STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495344	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kings Daughters Community Health & Rehab	1410 North Augusta Street Staunton, VA 24401

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and clinical record review, the facility staff failed to follow professional standards of care during medication administration for one of eleven residents (Resident #11).The findings include:A medication pass observation was conducted on 12/16/25 at 8:25 a.m. with licensed practical nurse (LPN #2) administering medications to Resident #11. Among medications administered to Resident #11 was one inhalation of Breo Ellipta (fluticasone furoate-vilanterol) aerosol powder 100-125 micrograms/actuation (mcg/act). After Resident #11 inhaled the medication from the device, LPN #2 administered the other prescribed oral medications. LPN #2 provided prompt or request for Resident #11 to rinse the mouth after inhaling the Breo Ellipta medication.Resident #11's clinical record documented a physician's order dated 7/10/25 for Breo Ellipta inhalation aerosol powder with breath activated device, 100-25 mcg/act with instructions to inhale one puff daily for treatment of COPD (chronic obstructive pulmonary disease).On 12/16/25 at 10:20 a.m., accompanied by LPN #2, Resident #11's Breo Ellipta medication was inspected at the medication cart. The Breo Ellipta pharmacy label and the manufacturer's labelling included instructions for the patient to rinse the mouth after each use. LPN #2 was interviewed at this time about not prompting Resident #11 to rinse and spit after the Breo Ellipta. LPN #2 stated, I didn't ask her to rinse. LPN #2 stated Resident #11 did not cooperate with rinsing the mouth. LPN #2 stated, [Resident #11] doesn't do it [rinse mouth].The Breo Ellipta manufacturer's patient use instructions documented on page 7, .Breo Ellipta contains fluticasone furoate .Localized infections of the mouth and pharynx with Candida albicans have occurred in patients treated with orally inhaled drug products containing fluticasone furoate .Advise the patient to rinse his/her mouth with water without swallowing following administration of Breo Ellipta to help reduce the risk of oropharyngeal candidiasis . (1) This finding was reviewed with the administrator and director of nursing on 12/16/25 at 2:30 p.m. with no further information provided prior to the end of the survey. (1) Breo Ellipta Instructions for Use. Revised May 2023. GlaxoSmithKline, [NAME], NC. 12/18/25. https://www.mybreo.com.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, the facility staff failed to follow physician orders for medication administration for four of eleven residents in the survey sample (Residents #1, #4, #7 and #8).The findings include: 1. Registered nurse (RN) #1 administered the medication methadone 5 mg (milligrams) to Resident #4 when the physician's order required a 2.5 mg dose.Resident #4 was admitted to the facility with diagnoses that included osteoarthritis, hypertension, chronic kidney disease, liver cirrhosis, mood disorder, atrial fibrillation, chronic pain and congestive heart failure. The minimum data set (MDS) dated [DATE] assessed Resident #4 with moderately impaired cognitive skills.Review of Resident #5's clinical record revealed a physician's order dated 6/28/24 for methadone 5 mg (milligrams) at each bedtime for treatment of chronic pain. This order was discontinued on 5/9/25 with a physician's order entered for methadone 5.0 mg, with instructions to give 1/2 tab (2.5 mg) at each bedtime for chronic pain. Resident 4's clinical record documented a nursing note dated 5/10/25 stating, .This writer was notified that the resident was given Methadone 5mg instead of scheduled 2.5mg at 2100 [5/9/25 at 9:00 p.m.] .On call provider notified after assessment was completed by assigned charge nurse. VS [vital signs] obtained .PERRLA [pupils equal, round, reactive to light and accommodations], A&O [alert and oriented] .at baseline. No s/s [signs/symptoms] of acute distress. Order given to reassess VS prior to end of shift and notify provider of any changes . The clinical record documented resident assessment following the error, no changes in condition noted and the provider ordered no further actions needed.On 12/16/25 at 12:55 p.m., the director of nursing (DON) was interviewed about Resident #4's methadone dose error. The DON stated she was not employed at the facility when this error occurred. The DON stated from reviewing the incident, the dose error occurred on the date the dosage order was changed. The DON stated dose change was entered on the medication administration record correctly but that the nurse must have pulled the wrong supply card when administering the medication. RN #1 that administered the incorrect dose of methadone to Resident #4 on 5/9/25 was not available for interview as she no longer worked at the facility. 2. LPN #5 administered the intravenous antibiotic (ertapenem sodium) at the wrong time to Resident #8.Resident #8 was admitted to the facility with diagnoses that included osteomyelitis, sepsis, pressure ulcers, anemia, hydrocephalus, metabolic encephalopathy, dysphagia, diabetes, long-term antibiotic use and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed Resident #8 with short and long-term memory problems and severely impaired cognitive skills.Resident #8's closed clinical record documented a physician's order dated 5/28/25 for ertapenem sodium 1 gram administered intravenously (IV) every 24 hours for treatment of osteomyelitis. Resident #8's medication administration record documented the ertapenem administration was scheduled each day at 6:00 a.m.Resident #8's clinical record documented a nursing note dated 6/4/25 stating the resident was administered the IV ertapenem at the incorrect time with notification made to the on-call provider. The on-call provider note dated 6/4/25 documented Resident #8 was receiving two IV antibiotics (ertapenem and daptomycin) for treatment of osteomyelitis. The note documented the licensed practical nurse (LPN #5) reported that he went to administer the daptomycin and administered the ertapenem instead. The note documented the ertapenem was scheduled at 6:00 a.m. and was given six hours early, on 6/4/25 at 12:15 a.m. Resident #8's clinical record documented vital signs and assessment of the resident resting peacefully in bed. The on-call provider ordered adjustment of the antibiotic administration times but no new care orders in response to the error.LPN #5, that administered the ertapenem to Resident #8 at the wrong time, was not available for interview as he no longer worked at the facility.On 12/16/25 at 12:55 p.m., the director of nursing (DON) was interviewed about the ertapenem medication error. The DON stated she was not employed in the facility when the error occurred. The DON stated the nurse apparently pulled the incorrect antibiotic and administered it at the wrong time.On 12/16/25 at 1:15 p.m., the medical director (other staff #7) was interviewed about the ertapenem error. The medical director stated she did not consider the timing error significant. 3. LPN #5 administered Resident #7 another resident's medications. Resident #7 was admitted to the facility with diagnoses that included liver cirrhosis, pancytopenia, insomnia, congestive heart failure, morbid obesity, respiratory failure, major depressive disorder, anxiety, dementia and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed Resident #7 with moderately impaired cognitive skills.Resident #7's closed clinical record documented a nursing note dated 7/5/25 stating, During evening med [medication] pass resident received the wrong medications. The NP

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based staff interview and facility document review, the facility staff failed to provide services of a registered nurse (RN) for at least 8 consecutive hours per day on three of seventeen days in December 2025 (12/7/25, 12/13/25 and 12/14/25).The findings include:On 12/17/25 at 10:25 a.m., the facility's as-worked nursing schedule for December 2025 was reviewed. The as-worked schedule documented no RN work hours on 12/7/25, 12/13/25 or 12/14/25.On 12/17/25 at 10:30 a.m., the scheduler (other staff #6) was interviewed about the days listed in December 2025 without RN coverage. The scheduler stated that no RNs worked on 12/7/25, 12/13/25 or 12/14/25 as she had no RN available to work. The scheduler stated the DON was on-call but that no RN actually worked on those dates.On 12/17/25 at 10:50 a.m., the director of nursing (DON) was interviewed about no RN coverage on the dates listed above. The DON stated the RN that typically worked weekends was out of medical leave on those dates and not available to work. The DON stated she had an abundance of licensed practical nurses but that she needed more RNs. This finding was reviewed with the administrator and director of nursing on 12/17/25 at 12:20 p.m. with no further information presented prior to the end of the survey.

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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** Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of eleven residents in the survey sample (Resident #5).The findings include:Resident #5 was admitted to the facility with diagnoses that included schizoaffective disorder, hypertension, insomnia, protein-calorie nutrition and dysphagia. The minimum data set (MDS) dated [DATE] assessed Resident #5 as cognitively intact.Resident #5's clinical record documented physician orders for treatment of head lice starting on 8/17/25 that included RID Super Max 5-in-1 kit, nit combing each day and contact precautions. The lice treatment was initiated on 8/17/25 with treatment/precautions discontinued on 8/25/25.Resident #5's clinical record included no notes regarding the assessment of head lice, any associated symptoms or notification to the provider.On 12/17/25 at 9:45 a.m., the licensed practical nurse infection preventionist (LPN #1) was interviewed about documentation in Resident #5's record regarding the lice treatment. LPN #1 stated she was the supervisor on 8/17/25 and a certified nurse's aide (CNA) caring for Resident #5 reported to her that she noted signs of lice on the resident's head. LPN #1 stated the provider was notified and treatment s/precautions were immediately initiated on that date. LPN #1 stated there should have been a note about the assessed lice and actions taken. LPN #1 stated she assumed the floor nurse documented the situation, but a note was not entered. LPN #1 stated she should have documented the incident in the clinical record.On 12/17/25 at 9:50 a.m., the unit manager caring for Resident #5 (LPN #6) was interviewed about any documentation regarding the lice treatment. LPN #6 stated, There definitely should have been documentation. LPN #6 stated she contacted the nurse practitioner about the lice who gave the verbal orders for treatment and the resident was told about the lice/treatment. LPN #6 stated the assessment, orders and actions taken should have been documented in the clinical record.This finding was reviewed with the administrator and director of nursing on 12/17/25 at 12:20 p.m. with no further information presented prior to the end of the survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview and facility document review, the facility staff failed to follow infection control practices during a medication pass on one of two units (East unit).The findings include: A medication pass observation was conducted on 12/16/25 at 8:45 a.m. with licensed practical nurse (LPN #3) administering medications to an East unit resident (Resident #11). LPN #3 used hand sanitizer prior to the start of the medication pass. LPN #3 removed oral medications for the resident that included aspirin, simethicone, omeprazole, and vitamin D from supply bottles, touching/handling the tablets/pills with her bare fingers/hands prior to placement in the medicine cup. LPN #3 then administered the oral medications to Resident #11.On 12/16/25 at 8:50 a.m., LPN #3 was interviewed about touching the medications with bare fingers/hands. LPN #3 stated that directly touching the tablets/pills was probably not a good habit.On 12/16/25 at 10:35 a.m., the East unit manager (LPN #6) was interviewed about LPN #3 directly touching pills/tablets during the medication pass observation. LPN #6 stated nurses were absolutely not to directly touch pills when administering medications.On 12/16/25 at 2:06 p.m., the infection preventionist (LPN #1) was interviewed about LPN #3 touching medications with bare fingers/hands. LPN #3 stated that pills in the bubble packs were supposed to be popped directly into the medicine cup. LPN #3 stated pills/tablets supplied in bottles were supposed to be poured into the bottle cap and then placed in the medicine cup. LPN #3 stated medications were not supposed to be touched directly with bare fingers/hands.The facility's policy titled Staff-Administered Medication Procedure (eff. 11/30/14) documented, .Offer the resident the ordered medication as indicated .Use a .medicine cup, not your hands .This finding was reviewed with the administrator and director of nursing on 12/16/25 at 2:30 p.m. with no further information presented prior to the end of the survey.