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	05/15/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on staff interviews, resident interviews and record reviews, the facility failed to protect residents from neglect. The facility failed to ensure licensed nursing services were available on the [NAME] Wing nursing unit from approximately 7:47 p.m. on 1/31/26 until 7:00 a.m. on 2/1/26. During this period, 39 residents were without access to licensed nursing assessment, medication administration, monitoring, physician notification, and nursing intervention. As a result, Resident #6 (R6), Resident #7 (R7), and Resident #8 (R8) experienced untreated pain, delayed or missed medications, anxiety, insomnia, and psychosocial distress. This deficient practice constituted neglect and resulted in Immediate Jeopardy. Following validation of corrective actions, the Immediate Jeopardy was removed and the deficiency remained cited at Level 2, Pattern noncompliance. The findings included:The facility neglected residents by failing to ensure the availability of licensed nursing services for approximately 12 hours on the [NAME] Wing nursing unit. No licensed nurse was available to administer medications, conduct resident assessments, monitor changes in condition, communicate with practitioners, receive physician orders, or respond to resident emergencies. Residents experienced missed medications, untreated pain, sleep disturbances, anxiety, and emotional distress resulting in psychosocial harm On 5/12/26 at 2:30 pm, an interview was conducted with licensed practical nurse #2 (LPN2). During the interview LPN2 was questioned about the incident that happened on 1/31/26. She stated that she did leave early on the 31st. LPN2 stated that she should not have left the medication cart without giving a report to a relief nurse or counting off the narcotics with someone. She stated that she told a nurse she passed in the hallway as she was leaving the facility that she wrote down report on the report sheet and counted against herself [a process of counting narcotic medications at the change of each shift/staff change to ensure an accurate accounting of narcotic medications on hand]. She asked the other nurse if there were any discrepancies with the narcotic count to give her a call. LPN2 stated she should not have left the keys in the narcotic book on top of the medication cart. LPN2 stated she was talked to by the DON and received a correction action.On 5/12/26 at 4:30 pm, a telephone interview was conducted with licensed practical nurse, LPN3. The interview was conducted in reference to an incident that happened on 1/31/26 on the west wing nursing unit. LPN3 stated the nurse that was supposed to relieve LPN2 called out at the last minute, so there was no relief nurse that took report, counted the narcotics, took the medication cart keys, or assumed the responsibility to oversee the care of residents on the unit. LPN3 stated she didn't feel comfortable taking the medication cart when LPN2 did not give her report or count the narcotics with her prior to leaving the facility. LPN3 stated that no nurse came into the facility that night and there was no nurse on west wing nursing unit medication cart until the nurse from first shift came in the following morning at 7:00 a.m. On 5/13/26 at 9:40 am, an interview was conducted with the DON. She said, neglect- it's intentionally not doing something that needs to be done considered neglecting a role as a nurse failure to provide any kind of care, medications, treatments, fluids, and notifying MD [physician] of changes. The DON said, I spoke with [name redacted] R6, and I told the resident [R6] I didn't think it was right for her to leave. The DON said, there were two sides to that story that happened on 1/31/26. I have what is right here in front of (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	me and then I have what the resident [R6] says and told the resident [R6] I will look into it. On 5/13/26 at 11:00 am, an interview was conducted with Resident #8 (R8). During the interview, R8 stated that she remembered that night because they had no nurse on the unit and it was snowing. R8 said that Tramadol helps keep my legs from hurting. R8 said, I asked when it was so late when I was going to get my medicine and someone said no nurse was here to give the medicine at bedtime. Anytime you have no nurse it upsets you.On 5/13/26 at 11:15 am, an interview was conducted with Resident #7 (R7). R7 was interviewed in reference to the incident that occurred on 1/31/26 on the west wing nursing unit. R7 stated that it was no nurse on the unit that night. R7 stated she requested pain medication several times during the night and there was no nurse to give her pain medication. R7 stated that she could not go back to sleep that night due to her pain. She stated she did not like not having a nurse. R7 said, scary with no nurse when you have things that I have and that is why I am here to be taken care of.On 5/13/26 at 11:30 am, an interview was conducted with R6. R6 stated that she was wide awake all night waiting on her medications. She stated 12 hours was a long time to go without any of my medications. R6 said, the nurse just took off and left us, and it pissed me off seeing her back in here the next morning. R6 stated every resident on the unit was upset about not having a nurse all night.On 5/13/26 at 12:00 pm, a clinical record review was conducted. A review of R6's medication administration record (MAR) was completed during the review. R6's MAR had not been signed off by a nurse for medications on the evening of 1/31/26 at bedtime. R6 was not given Melatonin for insomnia, Tizanidine for spasm, Tylenol for pain and Gabapentin for painR7's clinical record was reviewed. R7's MAR had no nurse signature on bedtime medications for 1/31/26. The medications R7 was supposed to receive at bedtime were Melatonin for insomnia, Trazodone for sleep, Flecainide for atrial fibrillation, Oxycontin ER 12 hours for pain, and Buspar for anxiety.R8's medication administration record was reviewed. There was no signature on R8's MAR for the evening on 1/31/26 at bedtime. R8 was supposed to get Metoprolol scheduled and she also gets Tramadol nightly, but it is as needed medication.The facility's failure to maintain licensed nursing coverage deprived residents of necessary care and services required to avoid physical harm, pain, mental anguish, and emotional distress. The deficient practice was not limited to staffing concerns; it resulted in the absence of nursing assessment, medication administration, clinical monitoring, and emergency response capabilities for all 39 residents residing on the [NAME] Wing nursing unit. Residents were exposed to the likelihood of serious injury, serious harm, serious impairment, or death. For approximately 12 hours, residents had no access to licensed nursing services needed to identify and respond to changes in condition, administer medications, obtain physician intervention, or implement emergency measures. Actual resident harm occurred, as evidenced by resident reports of untreated pain and missed medications.On 5/13/26 at 2:53 p.m., after consultation with state agency supervisory staff, Immediate Jeopardy was identified related to neglect as a result of the facility's failure to provide licensed nursing services on the [NAME] Wing nursing unit from 1/31/26 through 2/1/26. The deficient practice affected all 39 residents residing on the unit and resulted in actual resident harm as well as the likelihood of serious injury, serious harm, serious impairment, or death. On 5/13/26 at 8:50 pm, the facility submitted a removal plan that read as follows: F6001. Immediately upon notification of the Immediate Jeopardy, the Administrator and Director of Nursing verified that every nursing unit is staffed with licensed nurses.2. Staffing schedules for previous week were reviewed to confirm adequate coverage. The IDT [interdisciplinary team] reviewed all medication administration records for the previous 48 hours. Any identified missed medications were immediately addressed, with physician and family notifications completed as indicated.Investigation performed for all potential residents and FRI submitted. All residents were assessed for any psychosocial concerns. Nurse suspended pending investigation, report made to DHP [department of health professions].3. All staff will receive education prior to their next scheduled shift on Abuse and Neglect. Licensed nurses will be education on emergency staffing plan4.DON/ED will review daily staffing patterns to ensure licensed nurse coverage through the weekend. Results will be reported to QAPI for review and (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	adjustments made as needed.Date: 5/14/2026 Time: 3pmOn 5/14/26 at 3:00 pm, the survey team completed the following to verify the removal of the immediacy:1. Reviewed the medication administration records (MAR) that were reviewed 2. Reviewed the corrective action on missed medications from the MAR reviews3. Reviewed the FRI's submitted and the investigations completed4. Reviewed the nurse investigation, suspension and verified reporting to DHP 5. Reviewed the staffing patterns for the previous week 6. Interviewed staff for education regarding abuse and neglect and the emergency staffing plan.The IJ was determined to have been removed as of 3:00 pm on 5/14/26, at which time the scope and severity was lowered to level two pattern. On 5/13/26 a review of facility documentation was conducted. The facility document titled, Abuse, Neglect and Exploitation, and read in part, It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or requirements others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.On 5/13/26 at 8:50 pm, a meeting was called with the Administrator, Director of Nursing, and Regional Director of Clinical Services. They were informed of the above concerns. The RDCS reported that the staff member that the allegation of neglect was reported on was LPN2 and she was suspended on 5/13/26 pending investigation.No additional information was provided prior to exit conference.

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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. Based on staff interviews, resident interviews, clinical record reviews, and facility documentation reviews the facility staff failed to follow the facility's abuse, neglect, and exploitation policy after allegation of neglect were reported, resulting in residents not being adequately protected form potential ongoing harm. The findings included:The facility staff failed to implement their abuse policy after an allegation of neglect was reported.5/12/26 at 4:30 pm, a telephone interview was conducted with licensed practical nurse, LPN3. The interview was conducted in reference for a incident that happened on 1/31/26 on the west wing nursing unit. During the interview , LPN3 stated that she never observed LPN2 enter any resident rooms. LPN3 stated she was asked to come in and work as an aide that evening. LPN3 stated that she agreed to working as an aide but she would not take a medication cart that evening. LPN3 stated she only signed up for aide duties.LPN3 stated the nurse that was suppose to relieve LPN2 called out at the last minute, so there was no relief nurse that took report, counted the narcotics or took the medication cart keys. LPN3 stated she didn't feel comfortable taking the medication cart when LPN2 did not give her report or count the narcotics with her prior to leaving the facility. LPN3 stated she called the director of nursing (DON), and left a message. LPN3 stated the DON called back and commented she was ready for bed and not safe to come in the building, and told me to take the keys to the medication cart. LPN3 stated she refused to take the medication cart because it was unsafe for me to do so because I had no report, and didn't count the narcotics with LPN2 prior to her leaving the facility. LPN3 said, if I would have taken the keys to the medication cart it would be my responsibility. LPN3 stated that no nurse came in to the facility that night and there was no nurse on west wing nursing unit medication cart until the nurse from first shift came in the following morning at 7:00 a.m. LPN3 stated that she called the administrator several times and LPN3 said, and as of this day he has not returned my calls. LPN3 stated that LPN2 apparently passed the medications on the west wing unit A hall but didn't pass any medication on the b hall. She stated that some of the residents on the b hall were complaining and went to the east unit to see if the nurse on that unit could give them medications and she told them she didn't have keys to their medication cart and she gave the residents grievance forms to fill out with their concerns.LPN3 stated that when the nurse came in on dayshift, LPN4 she called the DON and told her she did not feel safe taking the keys and someone needed to come in to count with her. LPN3 also stated that LPN 2 was suppose to call her and let her know who received medications and who did not get their medications and she never called that evening to let her know. On 5/12/26 at 8:55 pm, a second telephone interview was conducted with LPN3. LPN3 stated that on the west wing unit A hall there were several resident that complained about not receiving their medications and called their families. LPN3 gave the names of Resident #6, Resident #7 and Resident #8. She also stated that Resident #9 filled out a grievance form about her pain medicated cream that was not applied. On 5/13/26 at 8:45 am, an interview was conducted with LPN5. Neglect was discussed during the interview. LPN5 stated that neglect in her role is not answering call bells timely, not providing basic needs as a nurse, not getting a proper medication to a resident when needed, and treatments not being completed as ordered. On 5/13/26 at 9:10 am, an interview was conducted with LPN7 and she said, neglect in my role would be not getting their meds on time not giving pain meds if requested not doing treatments and not answering their questions when they ask.On 5/13/26 at 9:40 am, an interview was conducted with the DON. She said, neglect- it's intentionally not doing something that needs to be done considered neglecting a role as a nurse failure to provide any kind of care, medications, treatments, fluids, and notifying MD [physician] of changes.On 5/13/26 at 11:00 am, an interview was conducted with Resident #8 (R8). During the interview, R8 stated that she remembered that night because we had no nurse on the unit and it was snowing. She stated that Tramadol helps keep my legs from hurting. R8 said, I asked when it was so late when I was going to get my medicine and someone said no nurse was here to give the medicine at bedtime. anytime you (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have no nurse it upsets you.On 5/13/26 at 11:15 am, an interview was conducted with R7. R7 was interviewed in reference to the incident that occurred on 1/31/26 on the west wing nursing unit. R7 stated that it was no nurse on the unit that night. R7 stated she requested pain medication several times during the night and there was no nurse to give her pain medication. R7 stated that she could not go back to sleep that night due to her pain. She stated she did not like not having a nurse. R7 said, scary with no nurse when you have things that I have and that is why I am her to be taken care of.On 5/13/26 at 11:30 am, an interview was conducted with R6. R6 stated that she was wide awake all night waiting on her medications. She stated 12 hours was a long time to go without any of my medications. R6 said, the nurse just took off and left us and it pissed me off seeing her back in here the next morning. R6 stated every resident on the unit was upset about not having a nurse all night.On 5/13/26 at 12:00 pm, a clinical record review was conducted. A review of R6's medication administration record (MAR) was completed during the review. R6's MAR had not been signed off by a nurse for medications on the evening of 1/31/26 at bedtime. R6 was not given Melatonin for insomnia, Tizanidine for spasms, Tylenol for pain and Gabapentin for painR7's clinical record was reviewed. R7's MAR had no nurse signature on bedtime medications for 1/31/26. The medications R7 was suppose to receive at bedtime was Melatonin for insomnia, Trazodone for sleep, Flecainde for atrial fibrillation, Oxycontin ER 12 hour for pain, and Buspar for anxiety R8's medication administration record was reviewed. There was no signature on R8's MAR for the evening on 1/31/26 at bedtime. R8 was suppose to get Metoprolol scheduled and she also gets Tramadol nightly, but it is as needed medication.On 5/13/26 a review of facility documentation was conducted. The facility document titled, Abuse, Neglect and Exploitation, and read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or requirements others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.On 5/13/26 at 2:53 a meeting was called with the administrator, director of nursing, and regional director of clinical services. They were informed of the above concerns.No additional information was provided prior to exit conference.

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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. Based on staff interviews, resident interviews, and facility documentation reviews the facility staff failed to follow their abuse policy and report an allegation of neglect. The findings included:The facility staff failed to report an allegation of neglect.5/12/26 at 4:30 pm, a telephone interview was conducted with licensed practical nurse, LPN3. The interview was conducted in reference for a incident that happened on 1/31/26 on the west wing nursing unit. LPN3 stated the nurse that was suppose to relieve LPN2 called out at the last minute, so there was no relief nurse that took report, counted the narcotics or took the medication cart keys. LPN3 stated she didn't feel comfortable taking the medication cart when LPN2 did not give her report or count the narcotics with her prior to leaving the facility. LPN3 stated that no nurse came in to the facility that night and there was no nurse on west wing nursing unit medication cart until the nurse from first shift came in the following morning at 7:00 a.m. On 5/13/26 at 8:45 am, an interview was conducted with LPN5. Neglect was discussed during the interview. LPN5 stated that neglect in her role is not answering call bells timely, not providing basic needs as a nurse, not getting a proper medication to a resident when needed, and treatments not being completed as ordered.On 5/13/26 at 9:10 am, an interview was conducted with LPN7 and she said, neglect in my role would be not getting their meds on time not giving pain meds if requested not doing treatments and not answering their questions when they ask.On 5/13/26 at 9:40 am, an interview was conducted with the DON. She said, neglect- it's intentionally not doing something that needs to be done considered neglecting a role as a nurse failure to provide any kind of care, medications, treatments, fluids, and notifying MD [physician] of changes. She said, I did not do a formal investigation and went by just what was on the grievance form.On 5/13/26 at 11:00 am, an interview was conducted with Resident #8 (R8). R8 said, I asked when it was so late when I was going to get my medicine and someone said no nurse was here to give the medicine at bedtime. anytime you have no nurse it upsets you.On 5/13/26 at 11:15 am, an interview was conducted with R7. During the interview she stated she had requested pain medication several times during the night and there was no nurse to give her pain medication. R7 stated that she could not go back to sleep that night due to her pain. She stated she did not like not having a nurse. R7 said, scary with no nurse when you have things that I have and that is why I am her to be taken care of.On 5/13/26 at 11:30 am, an interview was conducted with R6. R6 stated that she was wide awake all night waiting on her medications. She stated 12 hours was a long time to go without any of my medications. R6 said, the nurse just took off and left us and it pissed me off seeing her back in here the next morning. R6 stated every resident on the unit was upset about not having a nurse all night.On 5/13/26 at 12:00 pm, a clinical record review was conducted. A review of R6's medication administration record (MAR) was completed during the review. R6's MAR had not been signed off by a nurse for medications on the evening of 1/31/26 at bedtime. R6 was not given Melatonin for insomnia, Tizanidine for spasms, Tylenol for pain and Gabapentin for painR7's clinical record was reviewed. R7's MAR had no nurse signature on bedtime medications for 1/31/26. The medications R7 was suppose to receive at bedtime was Melatonin for insomnia, Trazodone for sleep, Flecainde for atrial fibrillation, Oxycontin ER 12 hour for pain, and Buspar for anxiety R8's medication administration record was reviewed. There was no signature on R8's MAR for the evening on 1/31/26 at bedtime. R8 was suppose to get Metoprolol scheduled and she also gets Tramadol nightly, but it is as needed medication.On 5/13/26 a review of facility documentation was conducted. The facility document titled, Abuse, Neglect and Exploitation, and read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or requirements others but has not yet been investigated and, if verified, could be indication of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noncompliance with the Federal related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.On 5/13/26 at 2:53 a meeting was called with the administrator, director of nursing, and regional director of clinical services. They were informed of the above concerns.No additional information was provided prior to exit conference.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on staff interviews, resident interviews, and facility documentation the facility staff failed to investigate an allegation of neglect that was reported, resulting in residents not being adequately protected from potential ongoing harm. The findings included:The facility staff failed to investigate an allegation of neglect that occurred at the facility.On 5/12/26 at 2:30 pm, an interview was conducted with LPN2. During the interview LPN2 was questioned about the incident that happened on 1/31/26. She stated this was the first weekend she had worked at the facility. She stated she was hired as the unit manager of the west wing. She stated that she did leave early on the 31st. LPN2 stated that she should not have left the medication cart without giving a report to a relief nurse or counting off the narcotics with someone. She stated that she told a nurse as she was leaving the facility that she wrote down report on the report sheet and counted against herself. She told the nurse if any discrepancies with the narcotic count to give her a call. LPN2 stated she should not have left the keys in the narcotic book on top of the medication cart. LPN2 stated she was talked to by the DON and received a correction action.5/12/26 at 4:30 pm, a telephone interview was conducted with licensed practical nurse, LPN3. The interview was conducted in reference for a incident that happened on 1/31/26 on the west wing nursing unit. LPN3 stated the nurse that was suppose to relieve LPN2 called out at the last minute, so there was no relief nurse that took report, counted the narcotics or took the medication cart keys. LPN3 stated she didn't feel comfortable taking the medication cart when LPN2 did not give her report or count the narcotics with her prior to leaving the facility. LPN3 stated that no nurse came in to the facility that night and there was no nurse on west wing nursing unit medication cart until the nurse from first shift came in the following morning at 7:00 a.m. On 5/13/26 at 9:40 am, an interview was conducted with the DON. She said, neglect- it's intentionally not doing something that needs to be done considered neglecting a role as a nurse failure to provide any kind of care, medications, treatments, fluids, and notifying MD [physician] of changes. She said, I did not do a formal investigation and went by just what was on the grievance form. She said she spoke with a resident and she told the resident she didn't think it was right for her to leave. The DON said, there was two sides to that story that happened on 1/31/26. I have what is right here in front of me and then I have what the resident says and told the resident I will look into it. On 5/13/26 at 11:00 am, an interview was conducted with Resident #8 (R8). R8 said, I asked when it was so late when I was going to get my medicine and someone said no nurse was here to give the medicine at bedtime. anytime you have no nurse it upsets you.On 5/13/26 at 11:15 am, an interview was conducted with R7. During the interview she stated she had requested pain medication several times during the night and there was no nurse to give her pain medication. R7 said, scary with no nurse when you have things that I have and that is why I am her to be taken care of.On 5/13/26 at 11:30 am, an interview was conducted with R6. She stated 12 hours was a long time to go without any of my medications. R6 said, the nurse just took off and left us and it pissed me off seeing her back in here the next morning. R6 stated every resident on the unit was upset about not having a nurse all night.On 5/13/26 a review of facility documentation was conducted. The facility document titled, Abuse, Neglect and Exploitation, and read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or requirements others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or (continued on next page)

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	495344	A. Building B. Wing	05/15/2026

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	harm.On 5/13/26 at 8:50 pm, a meeting was called with the administrator, director of nursing, and regional director of clinical services. They were informed of the above concerns. The RDCS reported that the staff member that the allegation of neglect was reported on, LPN2 was suspended on 5/13/26 pending investigation.No additional information was provided prior to exit conference.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and facility documentation review, the facility staff failed to review and revise the comprehensive person-centered care plan for two residents, Resident #1 (R1) and Resident #2(R2), out of a survey sample of nine residents.The findings included #1. The facility staff failed to implement wound interventions and precautions for R1 to the care plan. On 5/13/26, a clinical record review was conducted. During the review a physician order was reviewed. R1 was admitted on [DATE]. An order for a pressure-reducing mattress was noted on 12/9/24 and a pressure-reducing cushion to wheelchair was noted on 12/9/24. On 5/13/26, a clinical record review was conducted. A review was conducted on R1's care plan. Staff failed to implement the pressure reducing mattress and pressure reducing cushion to wheelchair on the care plan. On 5/14/26, a clinical review of R1's Braden Scale was conducted. R1's score was a 16 on admission which according to Braden Scale for Predicting Pressure Sore, put resident at risk for skin injury. On 5/14/26 @ 4:30pm, a staff interview was conducted with registered nurse (RN), which was the Minimum Data Set (MDS) coordinator. RN3 stated that facility follows policies and procedures for the prevention and treatment of skin breakdown. RN3 stated pressure reducing mattresses or cushions for wheelchairs are used for ones not so mobile, it helps for bony prominences. RN3 stated that the care plan was for individualized care. RN3 stated that if a doctor recommends it, then it is specific for that resident. She stated that if off-loading is entered by medical doctor, it was supposed to be on the care plan. #2. The facility staff failed to implement wound interventions and precautions for R2 to the care plan. On 5/11/26, a clinical record review was conducted. R2 was admitted on [DATE]. During the review, R2's care plan was reviewed. There were no interventions put in place for pressure prevention to prevent skin injury upon admission. On 5/13/26, a clinical review of order summary was conducted. On 10/5/25, there was an order for pressure reducing mattress and pressure reducing cushions to wheelchairs. Pressure relieving/reducing device on bed was implemented on the care plan on 1/12/26; however, it was ordered on 10/5/25. On 5/13/26, a clinical record review of R2's treatment record was conducted. During review there was no pressure reducing mattress or wheelchair cushions for October 2025 or November 2025 implemented on the treatment administration record; however, it was ordered on 10/5/25. On 5/13/26, a clinical record review was conducted. The Braden Scale for Predicting Pressure Sore Risk, dated 10/3/2025, was reviewed. R2's score was 13 which is category of moderate risk. On 5/15/25 a clinical review was conducted on Wound Evaluation and Management Summary, VOHRA wound physicians, dated 12/8/2025. During review it was noted for right heel approach as read in part,.Optimizing Moist Wound Healing, Off-loading, close monitoring, education and counseling, debridement as needed. Off-loading was not added to the care plan or treatment plan. On 5/14/26 @ 4:30pm, a staff interview was conducted with registered nurse (RN), which was the Minimum Data Set (MDS) coordinator. RN3 nurse stated that facility follows policies and procedures for the prevention and treatment of skin breakdown. RN3 stated pressure reducing mattresses or cushions for wheelchairs are used for ones not so mobile, it helps for bony prominences. She stated that care plans was individualized to each resident. RN3 stated that if a doctor recommends it, then it was specific for that resident. She stated that if off-loading was entered by medical doctor, it was supposed to be in the care plan. On 5/15/25, a facility documentation review was conducted. The facility policy titled Pressure Injury and Management, which reads in part .4a after completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. 4b Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). 4c (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include but are not limited to redistribute pressure (such as repositioning, protecting, and /or offloading heels, etc) i. Redistribute pressure (such as repositioning, protecting and /or offloading heels, etc); ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination; iii. Provide appropriate, pressure-redistributing, support surfaces; 4e The goals and preferences of the resident and/or authorized representative will be included in the plan of care. 4f Interventions will be documented in the care plan and communicated to all relevant staff. On 5/15/26 an end-of-day meeting was held with Administrator, DON (Director of Nursing) and Regional Director of Clinical Services and made aware of above concerns. No additional information was provided prior to exit conference.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record reviews, and facility documentation reviews the facility staff failed to ensure that professional standards of quality care were met for one resident, Resident #5 out of a survey sample of nine residents. The findings included:The facility staff failed to ensure that a registered nurse (RN) pronounced the resident's death in accordance with professional standard and facility policy. In addition, there was no physician order or documented authorization to release the resident's body to the funeral home. On [DATE] at 3:45 pm, an interview was conducted with a licensed practical nurse, LPN6, the unit manager on east wing. She said, when a patient becomes unresponsive assess the the scene attempt to get then to respond-obtain vitals, checking pulse, check code status, if a DNR [do not resuscitate] no pulse no blood pressure then do nothing call my DON because I am a LPN and need RN to pronounce. Initiate CPR [cardiopulmonary resuscitation] if a full code. LPN6 then stated that both nurses should document and there should be an order to release the body to the funeral home.On [DATE] at 4:00 pm, an interview was conducted with LPN1. She said, if a resident is unresponsive find out code status DNR, RN has to pronounce if a full code start CPR and call 911. If the RN pronounced they should chart it and should have an order to release body. The RN notifies the responsible person and physician. She stated that she thought there was a policy for release of body, release of body form and an physician order. LPN1 went and checked with the director of nursing (DON). When she came back she said, there was no policy just the advance directive lesson on there yearly in-services we take.On [DATE] at 5:00 pm, an interview was conducted with the DON. She stated that a RN has to pronounce death in the facility. If there was no RN int the building the charge nurse would call myself or another RN to come in the facility to pronounce. She said, that the resident would be assessed and if no vital signs we call the death at that time. She stated that the RN that pronounced the death should chart the assessment and time of death. The DON stated the RN should notify the physician and obtain an order for the release of body. The DON stated that any nurse can get the order to release the body and an order should be in the residents clinical record. On [DATE], a clinical record review was conducted. There was a progress note dated [DATE] at 4:34 pm, that read, this nurse went to administer medication. Upon entering pt [patient] room pt [patient] had no signs of life. On call number went straight to VM [voicemail], [name redacted] the DON was then notified, which I was informed that [name redacted] RN3 was on call. RN4 returned my phone call, she will be making her way in the building to pronounce. The physicians orders were reviewed and there was no order to release R5's body to the funeral. There was a progress note dated [DATE] at 11:06 pm, written by LPN3 that read in part, [name redacted] funeral home notified at 0730. There was no progress note written when R5's body was released to the funeral home and no progress note written by R4 about pronouncing, notifying physician or an order to release R5's body to the funeral home. There was not progress note that the physician was notified of R5's death by any nurse. On [DATE] at 9:00 am, a policy for code status and pronouncing of death in the facility was requested. The DON provided a policy titled, Residents Rights Regarding Treatment and Advance Directives. The DON stated that this was the only policy that she could provide. She said, we don't have a policy on pronouncing of death we just go by what the state rules are.According to accepted standards of nursing practice outlined in, Lippincott's Nursing Procedure Sixth Edition, page 38-40, read in part, Performing physical assessment calls for four basic techniques: inspection, palpation, percussion, and auscultation. Performing these techniques correctly helps elicit valuable information about the patient's condition. Document your assessment findings and the technique used to elicit those findings. Indicate who you notified of any abnormal findings and the time of the notificationXXX[DATE] 3:36 pm, a telephone call was placed to the RN4 that was suppose to come to the facility to pronounce and she did not answer or return the phone call. On [DATE] an end of day meeting was conducted with the DON and the regional of clinical services (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(RDCS). They were informed of the above concerns.On [DATE] at 6:30 pm, the RDCS and DON stated they had been trying to reach RN4 and was unable to reach her by phone and had called several times.On [DATE] at 10:10 am, the DON, and the RDCS came to the conference room and presented a QAPI minutes for infection control and the nurses notes from the night of R5's death and a death certificate. The RDCS said RN's name should be on the death certificate that pronounced R5. There was no RN's name on the death certificate and both of them reviewed it again. The DON left the room to look for something else and the RDCS stated that he didn't know what she was looking for, but that's all we have to present.On [DATE] at 11:00 pm, a meeting was held with the administrator, the RDCS and DON to inform them of the above concerns.No additional information was provided prior to exit conference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on staff interviews, resident interviews, clinical record reviews, and facility documentation reviews, the facility staff failed to ensure quality nursing care was provided to meet resident needs on one of three nursing units. Specifically, the facility failed to ensure licensed nurse coverage on the west wing nursing unit, resulting in no licensed nurse being available to administer medications, assess residents, respond to change in condition, provide treatments, or ensure resident safety. This deficient practice resulted in harm to residents #6, 7, and 8. The findings included:The facility staff failed to follow accepted standards of nursing practice by failing to ensure a licensed nurse was present on the unit, residents missed medications, lack of assessment for changes in condition, delayed response to emergencies, uncontrolled pain, medication errors, and lack of appropriate clinical oversight. This failure resulted in harm to Resident #6, 7, and 8. On 5/12/26 at 2:30 pm, an interview was conducted with LPN2, unit manager of west wing nursing unit. She said, I shouldn't have left the med cart without giving report and counting narcotics. I did get talked to by the DON about that and she did a corrective action on me about that. I know it wasn't later than 7:00 pm when I left I needed to work my schedule shift. I left the facility, left the medication cart keys in the narcotic book on top of medication cart, and I know leaving the keys in book was wrong. When leaving the unit, in the hallway I told a nurse that I wrote a report down and left it the nursing station and told her if she had any questions call me. I counted narcotics against myself. 5/12/26 at 4:30 pm, a telephone interview was conducted with licensed practical nurse, LPN3. The interview was conducted in reference for a incident that happened on 1/31/26 on the west wing nursing unit. During the interview , LPN3 stated that she never observed LPN2 enter any resident rooms. LPN3 stated she was asked to come in and work as an aide that evening. LPN3 stated that she agreed to working as an aide but she would not take a medication cart that evening. LPN3 stated she only signed up for aide duties.LPN3 stated the nurse that was suppose to relieve LPN2 called out at the last minute, so there was no relief nurse that took report, counted the narcotics or took the medication cart keys. LPN3 stated she didn't feel comfortable taking the medication cart when LPN2 did not give her report or count the narcotics with her prior to leaving the facility. LPN3 stated she called the director of nursing (DON), and left a message. LPN3 stated the DON called back and commented she was ready for bed and not safe to come in the building, and told me to take the keys to the medication cart. LPN3 stated she refused to take the medication cart because it was unsafe for me to do so because I had no report, and didn't count the narcotics with LPN2 prior to her leaving the facility. LPN3 said, if I would have taken the keys to the medication cart it would be my responsibility. LPN3 stated that no nurse came in to the facility that night and there was no nurse on west wing nursing unit medication cart until the nurse from first shift came in the following morning at 7:00 a.m. LPN3 stated that she called the administrator several times and LPN3 said, and as of this day he has not returned my calls. LPN3 stated that LPN2 apparently passed the medications on the west wing unit A hall but didn't pass any medication on the b hall. She stated that some of the residents on the b hall were complaining and went to the east unit to see if the nurse on that unit could give them medications and she told them she didn't have keys to their medication cart and she gave the residents grievance forms to fill out with their concerns.LPN3 stated that when the nurse came in on dayshift, LPN4 she called the DON and told her she did not feel safe taking the keys and someone needed to come in to count with her. LPN3 also stated that LPN 2 was suppose to call her and let her know who received medications and who did not get their medications and she never called that evening to let her know. On 5/12/26 at 8:55 pm, a second telephone interview was conducted with LPN3. LPN3 stated that on the west wing unit A hall there were several resident that complained about not receiving their medications and called their families. LPN3 gave the names of Resident #6, Resident #7 and Resident #8. She also stated that Resident #9 filled out a grievance form about her pain medicated cream that was not applied. On 5/13/26 at 8:45 am, an interview was conducted with LPN5. Neglect was discussed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	during the interview. LPN5 stated that neglect in her role is not answering call bells timely, not providing basic needs as a nurse, not getting a proper medication to a resident when needed, and treatments not being completed as ordered. On 5/13/26 at 9:10 am, an interview was conducted with LPN7 and she said, neglect in my role would be not getting their meds on time not giving pain meds if requested not doing treatments and not answering their questions when they ask.On 5/13/26 at 9:40 am, an interview was conducted with the DON. She said, neglect- it's intentionally not doing something that needs to be done considered neglecting a role as a nurse failure to provide any kind of care, medications, treatments, fluids, and notifying MD [physician] of changes.On 5/13/26 at 11:00 am, an interview was conducted with Resident #8 (R8). During the interview, R8 stated that she remembered that night because we had no nurse on the unit and it was snowing. She stated that Tramadol helps keep my legs from hurting. R8 said, I asked when it was so late when I was going to get my medicine and someone said no nurse was here to give the medicine at bedtime. anytime you have no nurse it upsets you.On 5/13/26 at 11:15 am, an interview was conducted with R7. R7 was interviewed in reference to the incident that occurred on 1/31/26 on the west wing nursing unit. R7 stated that it was no nurse on the unit that night. R7 stated she requested pain medication several times during the night and there was no nurse to give her pain medication. R7 stated that she could not go back to sleep that night due to her pain. She stated she did not like not having a nurse. R7 said, scary with no nurse when you have things that I have and that is why I am her to be taken care of.On 5/13/26 at 11:30 am, an interview was conducted with R6. R6 stated that she was wide awake all night waiting on her medications. She stated 12 hours was a long time to go without any of my medications. R6 said, the nurse just took off and left us and it pissed me off seeing her back in here the next morning. R6 stated every resident on the unit was upset about not having a nurse all night.On 5/13/26 at 12:00 pm, a clinical record review was conducted. A review of R6's medication administration record (MAR) was completed during the review. R6's MAR had not been signed off by a nurse for medications on the evening of 1/31/26 at bedtime. R6 was not given Melatonin for insomnia, Tizanidine for spasms, Tylenol for pain and Gabapentin for painR7's clinical record was reviewed. R7's MAR had no nurse signature on bedtime medications for 1/31/26. The medications R7 was suppose to receive at bedtime was Melatonin for insomnia, Trazodone for sleep, Flecainide for atrial fibrillation, Oxycontin ER 12 hour for pain, and Buspar for anxiety R8's medication administration record was reviewed. There was no signature on R8's MAR for the evening on 1/31/26 at bedtime. R8 was suppose to get Metoprolol scheduled and she also gets Tramadol nightly, but it is as needed medication.On 5/13/26, a facility documentation was reviewed. The facility policy titled, Medication Administration, read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review MAR to identify medication to be administered. Observe resident consumption of medication. 19. Wash hands using facility protocol and product. 20. Sign MAR after administered. For those medications requiring vital signs, record vital signs onto the MAR. 21. If medication is a controlled substance, sign narcotic book. 22. Report and document any adverse side effects or refusals. 23. Correct any discrepancies and report to nurse manager.The facility document titled, Pain Management, read in part, 2. Facility staff will observe for nonverbal indicators which may indicate the presence of pain. 3. Facility staff will be aware of verbal descriptors a resident may use to report or describe their pain. Based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary team (e.g., nurses, practitioner, pharmacists, and anyone else with direct contact with the resident). 8. a. Facility staff will reassess resident's pain management at established intervals for effectiveness and/or adverse consequences. b. If re-assessment findings indicate pain is not adequately controlled, the pain management regimen and plan of care will be revised as indicated. C. If pain has resolved or there is no longer an indication for pain medication, the interdisciplinary team will work to discontinue or taper (as needed to prevent withdrawal symptoms) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	analgesics. d. If a resident reports or there are signs of increased pain, the facility should evaluate whether there is a time or day pattern to ensure that the problem is not due to drug diversion. According to accepted standards of nursing practice outlined in, Lippincott's Nursing Procedure Sixth Edition, page 44, read in part, A nursing care plan serves as a database for planning assignments, giving change-of-shift reports, conferring with the doctor or other members of the health care team, planning patient discharge, and documenting patient care. In addition, the care plan can be used as a management tool to determine staffing needs and assignments. On 5/13/26 at 8:50 pm, a meeting was called with the administrator, director of nursing, and regional director of clinical services. They were informed of the above concerns. The RDCS reported that the staff member that the allegation of neglect was reported on, LPN4 was suspended on 5/13/26 pending investigation.No additional information was provided prior to exit conference.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, staff interviews, resident interview, and facility documentation the facility staff failed to ensure adequate interventions were implemented and followed to prevent the development and or worsening of pressure ulcers for one resident, resident #2 (R2) out of a survey sample of nine residents This failure resulted in harm as R2 developed in house acquired pressure ulcers. The findings include: The facility failed to provide preventative skin interventions for R2 who was at moderate risk for pressure ulcer development, which resulted in the resident developing an in-house acquired pressure ulcer, which constituted harm. On 5/12/26, a clinical record review was conducted. During the review, the Braden Scale for Predicting Pressure Sore Risk, dated 10/3/2025, which was R2's admission date was reviewed. R2's score was 13 which is category of moderate risk for developing pressure ulcers. A skilled nursing note dated 10/4/25 had R2's skin was warm and dry with no skin impairments noted. A progress note dated 12/4/25, by the medical provider under assessment and plan read in part . patient has a suspected deep tissue injury on her heel. Stating under general note read in part . patient has a small wound to the right heel, with protective dressings applied to both heels and legs. A skin/wound note dated 12/8/25 noted an unstageable wound on right heel, measuring 2.5x2x0. A skin assessment dated [DATE], was reviewed. The skin assessment read in part, .left heel pressure injury wound acquired in house, right heel pressure injury wound acquired in house, buttocks moisture associated skin damage wound acquired in house. A progress note dated 12/19/25 by the medical doctor (MD), read in part .patient reports soreness in both heels. The nursing aide have noted that the wounds appear to be worsening. The assessment portion of the note read in part, . Examination of the left heel reveals signs of infection, including erythema, warmth, and drainage, consistent with cellulitis with ulceration in the center. Examination of the right heel also shows signs of infection, similar to the left heel, indicating cellulitis. Under general plan note reads in part .patient, age [AGE], has infected bilateral heel wounds and appears stable otherwise. Please keep feet clean and elevated as needed. A review of physician orders was conducted. On 10/5/25, there was an order for pressure reducing mattress and pressure reducing cushion to wheelchair. The pressure relieving/reducing device on bed was implemented on the care plan dated 1/12/26. A review of R2's treatment record was conducted. During the review, the pressure reducing mattress and wheelchair cushion was not implemented on the treatment record for the month of October 2025 or November 2025. The Wound Evaluation and Management Summary, written by the wound physician dated 12/8/25 was reviewed. During the review, the summary read in part, .Optimizing Moist Wound Healing, Off-loading, close monitoring, education and counseling, debridement as needed. The wound physician's recommendations for off-loading were not implemented on the care plan or treatment administration record. On 5/13/26 at 2:00 pm, an observation of wound care was conducted. The wound nurse, which was a license practical nurse (LPN8) performed wound care to R2's stage three sacral wound which was pink in color and had moderate bleeding. LPN8 stated R2 was on a blood thinner, and she was going to apply pressure dressing until the bleeding stopped. Then LPN8 performed wound care to R2's stage four left heel pressure ulcer and the wound bed had slough tissue noted. All R2's wounds were in house acquired. During the observation it was observed that R2's heels were not off loaded prior to wound care. On 5/14/26 at 4:30 pm, a staff interview was conducted with registered nurse (RN), which was the Minimum Data Set (MDS) coordinator. RN3 stated that facility follows policies and procedures for the prevention and treatment of skin breakdown. RN3 stated pressure reducing mattresses or cushions for wheelchairs are used for ones not so mobile, it helps for bony prominences. RN3 stated that baseline care plans are started when a resident arrives. She stated care plans are updated for anything new such as, falls, weight loss, new diagnosis, psychiatric medications and anything we put in place. RN3 stated that the care plan was for how care is to be given. She stated that care plans are (continued on next page)

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	495344	A. Building B. Wing	05/15/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	personalized to each resident. RN3 stated that if a doctor recommends it, then it was specific for that resident. She stated, that if off-loading was entered by the medical doctor, it is in the care plan. On 5/15/26 at 9:15 am, an interview was conducted with R2. R2 has a diagnosis of cognitive impairment and a BMI (brief interview for mental status) score of nine. R2 was able to answer questions during the interview. R2 stated that she receives, good care, things change so much. Sometimes it's good and sometimes it's bad. R2 said, I do get turned to my left side in the evening but I'm on my back most of the time. I have a bad hip on the right side. During the interview, it was observed that R2's feet were not off loaded, and she was lying on her back. A license practical nurse (LPN1) came into the room to check R2's feet and put pillow under her legs, so her heels were not touching the mattress. R2 told LPN1 she was hurting and LPN1 stated that she was going to get her pain medication. LPN1 stated, maybe it will feel better now that we are floating heels and getting them off the bed. On 5/15/25, a facility documentation review was conducted. The facility policy titled Pressure Injury and Management, which reads in part .4a after completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. 4b Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). 4c Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include but are not limited to redistribute pressure (such as repositioning, protecting, and /or offloading heels, etc) i. Redistribute pressure (such as repositioning, protecting and /or offloading heels, etc); ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination; iii. Provide appropriate, pressure-redistributing, support surfaces; 4e the goals and preferences of the resident and/or authorized representative will be included in the plan of care. 4f Interventions will be documented in the care plan and communicated to all relevant staff. On 5/15/26 at 10:06 am, conducted an interview with Director of Nursing (DON) and Regional Director of Clinical Services (RDCS). The DON stated, I feel our skin and wound care was not robust in the past, that it is better now, more robust. RDCS stated that in March 2026, staff completed an eight-week prevention program. They became more focused and now more robust in trying to prevent skin break down. RDCS provided copies of the eight-week prevention program. On 5/15/26 an end-of-day meeting was held with Administrator, DON and Regional Director of Clinical Services and they were made aware of the above concerns. No additional information was provided prior to the exit conference.

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F 0697 Level of Harm - Actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on staff interviews, resident interviews, clinical record reviews, and facility documentation reviews the facility staff failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This deficient practice resulted in harm for three residents, Resident #6 (R6), Resident #7 (R7), and Resident #8 (R8) out of a survey sample of nine residents. The findings included:The facility staff failed to have a licensed nurse on the west wing for approximately 12 hours to assess, monitor and to administer pain medications to the residents for pain management, resulting in untreated pain for Resident #6 (R6), Resident #7 (R7), and Resident #8 (R8), which was harm. 5/12/26 at 4:30 pm, a telephone interview was conducted with licensed practical nurse, LPN3. LPN3 stated that no nurse came in to the facility that night and there was no nurse on west wing nursing unit medication cart until the nurse from first shift came in the following morning at 7:00 a.m. LPN3 stated that LPN2 apparently passed the medications on the west wing unit A hall but didn't pass any medication on the b hall. She stated that some of the residents on the b hall were complaining and went to the east unit to see if the nurse on that unit could give them medications and she told them she didn't have keys to their medication cart and she gave the residents grievance forms to fill out with their concerns. On 5/13/26 at 11:00 am, an interview was conducted with Resident #8 (R8). During the interview, R8 stated that she remembered that night because we had no nurse on the unit and it was snowing. She stated that Tramadol helps keep my legs from hurting. R8 said, I asked when it was so late when I was going to get my medicine and someone said no nurse was here to give the medicine at bedtime. anytime you have no nurse it upsets you.On 5/13/26 at 11:15 am, an interview was conducted with R7. R7 was interviewed in reference to the incident that occurred on 1/31/26 on the west wing nursing unit. R7 stated that it was no nurse on the unit that night. R7 stated she requested pain medication several times during the night and there was no nurse to give her pain medication. R7 stated that she could not go back to sleep that night due to her pain. She stated she did not like not having a nurse. R7 said, scary with no nurse when you have things that I have and that is why I am her to be taken care of.On 5/13/26 at 11:30 am, an interview was conducted with R6. R6 stated that she was wide awake all night waiting on her medications. She stated 12 hours was a long time to go without any of my medications. R6 said, the nurse just took off and left us and it pissed me off seeing her back in here the next morning. R6 stated every resident on the unit was upset about not having a nurse all night.On 5/13/26 at 12:00 pm, a clinical record review was conducted. A review of R6's medication administration record (MAR) was completed during the review. R6's MAR had not been signed off by a nurse for medications on the evening of 1/31/26 at bedtime. R6 was not given Melatonin for insomnia, Tizanidine for spasms, Tylenol for pain and Gabapentin for painR7's clinical record was reviewed. R7's MAR had no nurse signature on bedtime medications for 1/31/26. The medications R7 was suppose to receive at bedtime was Melatonin for insomnia, Trazodone for sleep, Flecainde for atrial fibrillation, Oxycontin ER 12 hour for pain, and Buspar for anxiety R8's medication administration record was reviewed. There was no signature on R8's MAR for the evening on 1/31/26 at bedtime. R8 was suppose to get Metoprolol scheduled and she also gets Tramadol nightly, but it is as needed medication.On 5/13/26, a facility documentation was reviewed. The facility policy titled, Medication Administration, read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review MAR to identify medication to be administered. Observe resident consumption of medication. 19. Wash hands using facility protocol and product. 20. Sign MAR after administered. For those medications requiring vital signs, record vital signs onto the MAR. 21. If medication is a controlled substance, sign narcotic book. 22. Report and document any adverse side effects or refusals. 23. Correct any discrepancies and report to nurse (continued on next page)

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	495344	A. Building B. Wing	05/15/2026

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F 0697 Level of Harm - Actual harm Residents Affected - Some	manager.The facility document titled, Pain Management, read in part, 2. Facility staff will observe for nonverbal indicators which may indicate the presence of pain. 3. Facility staff will be aware of verbal descriptors a resident may use to report or describe their pain. Based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary team (e.g., nurses, practitioner, pharmacists, and anyone else with direct contact with the resident). 8. a. Facility staff will reassess resident's pain management at established intervals for effectiveness and/or adverse consequences. b. If re-assessment findings indicate pain is not adequately controlled, the pain management regimen and plan of care will be revised as indicated. C. If pain has resolved or there is no longer an indication for pain medication, the interdisciplinary team will work to discontinue or taper (as needed to prevent withdrawal symptoms) analgesics. d. If a resident reports or there are signs of increased pain, the facility should evaluate whether there is a time or day pattern to ensure that the problem is not due to drug diversion. On 5/13/26 at 8:50 pm, a meeting was called with the administrator, director of nursing, and the regional director of clinical services. They were informed of the above concerns. No additional information was provided prior to exit conference.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on staff interviews, resident interviews, and facility documentation reviews, the facility staff failed to ensure sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident affecting 39 residents on the [NAME] Wing. Specifically, the facility failed to ensure licensed nurse coverage on the west wing, resulting in one of the three nursing units operating without a licensed nurse available to administer medications or provide nursing oversight for approximately 12 hours. This deficient practice resulted in the identification of immediate jeopardy (IJ), and subsequent substandard care. Following the removal of the IJ, the scope and severity was lowered to a level 3 widespread noncompliance. The findings included: The facility failed to provide sufficient licensed nursing staff to meet resident needs when the [NAME] Wing nursing unit operated without licensed nurse coverage from approximately 7:47pm on 1/31/26 until 7:00am on 2/1/26. During this 12-hour period, residents lacked access to licensed nursing assessment, medication administration and nursing intervention in response to changes of condition or emergencies. On 1/31/26 a licensed practical nurse (LPN2), who was the unit manager left the [NAME] Wing nursing unit, clocked out at 7:47 pm, and left the facility without another nurse being present to provide for resident needs. There was no oncoming nurse coverage. LPN2 did not give a verbal report to a nurse, did not count her narcotics with a nurse, and left the medication cart keys in the narcotic logbook on the medication cart. Another nurse did not arrive at the west wing unit to take care of the residents until the following day, 2/1/26 at 7 AM. On 5/12/26 at 4:46 pm, an interview was conducted with the director of nursing, DON. She stated that on 1/31/26 she was contacted by a licensed practical nurse, LPN3. She stated that LPN3 informed her that LPN2 had left the facility and placed the medication cart keys inside the narcotic logbook on top of the medication cart. The DON stated while she was speaking with LPN3 on the telephone, another call came through from a nurse employed at the facility who stated she was going to come into the facility and assume responsibility for the unit medication cart for the night shift on 1/31/26. The DON stated she was not contacted again and did not speak with any additional facility staff regarding the situation until the following morning. The DON acknowledged she later became aware that no nurse had come into the facility that night. On 5/12/26 at 2:30 pm, an interview was conducted with LPN2, unit manager of west wing nursing unit. She said, I shouldn't have left the med cart without giving report and counting narcotics. I did get talked to by the DON about that and she did a corrective action on me about that. I know it wasn't later than 7:00 pm when I left, I needed to work my schedule shift. I left the facility, left the medication cart keys in the narcotic book on top of medication cart, and I know leaving the keys in book was wrong. When leaving the unit, in the hallway I told a nurse that I wrote a report down and left it the nursing station and told her if she had any questions, call me. I counted narcotics against myself. On 5/12/26 at 4:30 pm, a telephone interview was conducted with LPN3. LPN3 stated the scheduled nurse called out at the last minute, and no one ever assumed responsibility for the medication cart keys. LPN3 stated she contacted both the director of nursing, (DON) and the administrator to notify them of the situation occurring at the facility and to obtain guidance. LPN3 was working the unit as an aide, to have sufficient staffing to care for the residents and was doing solely aide duties. LPN3 stated that the DON returned the call and instructed her to take the medication cart keys. LPN3 stated she informed the DON that she did not feel comfortable taking the keys because no resident report had been given and no narcotic count was completed. LPN3 stated the DON reported she was already in bed and that it was not safe for her to come into the facility. According to LPN3, the DON stated she would not be coming into the facility. LPN3 further stated the DON did not call back to follow up regarding nursing coverage for the unit and no licensed nurse came (continued on next page)

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	495344	A. Building B. Wing	05/15/2026

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	into the facility that night to assume responsibility for the oversight and nursing care of the residents on the unit, medication cart keys or provide medication administration coverage. LPN3 stated the administrator was also contacted; however, he never responded to the voicemail messages or text messages left regarding the situation. On 5/13/26 at 11:00 am, an interview was conducted with Resident #8 (R8). During the interview, R8 stated that she remembered that night because they had no nurse on the unit and it was snowing. R8 said that Tramadol helps keep my legs from hurting. R8 said, I asked when it was so late when I was going to get my medicine and someone said no nurse was here to give the medicine at bedtime. Anytime you have no nurse it upsets you.On 5/13/26 at 11:15 am, an interview was conducted with Resident #7 (R7). R7 was interviewed in reference to the incident that occurred on 1/31/26 on the west wing nursing unit. R7 stated that it was no nurse on the unit that night. R7 stated she requested pain medication several times during the night and there was no nurse to give her pain medication. R7 stated that she could not go back to sleep that night due to her pain. She stated she did not like not having a nurse. R7 said, scary with no nurse when you have things that I have and that is why I am here to be taken care of.On 5/13/26 at 11:30 am, an interview was conducted with R6. R6 stated that she was wide awake all night waiting on her medications. She stated 12 hours was a long time to go without any of my medications. R6 said, the nurse just took off and left us and it pissed me off seeing her back in here the next morning. R6 stated every resident on the unit was upset about not having a nurse all night.On 5/13/26 at 12:00 pm, a clinical record review was conducted. A review of R6's medication administration record (MAR) was completed during the review. R6's MAR had not been signed off by a nurse for medications on the evening of 1/31/26 at bedtime. R6 was not given Melatonin for insomnia, Tizanidine for spasm, Tylenol for pain and Gabapentin for painR7's clinical record was reviewed. R7's MAR had no nurse signature on bedtime medications for 1/31/26. The medications R7 was supposed to receive at bedtime were Melatonin for insomnia, Trazodone for sleep, Flecainide for atrial fibrillation, Oxycontin ER 12 hours for pain, and Buspar for anxiety.R8's medication administration record was reviewed. There was no signature on R8's MAR for the evening on 1/31/26 at bedtime. R8 was supposed to get Metoprolol scheduled and she also gets Tramadol nightly, but it is as needed medication.On 5/15/26 at 2:25 pm, an interview was conducted with LPN 4. She stated that she was the oncoming nurse on 2/1/26. She stated that there were no nurses to get reports from, count narcotics with and the medication cart keys were in the narcotic logbook on top of the medication cart. She said, this was the night of 1/31/26 and staff that were here told me the unit manager had left the evening before, and residents had not been medicated all night I called the DON [name redacted] and she came in and we counted the cards. I work [NAME] B Hall I cannot remember anyone on that hall but the [NAME] A Hall didn't get meds and were calling their families. She stated staffing and callouts was an issue and said, we just get burnt out as nurses. On 5/14/26 a review of facility documentation was conducted. The facility policy titled, During an emergency, staff currently on duty will be required to stay on duty until they are relieved by other staff. Staff may not leave during an emergency to attend to personal needs.The facility document title, Job Description-Executive Director I, read in part, The local standards, guidelines, and regulations direct the day-to-day functions of the facility in accordance with current federal, state, and that govern nursing facilities to ensure that the highest degree of quality care can be provided to ideas our residents and concepts at all that times provide leadership to all facility staff in meeting the goal of providing quality resident care. This evaluated in part based upon the performance duties of the job. You may be asked by the supervisors or managers to perform other duties. You will be employment, and either you or the employer of the tasks listed in this job description at any time. This job description is not a contract for may terminate employment at any time, for any reason. It was signed by the administrator on 3/5/2026.The facility document titled, Job description Director of Clinical Services I, read in part, Purpose of Your Job Position As the company Director of Clinical Services, you are entrusted with the responsibility of caring for our residents, families, co-workers. visitors, and all others; as well as demonstrating in all interactions. The primary (continued on next page)

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	495344	A. Building B. Wing	05/15/2026

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	purpose of your job position is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Executive Director to ensure that the highest degree of quality care is maintained at all times. Responsible for planning, organizing, and directing the functions for the nursing department. You will assume the primary role in ensuring the delivery of high quality, efficient nursing care. Supervises Nurse Practitioner. Assistant Director of Clinical Services, Clinical Nurses, and Nurse Techs. In the absence of the Executive Director, you are charged with carrying out the resident care policies established by this facility. either you or the employer may terminate employment at any time, any reason. It was signed by the DON on 11/19/2025LPN2 leaving the facility without an oncoming nurse left the [NAME] Wing nursing unit without nursing supervision, without someone to give medications, complete treatments, assess and monitor residents, identify changes in condition, communicate with the medical doctor/providers, receive new orders, or respond in the event of an emergency. As a result of the facility's failure to provide licensed nurse coverage, resident interviews confirmed negative outcomes, including untreated pain, delayed medication administration, anxiety and psychosocial harm. Resident #8 reported not receiving prescribed bedtime medication and stated. Anytime you have no nurse it upsets you. Staff interviews further confirmed residents did not receive medications during the overnight period and were contacting family members about lack of nursing staff. The facility needs to take immediate action to ensure the facility has adequate nurse staffing to meet the needs of residents. The likelihood of a serious injury, serious harm, serious impairment, or death is likely without a nurse to respond to resident changes. On 5/13/26 at 2:53 pm, after consulting with the state agency supervision, immediate jeopardy (IJ) was identified regarding insufficient staffing, which started 1/31/26. A meeting was held with the Administrator, the Director of Nursing, and the Regional Director of Clinical Services. They were informed that immediate jeopardy had been identified and a copy of the IJ template was provided. During the reading of immediate jeopardy (IJ) the Administrator said, did they [residents] remember that they didn't get medicine, they couldn't sleep and nobody was there. January February, March, April, May, 5 months later? It was explained on the night of 1/31/26 there were no nurses on west wing to meet their needs, and it was snowing is how this night was recalled by the residents. The Regional Director of Clinical Service said, as to the harm if nothing happened, no one went to the hospital, and nothing drastic, so what is the harm? He was asked to allow the IJ template to be read completely to answer his questions. The second section of the template was read which included the details of the resident interviews and after that the RDCS stated his question was answered. On 5/13/26 at 20:50 pm, the facility submitted a removal plan that read as follows: F725: 1. Immediately upon notification of the Immediate Jeopardy, the Administrator and Director of Nursing verified that every nursing unit had a licensed nurse.2. The facility implemented an emergency staffing protocol requiring that if scheduled relief fails to arrive: Initiate emergency staffing [NAME]. Off-going nurse must remain on duty.b. The Director of Nursing to be notified immediatelyc. On-call leadership staff or PRN staff to provide coverage until relief arrives3. All licensed nurses will be educated on emergency staffing plan.4. The DON/ED will review daily staffing patterns to ensure adequate coverage. Any identified gaps in coverage will be identified and corrected.QAPI meeting held with IDT review.Date: 5/14/2026 Time: 3pm On 5/14/26 at 3:00 pm, the survey team completed the following:1. Reviewed the emergency staffing protocol2. Reviewed the on-call leadership schedule3. Reviewed the staffing patterns throughout the weekend4. Interviewed staff for education regarding the emergency staffing plan. After verification of the plan of immediate jeopardy removal and consultation with state agency supervisory staff, the immediate jeopardy was removed on 5/14/26 at 3 PM at which time the facility administration was notified. Following the removal of immediate jeopardy status, this deficiency was cited at level three widespread.No additional information was provided prior to the exit conference.

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	495344	A. Building B. Wing	05/15/2026

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on facility documentation review, and staff interview the facility staff failed to ensure complete nurse staffing information was available for review. The findings included:The facility staff failed to provide the staff postings for the last two weeks of January that was requested for review.On 5/11/26 at 2:00 pm, a request was made for the staff posting for the month of January 2026; however, while reviewing the staff postings there were several days that was not provided. A second request was made for the staffing post for for the last week of January 2026 which would have been the days of the 24th through the 31st. I was provided with the assignment sheets on the units for the 25th and 31st of January and then the as worked schedule for the 25th, 29th, 30th and the 31st of January. Then a 3rd request was made for the staff posting and the social worker director, other staff #3, (OS3) provided the 25th, 29th - 31st of January copies of the staff information that is submitted for the payroll based journal report. On 5/12/26 at 3.45 pm, an interviewed was conducted with OS3 that had provided the payroll based journal reports. She was asked if they had the daily staff postings that was suppose to be posted daily where the visitors and residents knew what staff was suppose to be in the facility. She said, oh yes we have the one that are for nursing staff daily and it is posted at the time clock daily with corrections on it if a call off but these are the ones we submit for staffing and I will bring you the others. OS3 then provided the daily staffing reports for 1/25, 1/29, 1/30, 1/31 and May 11th through 15th 2026.On 5/13/26, the staff daily postings were reviewed. During the review, the staff daily posting that was provided did not have LPN2 listed on the posting as being at the facility on 1/31/26; however, she was the charge nurse on the west wing unit. The staff nursing posting for 1/31/26 was not an accurate posting of the staff that was working in the facility that day.On 5/13/26, an end of day meeting was conducted with the director of nursing, and the regional director of clinical services and they were informed of the above concerns. No additional information was provided prior to exit conference.

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	495344	A. Building B. Wing	05/15/2026

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on staff interviews, resident interviews, clinical record reviews, and facility documentation review the facility staff failed to ensure residents were provided pharmaceutical services that included administration of medications to meet the needs of each resident. The findings included:The facility staff failed to have a licensed nurse on the medication cart to administer medications for approximately 12 hours on 1/31/26.On 5/12/26 at 4:30 pm, an interview was conducted with a licensed practical nurse, LPN3. During the interview, LPN3 stated that LPN2 apparently passed the medications on the west wing unit A hall but didn't pass any medication on the b hall. She stated that some of the residents on the b hall were complaining and went to the east wing unit to see if the nurse on that unit could give them medications and she told them she didn't have keys to their medication cart and she gave the residents grievance forms to fill out with their concerns. LPN3 also stated that LPN 2 was suppose to call her and let her know who received medications and who did not get their medications and she never called that evening to let her know. On 5/13/26 at 11:00 am, an interview was conducted with Resident #8 (R8). During the interview, R8 stated that she remembered that night because we had no nurse on the unit and it was snowing. She stated that Tramadol helps keep my legs from hurting. R8 said, I asked when it was so late when I was going to get my medicine and someone said no nurse was here to give the medicine at bedtime. anytime you have no nurse it upsets you.On 5/13/26 at 11:15 am, an interview was conducted with R7. R7 was interviewed in reference to the incident that occurred on 1/31/26 on the west wing nursing unit. R7 stated that it was no nurse on the unit that night. R7 stated she requested pain medication several times during the night and there was no nurse to give her pain medication. R7 stated that she could not go back to sleep that night due to her pain. She said, I did not like not having a nurse. R7 said, scary with no nurse when you have things that I have and that is why I am her to be taken care of.On 5/13/26 at 11:30 am, an interview was conducted with R6. R6 stated that she was wide awake all night waiting on her medications. She stated 12 hours was a long time to go without any of my medications. R6 said, the nurse just took off and left us and it pissed me off seeing her back in here the next morning. R6 stated every resident on the unit was upset about not having a nurse all night.On 5/13/26 at 9:40 am, an interview was conducted with the director of nursing (DON). She said she spoke with a resident about no nurse being on the unit and stated I don't think it was right ; however, there are two sides to that story that happened on 1/31/26, she said, I have what is right here in front of me [medication administration record and narcotic control log book] and what you [resident] say, I will look into it. She stated that she came in the next morning and on Sunday morning she counted with the nurse, compared the narcotic medication cards with the MAR and stated that the count was correct. She stated that there were no discrepancies with the narcotic count and she was not aware of any missed medications that evening. She stated that she had LPN2 come in and sign off the narcotic log book for the medications that was given by LPN2 on 1/31/26. The DON stated that she did not do a formal investigation and was only going by the grievance that was submitted.On 5/13/26 at 12:00 pm, a clinical record review was conducted. A review of R6's medication administration record (MAR) was completed during the review. R6's MAR had not been signed off by a nurse for medications on the evening of 1/31/26 at bedtime. R6 was not given Melatonin for insomnia, Tizanidine for spasms, Tylenol for pain and Gabapentin for painR7's clinical record was reviewed. R7's MAR had no nurse signature on bedtime medications for 1/31/26. The medications R7 was suppose to receive at bedtime was Melatonin for insomnia, Trazodone for sleep, Flecainide for atrial fibrillation, Oxycontin ER 12 hour for pain, and Buspar for anxiety R8's medication administration record was reviewed. There was no signature on R8's MAR for the evening on 1/31/26 at bedtime. R8 was suppose to get Metoprolol scheduled and she also gets Tramadol nightly, but it is as needed medication and was unable to request the Tramadol because there was no nurse to administer the as (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed medications.On 5/13/26, a facility documentation was reviewed. The facility policy titled, Medication Administration, read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review MAR to identify medication to be administered. Observe resident consumption of medication. 19. Wash hands using facility protocol and product. 20. Sign MAR after administered. For those medications requiring vital signs, record vital signs onto the MAR. 21. If medication is a controlled substance, sign narcotic book. 22. Report and document any adverse side effects or refusals. 23. Correct any discrepancies and report to nurse manager.On 5/13/26 at 2:53 pm, the regional director of clinical services, RDCS. He stated, after IJ [immediate jeopardy] was called, said, that we know that we had done wrong. We did it and accepted and moved on; however, my concern was between the harm versus staffing, and we had already started working on notifying the physician, looking at the MARS and clinical records of the resident's and looking at staffing, and we need to concentrate on not having this issue. It was staffing issues back then and it was bad.On 5/14/26 at 6:30 pm, we had an end of day meeting with the administrator, DON, and the RDCS. Above concerns were discussed. Explained we would be back tomorrow for the removal of IJ and requested the items that was needed.No additional information was provided prior to exit conference.

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F 0835 Level of Harm - Actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on staff interviews, resident interviews, and facility documentation the facility staff failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident which resulted in harm to several residents, who had untreated pain, residing on one unit out of three units. The findings includedThe facility administration failed to ensure a licensed nurse was present on an entire unit for approximately a 12-hour period to administer scheduled medications, assess for changes in condition, communicate with the doctor, receive new orders, initiate life-saving measures in the event of an emergency, and provide any skilled nursing care such as enteral feedings, intravenous medications and fluid management, dialysis port monitoring, etc. This failure to have a nurse available on the unit had the potential to result in harm to all residents on the unit. On 5/12/26 at 4:46 pm, an interview was conducted with the director of nursing, DON. She stated that on 1/31/26 she was contacted by a licensed practical nurse, LPN3. She stated that LPN3 informed her that LPN2 had left the facility and placed the medication cart keys inside the narcotic logbook on top of the medication cart. The DON stated while she was speaking with LPN3 on the telephone, another call came through from a nurse employed at the facility who stated she was going to come into the facility and assume responsibility for the unit medication cart for the night shift on 1/31/26. The DON stated she was not contacted again and did not speak with any additional facility staff regarding the situation until the following morning. The DON acknowledged she later became aware that no nurse had come into the facility that night. The DON stated that the following morning she came into the facility, completed the narcotic count with the oncoming nurse, and had LPN2 come into the facility to sign out the narcotic logbook for the medications administered on 1/31/26. The DON further stated she completed corrective action/counseling with LPN2 on the Monday following the incident. On 5/12/26 at 2:30 pm, an interview was conducted with LPN2, who was the unit manager of west wing nursing unit. She said, I shouldn't have left the med cart without giving report and counting narcotics. I did get talked to by the DON about that and she did a corrective action on me about that. I know it wasn't later than 7:00 pm when I left, I needed to work my scheduled shift. I left the facility, left the medication cart keys in the narcotic book on top of medication cart, and I know leaving the keys in book was wrong. When leaving the unit, in the hallway I told a nurse that I wrote a report down and left it [the report] at the nursing station and asked her if she had any questions to call me. I counted narcotics against myself. On 5/12/26 at 4:30 pm, a telephone interview was conducted with LPN3. LPN3 stated the scheduled nurse called out at the last minute, and no one ever assumed responsibility for the medication cart, keys, or unit. LPN3 stated she contacted both the director of nursing, (DON) and the administrator to notify them of the situation occurring at the facility and to obtain guidance. LPN3 stated that the DON returned the call and instructed her to take the medication cart keys. LPN3 stated she informed the DON that she did not feel comfortable taking the keys because no narcotic count had been given. LPN3 stated the DON reported she was already in bed and that it was not safe for her to come into the facility. According to LPN3, the DON stated she would not be coming into the facility. LPN3 further stated the DON did not call back to follow up regarding nursing coverage for the unit and no licensed nurse came into the facility that night to assume responsibility for the medication cart keys or provide medication administration coverage. LPN3 stated the administrator was also contacted; however, he never responded to the voicemail messages or text messages left regarding the situation. On 5/13/26 at 2:53 pm, during the reading of immediate jeopardy (IJ) template regarding the incident, the administrator said, did they [residents] remember that they didn't get medicine, they couldn't sleep and nobody was there. January February, March, April, May, five months later? The surveyor explained on the night of 1/31/26 there was no nurse on west wing to meet their needs, and it was snowing was how that night was recalled by the residents. The Regional Director of Clinical Services (RDCS) said, as to the harm if nothing happened, no one (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Few	went to the hospital, and nothing drastic, so what is the harm? He was asked to allow the IJ template to be read completely to answer his questions. The second section of the template was read and after that the RDCS stated his question was answered. On 5/15/26 at 2:25 pm, an interview was conducted with LPN 4. She stated that she was the oncoming nurse on 2/1/26. She stated that there were no nurses to get reports from, count narcotics with and the medication cart keys were in the narcotic logbook on top of the medication cart. She said, this was the night of 1/31/26 and staff that were here told me the unit manager had left the evening before, and residents had not been medicated all night I called the DON [name redacted] and she came in and we counted the cards. I work [NAME] B Hall I cannot remember anyone on that Hall but the west a Hall didn't get meds and were calling their families. She stated staffing and callouts were issues and said, we just get burnt out as nurses.On 5/13/26 at 11:00 am, an interview was conducted with Resident #8 (R8). During the interview, R8 stated that she remembered that night because we had no nurse on the unit and it was snowing. She stated that Tramadol helps keep my legs from hurting. R8 said, I asked when it was so late when I was going to get my medicine and someone said no nurse was here to give the medicine at bedtime. anytime you have no nurse it upsets you.On 5/13/26 at 11:15 am, an interview was conducted with R7. R7 was interviewed in reference to the incident that occurred on 1/31/26 on the west wing nursing unit. R7 stated that it was no nurse on the unit that night. R7 stated she requested pain medication several times during the night and there was no nurse to give her pain medication. R7 stated that she could not go back to sleep that night due to her pain. She said, I did not like not having a nurse. R7 said, scary with no nurse when you have things that I have and that is why I am her to be taken care of.On 5/13/26 at 11:30 am, an interview was conducted with R6. R6 stated that she was wide awake all night waiting on her medications. She stated 12 hours was a long time to go without any of my medications. R6 said, the nurse just took off and left us and it pissed me off seeing her back in here the next morning. R6 stated every resident on the unit was upset about not having a nurse all night.On 5/14/26 a review of facility documentation was conducted. The facility policy titled, During an emergency, staff currently on duty will be required to stay on duty until they are relieved by other staff. Staff may not leave during an emergency to attend to personal needs.The facility document title, Job Description-Executive Director I, read in part, Purpose of Your Job, is responsible but for management of the facility in a manner which exemplifies the company's standard of not limited to creating an environment in which employees demonstrate the Company's core values primary towards purpose one another of the and Executive everyone Director they come is to into contact with, and business practices are conducted with those same core values. The local standards, guidelines, and regulations direct the day-to-day functions of the facility in accordance with current federal, state, and that govern nursing facilities to ensure that the highest degree of quality care can be provided to ideas our residents and concepts at all those times. continually You are entrusted to provide innovative, responsible healthcare with the creation and implementation of new improve systems and processes to achieve superior results. Job Functions assigned Executive duties. Director Responsible I, you for are delegated the administrative authority, responsibility, and accountability necessary for carrying out your day-to-day clinical and administrative activities of the facility, including profit and loss responsibility and ensures Office Coordinator, compliance with Director all state and federal regulations. It was signed by the administrator on 3/5/2026.The facility document titled, Job Description Director of clinical services I, read in part, Purpose of Your Job Position As the company Director of Clinical Services, you are entrusted with the responsibility of caring for our residents, families, co-workers. visitors, and all others; as well as demonstrating in all interactions, The company's core values. The primary purpose of your job position is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Executive Director to ensure that the highest degree of quality care is maintained at all times. You are entrusted to provide innovative, responsible healthcare with the creation and (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Few	implementation of new ideas and concepts that continually improve systems and processes to achieve superior results. Job Functions As Director of Clinical Services I, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Responsible for planning, organizing and directing the functions for the nursing department. You will assume the primary role in ensuring the delivery of high quality, efficient nursing care. Supervises Nurse Practitioner. Assistant Director of Clinical Services, Clinical Nurses, and Nurse Techs. In the absence of the Executive Director, you are charged with carrying out the resident care policies established by this facility. This job description does not list all the duties of the job. You may be asked by the supervisors or managers to perform other duties. You will be evaluated in part based upon your performance of the tasks listed in this job description at anytime. This job description is not a contract for employment, and either you or the employer may terminate employment at any time, any reason. It was signed by the DON on 11/19/2025.On 5/15/26 at 12:30 pm, an exit conference was being conducted and during the exit conference the administrator was smacking his hand on the table and saying several times that he would fight this that he would bust hell wide open before this went on his administrative license. The administrator again stated he would fight it because he was not here in Virginia when it occurred and said again, I will fight bust hell wide open because I was not going to take a hit to my administrators license, when I was not even in the state of Virginia. Then he stated to the regional director of clinical services and the DON and said, as y'all will lose a good administrator because I'm not renewing my license in the state of Virginia.No additional information was provided prior to the end of the exit conference.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, staff interviews, and facility documentation the facility staff failed to maintain an infection prevention and control program designed to provide residents with a safe, sanitary and comfortable environment for one of ten residents (Resident #10). The findings included:The facility staff failed to follow infection prevention and control practices when staff wore gloves in the hallway and Resident #10's foley catheter drainage bag was lying on the floor with an over bed table sitting on top of the foley bag.On 5/11/26 at 12:00 pm, during the initial tour of the nursing units of the facility it was observed on the east wing nursing unit several staff members wearing gloves in the hallway and Resident #10's foley catheter drainage bag on the floor with a over-bed table sitting on top of the foley bag. The foley bag was observed to be excessively full.On 5/11/26 at 12:08 pm, a certified nursing assistant, CNA (CNA1) was interviewed. CNA1 observed the foley drainage bag on the floor lying under the over bed table. CNA1 said, urine bags should be on the bed frame hanging, this bag needs to be emptied, it's about to burst.On 5/12/26 at 5:30 pm, an end of day meeting was held with the director of nursing, and the regional director of clinical services. They were made aware of the above concerns. On 5/13/26 at 10:00 am, the director of nursing and regional director of clinical services presented a Quality Assurance and Performance Improvement (QAPI) Meeting concerning infection control. A review of the QAPI meeting was conducted. The QAPI minutes read in part, .witnessed staff carrying linen unbagged to soiled utility, gloves in hallway, analysis rushing not doing what they are suppose to do education. On 5/13/26 at 6:00 pm, and end of day meeting was held with the director of nursing and the regional director of clinical services. The above concerns were discussed. They asked if the QAPI meeting minutes were reviewed and they were informed the QAPI minutes provided was reviewed.On 5/14/26 at 5:10 pm, an interview was conducted with CNA3. She stated she knew gloves were not suppose to be worn in the hallways. She said, you are suppose to take them off before you leave the residents room and clean your hands that they are not supposed to be worn out in the common areas.On 5/14/26 at 5:20 pm, an interview was conducted with CNA2 about wearing gloves in the hallway. She stated that gloves should not be worn in the hallways.On 5/14/26, a facility document was reviewed. During the facility documentation review, the facility policy titled, Standard Precautions Infection control, read in part, .All staff are to assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Therefore, all staff shall adhere to Standard Precautions to prevent the spread of infection to residents, staff and visitors Standard Precautions refer to the infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. This includes hand hygiene, selection and use of PPE (e.g., gloves, gowns, facemasks, respirators, eye protection), respiratory hygiene and cough etiquette, safe injection practices, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment.On 5/14/26 at 5:00 pm, and end of day meeting was held with the director of nursing and the regional director of clinical services. The above concerns were discussed. No additional information was provided prior to exit.

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. Based on observation, resident interviews, staff interviews, and facility documentation the facility staff failed to ensure resident furnishings and equipment were maintained in good repair and safe condition for one resident, Resident #7 (R7) out of a survey sample of nine residents. The findings included:The facility staff failed to ensure that the resident's furniture was safe and functional.On 5/13/26 at 11:15 am, an observation was made of R7 in her room holding the facing of a dresser drawer after the drawer had fallen apart. The resident's belongings were observed lying on the floor. While the surveyor was present in the room the maintenance assistant entered to repair the wrong piece of furniture and had to be redirected to the broken dresser drawer. The maintenance assistant picked up the broken wood, stated someone would be in to sweep the floor, and reported the drawer would be fixed. R7 reported that the dresser drawer facing had struck her knee when the drawer fell apart, and the concern was reported to nursing staff.On 5/13/26 at 11:15 am, an interview was conducted with R7. She stated that she had asked several times for the dresser to be replaced because two to three drawer facings would come off when the drawers were opened and the dresser was broken.On 5/14/26 at 6:30 pm, an end of day meeting was held to discuss the concerns above. The regional of clinical services stated a new dresser was placed in the room yesterday. He said, the resident came to me, asked was I from the state. I told her no, but I could help her so he went into the room. She showed me the dresser and they put in a new one.On 5/14/26 at 7:16 pm, an interview was conducted with the maintenance director. He stated that R7 had asked him several times for another dresser; however, he assumed she wanted an additional dresser and told her there was not enough room in the room for two dressers. The maintenance director stated he never checked the dresser and was unaware it was broken until the previous day, at which time repairs were initiated. On 5/14/26, a review of the facility documentation was conducted. The facility policy titled, Safe and Homelike Environment, read in part, .In environment, accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike includes allowing the resident to use his or her personal belongings to the extent possible. This facility, both ensuring inside that the resident can receive care and services safely and that the physical layout of the and outside, maximizes resident independence and does not pose a safety risk. Environment to) the residents' refers to any environment in the facility that is frequented by residents, including (but not and activity areas. rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas A extent homelike possible, environment is one that de-emphasizes the institutional character of the setting, to the and allows the resident to use those personal belongings that support a homelike environment. environment. A determination of homelike should include the resident's opinion of the living.No additional information was provided prior to exit conference.On 5/15/26 at 12:30 pm, during the exit conference the administrator stated he did not understand why the concern was being cited because the dresser was repaired quickly after being identified; however, the dresser had not been maintained in safe and functional condition prior to the surveyor's observation.