

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Emporia Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Weaver Avenue Emporia, VA 23847	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on staff interview, clinical record review, and facility record review, the facility failed to have evidence that alleged violations were investigated thoroughly for 1 of 28 residents in the sample, Resident #117 (R117). The findings include: For R117 the facility failed to thoroughly investigate all allegations regarding alleged abuse. Diagnoses for R117 include schizophrenia and osteoarthritis. On the most recent applicable Minimum Data Set (MDS) assessment, a quarterly assessment with an Assessment Reference Date (ARD) of 12/5/2024, R117 scored a 9 out of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. A progress note in the clinical record dated 4/29/2024 stated that R117 made facility staff aware of allegations of abuse. R117 stated that a Certified Nursing Assistant (CNA) #4 hit him in the head and threw him into a wheelchair. R117 stated that a second CNA, CNA #5, was present during this alleged incident and did not intervene. Review of the incident synopsis revealed that both CNA #4 and CNA #5 were both listed as alleged perpetrators in the incident. Review of the incident summary demonstrated that CNA #4 was suspended from work during the investigation. The incident summary failed to include a statement from the CNA #5. Review of the personnel file for CNA #5 revealed that CNA #5 was not suspended from work during the investigation. The incident summary stated that allegations were unsubstantiated as The CNA would not have been able to transfer the resident from the bed to the chair without assistance. This result failed to include the presence of CNA #5 during the alleged incident. During an interview with the Administrator that took place on 6/3/2026 at 9:25 AM, the Administrator stated that CNA #4 was terminated following their return to work after the suspension for an unrelated issue. The Administrator reviewed the personnel file of CNA #5 and was unable to demonstrate evidence that showed that CNA #5 was suspended during the investigation. In addition, the Administrator was unable to provide any evidence showing that CNA #5 had been interviewed regarding the alleged incident. Review of the facility policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation revealed that upon notification of alleged abuse, the Director of Nursing Services, Administrator, or designee will Obtain statements from direct care staff and Suspend the accused Team Member pending completion of the investigation. The above information was presented to facility leadership on 6/3/2026 at 2:00 PM. No additional 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on resident interview, staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of 28 residents in a survey sample, Resident #97. The findings include: The Treatment Administration Record (TAR) and Medication Administration Record (MAR) inaccurately documented all treatments and medications were refused by Resident #97 (R97). R97 diagnoses include paraplegia, diabetes, and neuromuscular dysfunction of bladder requiring suprapubic catheter. The most recent MDS (minimum data set) was a quarterly assessment 3/25/26 and indicated R97 was cognitively intact. On 6/1/2026 at 1:20 p.m. R97 requested to be interviewed by the surveyor. During the interview R97 reported that on 5/26/26 R97 did not receive medications or catheter flush from the evening nurse. R97 said because of this R97 called the police, the police came over and after interviewing R97 was told by the police that it was documented that he had refused medications. R97 verbalized he had not refused any medications and had asked the assigned certified nursing assistant (CNA) to ask the nurse to get the medications. Review of R97's active orders indicated R97 was ordered Atorvastatin Calcium 40 milligrams to be given at 9:00 p.m. each evening for hyperlipidemia, Docusate Sodium 100 milligrams given at 9:00 p.m. each evening for constipation, and to flush suprapubic catheter every shift with 30 cc's of Normal Saline. The Medication Administration Record (MAR) and the Treatment Administration Record were reviewed and documented R97 had refused the medications and catheter flush. It was also noted in the MAR and TAR for the month of May that R97 had not refused any of these medications or treatments any other time in the month. Further review of R97's TAR also documented on 5/26/26 refusals of catheter privacy bag in place, air mattress function, placement of catheter strap, monitor liquid intake, and to ensure enhanced barrier precautions. All are observational check off's that don't necessarily require a task to be performed. Review of R97's care plan indicates that R97 is resistive to care (last revised on 4/26/22) and provides an intervention when being resistant to leave and return five to ten minutes later. Review of R97's progress notes dated 5/26/26 and 5/27/26 indicated a linked EMAR (Electronic Medication Administration Record) note referencing R97 refusing care and medication. The EMAR notes are automatically populated into the progress notes when documenting in the MAR or TAR. There were no other nursing progress notes regarding the incident of refusals. On 6/2/26 at 3:45 p.m. LPN #8 (evening supervisor where R97 resides) was interviewed. LPN #8 verbalized unawareness of the incident at the time that it was happening and it was not reported to her by the assigned nurse (identified as LPN #7) and found out about the incident about a day later. LPN #8 verbalized after finding out about the incident, she also found out the assigned certified nursing assistant (CNA #3) had been asked by R97 to get the nurse to do catheter care and give medications but CNA #3 was unable to find the nurse and had asked another staff member to send the nurse to R97's room when she comes back from break. LPN #8 verbalized R97 can be resistive to care and refuses treatments and medications at times, when this happens it should be reported so that another staff member could possibly provide the care needed. On 6/2/26 at 5:15 p.m. CNA #3 was interviewed via telephone. CNA #3 said that R97 can be picky and sometimes will only allow certain people to take care of him. CNA #3 said that on 5/26/26 R97 had complained about not getting his medications and catheter flushed and wanted to get it done, so (CNA #3) went to find the nurse (LPN #7) who was also working on the back hall but could not find LPN #7, so had asked another staff member to tell LPN #7 that R97 was wanting his medications and catheter flush. CNA #3 was unaware if LPN #7 had or had not gone to R97's room and verbalized R97 did not indicate not wanting LPN #7 to be assigned to him. On 6/2/26 at 5:25 p.m. LPN #7 was interviewed via telephone. LPN #7 verbalized being assigned to R97 on 5/26/26 from 7:00 p.m. to 11:00 p.m. and going to R97's room between 9:00 p.m. and 10:00 p.m. LPN #7 said that when entering R97's room to do catheter care and give a medication, R97 refused care and had gotten angry calling LPN #7 a white [expletive] because R97 thought I didn't (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	know how to do a flush the catheter. LPN #8 said that she did not hear from other staff that R97 was requesting treatments or medications prior to entering R97's room to do the treatment and give medications. When asked about documenting the incident, LPN #7 said refusing care was documented, but did not report this to anyone and wasn't sure what the protocol was. LPN #7 then verbalized that the incident should have been documented. LPN #7 verbalized regarding documenting refusals of air mattress functioning, catheter privacy bag in place and other checks offs mentioned above, that it was done in error. On 6/3/26 9:00 a.m. R97 was interviewed again and said that there was no confrontation between himself and the nurse assigned, had not seen the nurse come to the room, and did not tell anyone he did not want treatments or medications. On 6/3/26 at 9:35 a.m. the assistant director of nursing (ADON) was interviewed. The ADON verbalized typically when a resident refuses care from a staff member or does not get along with a staff member then it should be reported so that care can still be provided by another staff member. On 6/3/26 at 9:50 a.m. the director of nursing (DON), administrator, and nurse consultant was presented with the above finding. The administrator verbalized when a resident refuses or does not get along with a staff member, that it is the facilities protocol and expectation to reassign staff to the resident or have another staff member try and perform a treatment or give a medication so it can be documented as being performed. The administrator reviewed R97's TAR and agreed that the monitoring tasks should not have been documented as being refused. No other information was presented prior to exiting the facility on 6/3/26.		