STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and facility document review, the facility staff failed to notify the physician per the physician orders for one of four residents in the survey sample, Resident #202.The findings include:For Resident #202 (R202) the facility failed to notify the physician of blood sugars outside the physician ordered parameters.R202 was admitted to the facility on [DATE] with recent readmission on [DATE], with diagnoses that included but were not limited to: insulin dependent diabetes, stroke, underweight, depression, anorexia, dementia and high blood pressure.The most recent MDS (Minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/16/2026, coded the resident as scoring a 99, indicating the resident was unable to complete the interview. In Section C0700, the resident was coded as having but short- and long-term memory difficulties. In Section N - Medication, the resident was coded as receiving three insulin injections over the past seven days. The physician order dated, 7/20/2026, documented, Insulin Lispro Injection Solution 100 UNIT/ML (milliliter); Inject 4 units subcutaneously three times a day for *HOLD IF BLOOD SUGAR IS LESS THAN 120 PER (NAME OF NURSE PRADCTTIONER) RELATED TO Tyle 2 DIABETES Mellitus with hyperglycemia (high blood sugar). Call MD (medical doctor) if BG (blood glucose) is < (less than) 60 or > 250.The May 2026 MAR (medication administration record) documented the above order. On the following dates and times, the blood sugars were documented:5/2/2026 at 1:00 p.m. = 3185/3/2026 at 9:00 a.m. = 347; 1:00 p.m. = 3195/4/2026 at 9:00 a.m. = 308; 1:00 p.m. = 256; 5:00 p.m. = 3085/5/2026 at 9:00 a.m. = 278; 1:00 p.m. = 312Review of the clinical record failed to evidence documentation that the physician or nurse practitioner was notified of the above blood sugars per the physician orders. The physician order dated 4/26/2026 documented, Insulin Lispro Injection Solution; Inject as per sliding scale: if 140-199= 0 units; 200-259 = 2 units; 300-349=4 units; 350-400=Call MD, subcutaneously before meals for DM (diabetes mellitus).An interview was conducted with LPN (licensed practical nurse) #1 on 7/1/2026 at 2:35 p.m. The above orders and MAR were shown to LPN #1 who worked on several of the days there was no documented notification to the doctor or NP. When asked if she notified the nurse practitioner or doctor of the blood sugars according to the order, LPN #1 stated, I didn't call anyone. When asked should she have called, LPN #1 stated, Yes.An interview was conducted on 7/1/2026 at 3:21 p.m. with the Medical Director. The Medical Director stated that if there is an order for he or the nurse practitioner to be call, then he would expect them to call. The above orders were reviewed with the Medical Director. He stated he felt the order for to call for a blood sugar greater than 150 is a bit low for notification, but if an order is there, then it should be followed.The Administrator and the DON were made aware of the above findings on 7/2/2026 at 10:00 a.m.No further information was provided prior to exit.

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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, the facility staff failed to prevent an alleged allegation sexual abuse for one of four residents in the survey sample, Resident #202.The findings include: For Resident #202 (R202), the facility staff failed to protect the resident from an allegation of alleged sexual abuse from Resident #203 (R203)R202 was originally admitted to the facility on [DATE] with diagnoses that included but were no limited to: vascular dementia, peripheral vascular disease, anxiety disorder, and unsteadiness on her feet.The most recent MDS (minimum data set) assessment, a Medicare five-day assessment, with an assessment reference date (ARD) of 6/3/2026, the resident was coded as having both short- and long-term memory difficulties.Resident #203 was initially admitted to the facility on [DATE] with diagnoses that included but were not limited to: stroke, diabetes, alcohol dependence with alcohol-induced persisting dementia, altered mental status obsessive-compulsive behavior and anxiety disorder.The most recent MDS, an annual assessment with an ARD of 5/11/2026, coded the resident as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired for making daily decisions.The facility synopsis of the event documented in part, On 6/9/2026 at approximately 11:15 a.m., (name of another resident) alerted the Business Office Manager [BOM], who was coming down the hall toward the Unit 2 Nurse Station, that another resident, (R203) was touching a female resident (R204). The Business Office Manager went over and observed (R203), leaning over on (R204)'s chair, he had his arm around her and his other hand between her legs rubbing, mid-thigh. She asked him to stop and move away, which he did. The Unit Manager and Nurse returned to the Nurse Station after hearing (name of resident) alert the BOM. The Nurse did a complete body assessment on (R204) and there were no areas of concern, (R203) was immediately place on continuous 1:1 and was subsequently relocated to a different unit.An interview was conducted with the BOM on 7/2/2026 at approximately 9:12 a.m. The BOM verified the above information of the occurrence between R203 and R204.The facility presented information of the actions taken after the incident;1. R204 was assessed for injuries, and none were noted. R203 was immediately placed on 1:1 continuous monitoring. The MD/NP (medical doctor and nurse practitioner) were notified, and no new orders were given. An evaluation was conducted for both residents by the psych (psychiatric) NP with no changes in current medication regimen. Responsible Parties for both Residents were notified. No concerns were expressed. (Name of Local Police Department) was notified. APS (Adult Protective Services) was notified.2. All female resident on the unit with BIMS under 9 was given a skin assessment. Female resident with BIMS score above 9 were interviewed regarding recent inappropriate interactions with male residents. No concerns were raised.3. The facility completed an in-service on Abuse - Resident to Resident for all staff. The education was completed on 6/11/2026.4. Allegation of compliance was 6/11/2026.This citation is being cited as past non-compliance.

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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** For Resident #202 (R202), the facility staff failed to clarify two orders for insulin.R202 was admitted to the facility on [DATE] with recent readmission on [DATE], with diagnoses that included but were not limited to: insulin dependent diabetes, stroke, underweight, depression, anorexia, dementia and high blood pressure.The most recent MDS (Minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/16/2026, coded the resident as scoring a 99, indicating the resident was unable to complete the interview. In Section C0700, the resident was coded as having but short- and long-term memory difficulties. In Section N - Medication, the resident was coded as receiving three insulin injections over the past seven days. The physician order dated, 7/20/2026, documented, Insulin Lispro Injection Solution 100 UNIT/ML (milliliter); Inject 4 units subcutaneously three times a day for *HOLD IF BLOOD SUGAR IS LESS THAN 120 PER (NAME OF NURSE PRADCTTIONER) RELATED TO Tyle 2 DIABETES Mellitus with hyperglycemia (high blood sugar). Call MD (medical doctor) if BG (blood glucose) is < (less than) 60 or > 250.The May 2026 MAR (medication administration record) documented the above order. On the following dates and times, the blood sugars were documented:5/2/2026 at 1:00 p.m. = 3185/3/2026 at 9:00 a.m. = 347; 1:00 p.m. = 3195/4/2026 at 9:00 a.m. = 308; 1:00 p.m. = 256; 5:00 p.m. = 3085/5/2026 at 9:00 a.m. = 278; 1:00 p.m. = 312Review of the clinical record failed to evidence documentation that the physician or nurse practitioner was notified of the above blood sugars per the physician orders. The physician order dated 4/26/2026 documented, Insulin Lispro Injection Solution; Inject as per sliding scale: if 140-199= 0 units; 200-259 = 2 units; 300-349=4 units; 350-400=Call MD, subcutaneously before meals for DM (diabetes mellitus).May 2026 MAR documented the above order. On 5/1/2026 at 11:30 a.m. the resident's blood sugar was documented as 500. The nurse practitioner (NP) was notified.An interview was conducted with LPN (licensed practical nurse) #1 on 7/1/2026 at 2:35 p.m. The above orders and MAR were shown to LPN #1 who worked on several of the days there was no documented notification to the doctor or NP. When asked if she notified the nurse practitioner or doctor of the blood sugars according to the order, LPN #1 stated, I didn't call anyone. When asked should she have called, LPN #1 stated, Yes.An interview was conducted with the Director of Nursing (DON), on 7/1/2026 at 4:56 p.m. The above orders were reviewed with the DON. She stated the orders should have been clarified.The Administrator and the DON were made aware of the above findings on 7/2/2026 at 10:00 a.m.No further information was provided prior to exit.