conducted with ADCS. She stated that there were no snacks or drinks stocked anywhere inside the nourishment room. At approximately 8:52 a.m. an observation of the inside of the cabinets, drawers, refrigerator and freezer inside the facility's nourishment room on Unit 200 was conducted with ADCS. The observation revealed eight packages of chocolate covered rolled cakes with cream filling approximately 3.4 ounces for each package. Further observation within the room failed to evidence any other type of snacks or drinks. When asked if the snacks described above were adequate for the residents ADCS stated no. At approximately 9:00 a.m. an observation of the facility's Dry storage room within the facility kitchen was observed with ADCS. [NAME] examining the stock in the dry storage room ADCS stated that there were no supplies of any type of snacks or snack drinks. ADCS stated that staff could also obtain ice cream for residents as a snack if they preferred it and that the staff could obtain the ice cream from the walk-in freezer in the facility kitchen. Observation of the inside of the walk-in freezer with ADCS revealed a box of vanilla and chocolate individual ice cream cups, three ounces each. After completing the observation stated above, ADCS was asked if there were enough snacks and variety of snacks and drinks to meet the needs of the facility's residents, she stated no.<br><br>On 05/07/2026 at approximately 12:47 p.m. the facility Executive Director and Director of Clinical Services were made aware of the above findings.<br><br>No further information was provided prior to exit.<br><br>5. For Resident #4 (R4), facility staff failed to offer snacks.<br><br>R4 was admitted to the facility with a diagnosis that included but not limited to swallowing difficulties.<br><br>On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/06/2026, R4 scored 2 (two) of 15 on the BIMS (brief interview for mental status), indicating R4 was severely impaired of cognition for making daily decisions.<br><br>On 05/06/2026 at approximately 2:00 p.m. an observation of the facility's nourishment rooms revealed the following: Unit 200 – four small chocolate snack cakes; Unit 300 - seven peanut butter sandwiches, seven mighty shakes, two vanilla ice cream cups and Unit 400 – no evidence of any snacks.<br><br>On 05/06/2026 at approximately 3:40 p.m. an observation of the facility's dry storage room failed to evidence a supply of snacks, such as chips, crackers, cookies, etc, for residents.<br><br>On 05/07/2026 at approximately 7:50 a.m. observation of the facility's nourishment rooms revealed the following: Unit 200 - eight small packs of chocolate snack cakes; Unit 300 - eight small packs of chocolate snack cakes, two vanilla ice cream cups, ten mighty shakes, three one-half peanut butter sandwiches.<br>(continued on next page) |

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|---|---|
| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 05/06/2026 at approximately 2:58 p.m. interview was conducted with the facility's Dietary Manager regarding the availability of snacks for the facility's residents. He stated that a tray of snacks such as sandwiches, peanut butter and jelly and /or cold cuts, and oatmeal cream cookies, are taken to the nurse's stations at approximately 2:00 and 7:00 p.m. and the nurses distribute them to the diabetic residents. When asked about other types of snacks for the rest of the facility's residents he stated he does not provide snacks for the whole building.<br><br>On 05/06/2026 at approximately 3:31 p.m. an interview was conducted with CNA (certified nursing assistant) #1 regarding snacks for R4. She could not recall R4 receiving snacks. When asked about snacks for residents who were not diabetics, she stated that residents would receive snacks only if the facility had any snacks and they were kept in nutrition rooms on the hallways. She stated that the facility did not always have snacks for the residents. When asked who stocked the nutrition rooms, she stated the kitchen staff were responsible for stocking the nutrition rooms. She further stated that on the weekends when she worked on during the 7:00 p.m. to 7:00 a.m. shift on Saturdays and Sundays, if a resident wanted a snack and if the nourishment room did not have any and she would check the dry storage room in the kitchen and if there were no snacks there she would get the resident something from the vending machine using her own money. When asked how they evidence a resident is offered a snack she stated that it is documented on the ADL record.<br><br>On 05/07/2026 at approximately 8:00 a.m. an interview was conducted with CNA #5 regarding snacks for R4. She could not recall R4 receiving snacks. She stated that she works the 7:00 a.m.- 3:00 p.m. shift and had seen any snacks given out or supplied in the nutrition room on the unit. She further stated if a resident asked for a snack she would go to the kitchen and ask for something or if they had their own snacks in their room she would provide those snacks to the resident. When asked how they evidence a resident is offered a snack she stated that it is documented on the ADL record.<br><br>On 05/07/2026 at approximately 8:45 a.m. an interview was conducted with the facility's ADCS (Assistant Director OF Clinical Services) regarding snacks for residents who are not diabetic. She stated snacks are offered to the residents by the nursing staff twice daily, in the afternoon and evening, around the resident's bedtime usually around 8:00 p.m. to 9:00 p.m. She stated snacks were stocked in the nourishment rooms on each unit by the dietary staff. She further stated if the nourishment room run out of snacks, the staff can access additional snacks in the facility's dry storage room and freezer in the kitchen. At approximately 8:50 a.m. an observation of the inside of the cabinets, drawers, refrigerator and freezer inside the facility's nourishment room on Unit 400 was conducted with ADCS. She stated that there were no snacks or drinks stocked anywhere inside the nourishment room. At approximately 8:52 a.m. an observation of the inside of the cabinets, drawers, refrigerator and freezer inside the facility's nourishment room on Unit 200 was conducted with ADCS. The observation revealed eight packages of chocolate covered rolled cakes with cream filling approximately 3.4 ounces for each package. Further observation within the room failed to evidence any other type of snacks or drinks. When asked if the snacks described above were adequate for the residents ADCS stated no. At approximately 9:00 a.m. an observation of the facility's Dry storage room within the facility kitchen was observed with ADCS. [NAME] examining the stack in the dry storage room ADCS stated that there were no suppl of any type of snacks or snack drinks. ADCS stated that staff could also obtain ice cream for residents as a snack if they preferred it and that the staff could obtain the ice cream from the walk-in freezer in the facility kitchen. Observation of the inside of the walk-in freezer with ADCS revealed a box of vanilla and chocolate individual ice cream cups, three ounces each. After completing the observation stated above, ADCS was asked if there were enough snacks and variety of snacks and drinks to meet the needs of the facility's residents, she stated no.<br>(continued on next page) |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 05/07/2026 at approximately 12:47 p.m. the facility Executive Director and Director of Clinical Services were made aware of the above findings.<br><br>No further information was provided prior to exit. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, staff interview and facility document review, the facility staff failed to prepare food in a sanitary manner in one of one facility kitchens.The findings include:On 05/06/2026 at approximately 9:40 a.m. an observation of the facility's kitchen revealed the Dietary Manager plating and covering slices of caramel apple cake for the resident's dessert and did not have his mustache covered. On 05/06/2026 at approximately 11:08 a.m. an observation of the Dietary Manager making peanut butter protein drinks for the resident's and did not have his mustache covered.On 05/06/2026 at approximately 2:58 p.m. interview was conducted with the facility's Dietary Manager regarding the purpose of hair, beard and mustache guard he stated that they were worn to prevent hair from falling into food. After informed of the above observation he stated he should have had his mustache covered.The facility's policy Staff Attire documented in part, Policy Statement. All employees wear approved attire for the performance of their duties.On 05/07/2026 at approximately 12:47 p.m. the facility Executive Director and Director of Clinical Services were made aware of the above findings.No further information was provided prior to exit. |