STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarksville Health & Rehab Center	184 Buffalo Road Clarksville, VA 23927

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, resident interview, staff interview, and facility documentation review, the staff failed to uphold the residents right to receive services with reasonable accommodation of individual needs for one resident, Resident #76 (76) out of a survey sample of 36 residents. The findings included:The facility staff failed to respond to resident call lights in a timely manner and turned off call lights before care or assistance was provided. On 6/9/26 at 1:00 pm, an observation was conducted. R76 had activated her call light requesting assistance for incontinence care. A certified nursing assistant entered the room to pick up R76's lunch tray and asked the resident what assistance was needed, and informed the resident she would return to assist her. Shortly after that a registered nurse, RN1 entered the room and turned off the call light without determining the resident's needs or ensuring the requested assistance had been provided. On 6/9/26 at 1:45 pm, an interview was conducted with R76. During the interview, R76 said. I have not received any care yet and I am wet and needed changing for a long time. R76 activated her call light again for assistance. The Administrator entered the room and asked R76 what assistance was needed. The Administrator then left the room to obtain staff assistance for the resident. Observation revealed that R76 was waiting for over 45 minutes for incontinence care to be provided. On 6/10/26 at 8:30 am, an observation was made of R76's call light that was activated and needed assistance with moving her over bed table from one side of her bed to the other side. The call bell was activated for approximately 12 minutes before assistance was provided. Two staff members went in the room, a certified nursing assistance (CNA) and a housekeeping employee and did not acknowledge that the call light was activated or offer any assistance. It was observed, that several facility employees walked by the room with the call light activated and never responded to the call light. CNA6 went into the room to pick up R76's breakfast tray and acknowledged the call light and provided assistance. On 6/10/26 at 9:00 am, an interview was conducted with a certified nursing assistant, CNA6. During the interview, CNA6 stated that she answers the call light and provides the assistance at that time; however, if she was unable to provide the assistance at that time she would come back and give the assistance. CNA6 stated that the call bell lights was not to be turned off until the resident received their care or assistance they were requesting. On 6/10/26 at 10:00 am, an interview was conducted with RN1, who was the unit manager of the 400 unit. She stated anyone can answer call lights. If someone was unable to provide the assistance needed then they would go get staff for assistance. RN1 stated the call light should not be turned off until assistance is provided. On 6/10/26, a review of facility documentation was conducted. The facility policy titled, Call Light Resident Communication System Policy, read in part, It is the policy of the facility to provide residents with a means of communicating with staff. A call system is installed in each resident room and toilet/bath areas. The facility responds to resident needs and requests. Steps in Procedure: 1. Turn off the call light. 2. Identify yourself and call the resident by his/her name (use Mr. or Mrs.) and ask 'how may I help you?' 3. Listen to the resident's request. 4. Do what the resident requests, if capable/allowed. Otherwise seek assistance of charge nurse or someone who can assist If you have promised the resident you will return with an item or information, do so promptly.On 6/10/26 at 5:24 pm, an end of day meeting was held with the Administrator, Director of Nursing, Regional Director of Clinical Services and Administrator from a (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sister facility and they were informed of the above concerns.No additional information was provided prior to the end of the survey.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and facility documenation review, the facility staff failed to maintain a homelike environment on two of six units (Sundrop and [NAME] Lane units). The findings included: For the Sundrop and [NAME] Lane units, the facility staff failed to maintain comfortable water temperatures and provide consistent hot water for residents. On 6/10/26 at 8:37 AM, during observations of Resident #145's (R145) room, it was noted that the water in the bathroom never reached a temperature above lukewarm despite the water running for about five minutes. On 6/10/26 at 9:16 AM, an interview was conducted with licensed practical nurse #5 (LPN #5), who worked on the Sundrop unit. When asked about the water temperature, LPN #5 confirmed she was aware there was a problem a while back and someone had to come in and fix it. On 6/10/26 at 9:20 AM, the water in Resident #18's (R18) room was checked. It was noted that the water never reached a comfortable temperature and was barely lukewarm even after running for several minutes. On 6/10/26 at 9:27 AM, an interview was conducted with certified nursing assistant #5 (CNA #5). CNA #5 reported that the water on the Sundrop unit doesn't get hot and she comes in and turns all her water faucets on to let it run to get hot so she can give baths. CNA #5 went on to say, Resident's complain and say the water is cold. I have to go to the spa and get hot water. The maintenance director says we are too far from the water heater. On 6/10/26 at 9:36 AM, during an interview with Resident #99 (R99) the resident said, the water only gets warm, not hot and it takes a long time to get warm. I would like it hotter. On 6/10/26 at 1:30 PM, during the resident council group interview, multiple residents expressed concern that the water never gets hot and other times it gets hot just like that. On 6/10/26 at 4:17 PM, a tour of the facility was conducted with the maintenance director, and water temperatures were taken at various points within the facility. The maintenance director stated that he wants to maintain hot water temperatures between 105 and 120 degrees [NAME] height. When checking water temperatures, the maintenance director commented when the water in one room on the [NAME] Lane didn't get hot, he said, This is the one hall that has trouble getting to temperature. I have [contractor company name redacted] coming tomorrow to research the potential problem. In another room on the [NAME] Lane unit the water ran for several minutes and only reached a lukewarm status, the maintenance director commented, I don't understand, it is almost like a mixing valve is open. During the above interview, the maintenance director reported that several months ago they lost a water heater and they had to take it offline for about a week while repairs were being made. Review of the resident council minutes revealed in March and May 2025 meetings, Residents reported (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	water turning cold during bathing. On 6/10/26, during an end-of-day meeting with the facility Administrator and Director of Nursing, the above findings were discussed. No additional information was provided. 2. The facility failed to ensure the fish aquarium located in the dining room on the 400 nursing unit was maintained in a clean and sanitary condition. On 6/09/2026 at 2:09 PM, an observation was made of the fish tank on the 400 nursing unit in the dining area. The glass was black with algae like material and unable to see the fish inside the tank. The top of the fish tank had food particles noted and the motor/filter had corrosion like material noted. On 6/10/26 at 8:15 AM, a second observation was made of the fish aquarium on the 400 nursing unit in the dining area and pictures were taken of the fish aquarium. On 6/10/2026 at 8:53 AM, an interview was conducted with a licensed practical nurse, LPN7. LPN7 stated that she tried to keep it clean. She said, once a month I try to clean it. I do feed them and I try to vacuum out the rocks. LPN7 stated to ask the Administrator who was responsible for the cleaning of the fish tank. On 6/10/26 at 9:00 AM, an interview was conducted with the Administrator about the cleaning of the fish aquarium on the 400 nursing unit in the dining room. She stated that LPN7 was suppose to be in charge of cleaning the fish aquarium. The Administrator stated she would buy the supplies when LPN7 requested. On 6/10/2026 at 11:00 AM, another observation was made of [NAME] units dining room and the fish aquarium was removed from the dining room area. On 6/10/26, a request for a home like environment/cleanliness/or any policy pertaining to the cleaning of the fish aquarium was requested and the Administrator stated that there was no policy for these areas to offer. On 6/10/26 at 5:24 PM, an end of day meeting was held with the Administrator, Director of Nursing, Regional Director of Clinical Services, and Administrator from a sister facility. They were informed of the above concerns. No additional information was provided prior to the end of the survey.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility documentation review, the facility staff failed to maintain an enviornment free of accident hazards regarding water temperatures on two of six units (Sundrop and [NAME] Lane). The findings included:The facility failed to maintain water temperatures at a safe level to prevent the risk of scalding on two units. On 6/10/26 at 8:37 AM, during observations several resident rooms were noted to have water temperatures that were too hot for you to hold your hand under. On 6/10/26 at 9:16 AM, an interview was conducted with licensed practical nurse #5 (LPN #5), who worked on the Sundrop unit. When asked about the water temperature, LPN #5 confirmed she was aware there was a problem a while back and someone had to come in and fix it. On 6/10/26 at 1:30 PM, during the resident council group interview, multiple residents expressed concern that the water never gets hot and other times it gets hot just like that. On 6/10/26 at 4:17 PM, a tour of the facility was conducted with the maintenance director, and water temperatures were taken at various points within the facility. The maintenance director stated that he wants to maintain hot water temperatures between 105 and 120 degrees [NAME] height. The water temperature in room [ROOM NUMBER], which was unoccupied measured 125.1 degrees. The maintenance director commented, That's a little warm. When asked what the potential risk to residents is, the maintenance director said, potential scalding. During the above tour with the maintenance director the water temperature in room [ROOM NUMBER] was identified to be 129.4 degrees. The maintenance director reported he had a contractor coming the following day to research the potential problem. On 6/10/26, during an end-of-day meeting with the facility Administrator and Director of Nursing, the above findings were discussed. The administrator reported they had adjusted and turned the water temperature down. When a facility policy regarding water temperatures was requested, the Administrator reported they had no policy for this.No additional information was provided.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility documentation review the facility failed to ensure appropriate monitoring and assessment of a change in condition related to a urinary catheter for one resident, Resident #156 (R156) out of a survey sample of 36 residents. The findings included:The facility failed to monitor R156's urinary catheter when hematuria (blood in urine) was observed and failed to notify the medical provider of the change in condition. On 6/11/2026 at 9:43 AM, an interview was conducted with a registered nurse, RN1. She stated that if she was to observe blood in a residents urine she would notify the doctor unless it was something the doctor was already aware of or if it was expected example kidney stones. RN1 stated if the blood in the urine was a new finding then the doctor should be notified. She also stated if the progress note stated to monitor then, I would expect a follow up note after the note that said to continue to monitor. On 6/11/26 at 9:22 AM, an interview was conducted with RN3. She stated if blood in the urine was observed, I would report to the doctor, follow the doctor's instructions, report it to the next shift , and document that the report was given to the on coming shift to monitor.On 6/11/26, a clinical record review was conducted. R156's progress notes were reviewed. A note dated 1/1/26 at 1:38 PM, written by a registered nurse, RN4 read, resident lying in bed moaning and groaning prn [as needed] pain med [medication] given Vital signs stable 111/66,97.4,78,18 o2sats [oxygen saturations] 96%on RA [room air] catheter draining bloody urine will continue to monitor. There was no follow up note in the medical record and no progress note of notification to the medical doctor. R156 was sent out to the hospital on 1/4/26 and did not return to the facility.On 6/11/26, facility documentation was reviewed. The facility document was titled, Indwelling Urinary Catheter Care Procedure, read in part, . Clinical staff with demonstrated competence may provide urinary catheter care. Such care will help to prevent catheter association urinary tract infections (CAUTIs) and prolong the life of the catheter system. A second facility documentation was reviewed. The facility document was titled, Resident Change in Condition Policy, read in part, .The facility will inform the resident; consult with the resident's physician/provider; and notify the resident representative(s) when there is: a) An accident involving the resident which results in injury and has the potential for requiring physician/provider intervention; b) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); c) adverse A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to consequences, or to commence a new form of treatment); d) A decision to transfer or discharge the resident from the facility.On 6/11/26 at 1:36 PM, a pre-exit meeting was held with the Administrator, Director of Nursing, and Regional of Clinical Services. They were informed of the above concerns.No additional information was provided prior to exit conference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for five of thirty-six residents in the survey sample (Residents #5, #6, #12, #14 and #152). The findings include: 1. Resident #5's clinical record documented a tracheostomy inner cannula was changed once every three months when the resident did not have/use an inner cannula. Resident #5 (R5) was admitted to the facility with diagnoses that included peripheral vascular disease, history of vocal cord paralysis with tracheostomy, diabetes, hypertension, anemia, atrial fibrillation, depression, anxiety, schizophrenia and bradycardia. The minimum data set (MDS) dated [DATE] assessed R5 with moderately impaired cognitive skills. R5's clinical record documented a physician's order dated 3/6/25 for tracheostomy care with instructions to change the inner cannula once every three months. R5's treatment administration record documented the inner cannula was changed on 12/1/25, 3/1/26 and 6/1/26. On 6/10/26 at 1:46 p.m., with R5's permission, daily tracheostomy care performed by the licensed practical nurse unit manager (LPN #1) was observed. During this treatment, R5 stated he did not use an inner cannula with his tracheostomy and that he had never had an inner cannula. R5 stated the tracheostomy tube was changed and/or cleaned every three months. LPN #1 also stated at this time that R5's tracheostomy did not have an inner cannula. On 6/10/26 at 1:55 p.m., the unit manager (LPN #1) was interviewed about the physician's order referencing an inner cannula change. LPN #1 stated regarding the order for the inner cannula change, I know the order says inner cannula but he [R5] only has the trach [tracheostomy] tube. LPN #1 stated the resident's tracheostomy tube was disposable and that the tube was changed once every three months, not the inner cannula as listed. LPN #1 was not sure why the physician's order had not been revised or clarified. On 6/10/26 at 3:50 p.m., the director of nursing (DON) was interviewed about R5's order for inner cannula change and nurses documenting an inner cannula change when the resident had no inner cannula. The DON stated the physician's order needed to be clarified as the resident did not use an inner cannula and had never had/used an inner cannula. The facility's policy titled Physician/Provider Orders Policy (revised 10/7/24) documented, .The Charge Nurse shall transcribe and review all physician/provide orders .Orders will [be] reviewed at the frequency required by state regulation but not less than bi-monthly . These findings were reviewed with the administrator and DON during a meeting on 6/10/26 at 5:30 p.m. with no further information presented prior to the end of the survey. 2. For Resident #6 (R6), the facility failed to ensure an accurate clinical record by documenting continued monitoring for side effects of a medication that had been discontinued. Diagnoses for R6 include dementia with other behavioral disturbances, Alzheimer's disease, atrial (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fibrillation, hypertension, generalized anxiety disorder, and diabetes mellitus. On the most recent Minimum Data Set (MDS), a quarterly assessment with an assessment reference date (ARD) of 3/7/26, R6 scored two out of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. On 2/19/26 a physician's order for risperdone (an antipsychotic medication) 0.5 milligrams (mg) three tablets daily was placed into the clinical record. An additional physician's order to monitor for side effects of risperdone (tremors, gait issues, agitation, restlessness, and involuntary movements of the mouth/tongue) every shift was concurrently placed in the clinical record on the same date. Review of the clinical record demonstrated that risperdone was discontinued on 3/2/26. Following the discontinuation of the medication, the physician's order to monitor side effects of risperdone remained active. Review of the medication administration record (MAR) revealed that nursing documented continued monitoring for the side effects of risperdone every shift in March, April, May, and June. An interview was conducted with Licensed Practical Nurse (LPN) #6 on 6/11/2026 at 9:18 AM. LPN #6 stated that they monitor the side effects of this medication every shift. LPN #6 checked the clinical record and verified that R6 was no longer on this medication. LPN #6 was not aware of the date the medication had been discontinued. LPN #6 stated it would not be indicated to continue to monitor for side effects of a medication that had been discontinued. LPN #6 stated that the order to monitor side effects of risperdone could be discontinued in the clinical record by nursing. Review of a facility policy titled, Physician/Provider Orders Policy, effective 1/27/11 and most recently revised/reviewed 10/7/24 revealed that physician's orders are to be reviewed at the frequency required by state regulation but not less than bi-monthly. This information was presented to the facility administrative staff on 6/11/26 at 2:00 PM. No additional information was provided prior to exit. 3. For Resident #12 (R12), the facility failed to ensure an accurate clinical record by documenting continued monitoring for side effects of a medication that had been discontinued. Diagnoses for R12 include dementia without behavioral disturbance, mood disorder, atrial fibrillation, and major depressive disorder. On the most recent Minimum Data Set (MDS), an annual assessment with an assessment reference date (ARD) of 5/10/26, R12 was unable to perform the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. On 5/23/24, a physician's order for Zoloft (an antidepressant medication) 50 milligrams (mg) daily was placed into the clinical record. An additional physician's order to monitor for side effects of Zoloft (withdrawn, anxious, talking to self) every shift was placed into the clinical record on 8/19/25. Review of the clinical record demonstrated that Zoloft was discontinued on 1/5/26. Following the discontinuation of the medication, the physician's order to monitor for side effects of Zoloft remained active. Review of the medication administration record (MAR) revealed that nursing documented continued monitoring for the side effects of Zoloft every shift in March, April, May, and June. An interview was conducted with Licensed Practical Nurse, LPN#6 on 6/11/2026 at 9:18 AM. LPN #6 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that they monitor the side effects of this medication every shift. LPN #6 stated that it would not be indicated to continue monitoring for side effects of a medication that had been discontinued for months. LPN #6 stated that the order to monitor for side effects of Zoloft could be discontinued in the clinical record by nursing. Review of a facility policy titled, Physician/Provider Orders Policy, effective 1/27/11 and most recently revised/reviewed 10/7/24 revealed that physician's orders are to be, reviewed at the frequency required by state regulation but not less than bi-monthly. This information was presented to the facility administrative staff on 6/11/26 at 2:00 PM. No additional information was provided prior to exit. 4. For resident #14, the Registered Dietician (RD) documented the resident's weight as 119 lbs. instead of 219 lbs. on a document entitled, Medical Nutritional Therapy Observation dated 3/26/26. The Resident Face Sheet indicated the facility admitted the resident on 3/15/24 with a medical history that included recent stroke, vascular dementia, type 2 diabetes, morbid obesity and moderate protein-calorie malnutrition. Resident #14's comprehensive care plan included a focus that read, Resident has increased nutrition/hydration risk related to: dx (diagnoses) of cerebral infarction (stroke), HLD (hyperlipidemia or high cholesterol), dementia, HTN (hypertension), T2DM (type 2 diabetes) muscle wasting and atrophy, hemiplegia and hemiparesis affecting left non-dominant side, morbid obesity and moderate protein-calorie malnutrition. One of the interventions listed was to monitor weight per protocol. The weight record for resident #14 was reviewed and included a weight documented in February of 219 lbs. and a reweight of 229 lbs. 06/11/2026 9:19 AM The RD was interviewed. When asked to review her March assessment the RD stated, That was a clerical error on my part. The RD provided documentation that she recommended a reweight due to a significant weight loss from 234 lbs. to 219 lbs. The reweight was done and documented which revealed the resident did not in fact have a significant weight loss. I honestly just hit the wrong numbers when I was typing it in. On 6/11/26 at 1:36 PM the survey team met with the Administrator, Director of Nursing and Regional Director of Clinical Services (RDCS). This concern was discussed with them at that time. The RDCS stated they had no policy related to accurate documentation. No further information was provided to the survey team prior to the exit conference. 5. For Resident #152, the facility staff failed to maintain accepted professional standards of practice, accurate representation, and/or a systemically organized accounting of the events that occurred during a fall that resulted in a right humerus fracture on 09/09/2024. Findings included: Resident #152's diagnosis list indicated diagnoses that included, but were not limited to, muscle wasting and atrophy, difficulty in walking, history of falling, unspecified fracture of upper end of right (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	humerus, and adult failure to thrive. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/05/2024, assigned the resident a brief interview for mental status (BIMS) summary score of 0 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of Resident #152's clinical record disclosed the following: A nursing progress note dated 09/09/2024 at 16:19 (4:19 PM) disclosed the resident hit elbow while a CNA (Certified Nursing Assistant) was weighing resident with a Hoyer lift (an assistive medical device used to transfer individuals with limited mobility between surfaces (like a bed, wheelchair, or toilet) without physically lifting them, using a supportive sling and a mechanical frame), the resident complained of pain in the arm. A review of a Post Fall Huddle Form dated 09/09/2024 disclosed the resident's legs gave away and the resident was assisted off the floor with a mechanical lift. A medical provider progress note dated 09/12/2024 with a service date of 09/10/2024, disclosed Resident #152 was seen for right shoulder pain and the medical provider indicated notification earlier in the day that while the patient was being assisted for measurement of weight, the resident experienced sudden weakness to the legs and was lowered in a controlled manner, as a gait belt was being appropriately used, to the floor. While the patient was being lowered to the floor it was reported that the resident was observed by a care companion in the room and that the resident's elbow struck the bed. After a Hoyer lift was used to help lift the patient off the floor and placed back in bed, the patient reported right shoulder pain. The mobile x-ray of the right arm and shoulder did demonstrate an acute fracture of the upper humerus with 17 mm displacement. The patient's right arm was appropriately placed into a sling. This concern was discussed on 06/10/2026 at 11:25 AM, with the Administrator, Director of Nursing, and an Administrator from a sister facility. Requested all information related to this incident. The Administrator stated that the Certified Nursing Assistant (CNA) who cared for Resident #152 at the time of the incident was no longer employed at the facility. For purposes of this investigation, the CNA was identified and will be referred to as (CNA#1). On 06/10/2026 at 12:44 PM, the Director of Nursing (DON) reviewed the information and agreed there is a discrepancy in what actually happened, as the nurse's note revealed the resident bumped the arm while on the Hoyer lift and the medical provider note stated the resident was being transferred with a gait belt and the resident's legs buckled. On 06/10/2026 at 1:17 PM, the discrepancies in the documentation were reviewed with the Administrator (ADM). On 06/10/2026 at 1:33 PM, the ADM stated the resident sat self-up on the side of the bed and bumped elbow on bed frame and then slid off the bed and staff used the Hoyer lift to get the resident back up off the floor. On 06/10/2026 at 1:59 PM, Licensed Practical Nurse #3 (LPN#3) was interviewed via phone conversation and stated she recalled the resident's fall in September 2024. LPN#3 stated she was not in the resident's room at the time of the incident, but Certified Nursing Assistant #1 (CNA#1) told her (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarksville Health & Rehab Center	184 Buffalo Road Clarksville, VA 23927

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that the resident was placed in a wheelchair to be taken for a weight and the resident got upset when they found out they were leaving the room. Resident #152 did not want to leave the room, so the resident attempted to get out of the wheelchair unassisted and fell and bumped the arm. There were no witness statements for this incident for further review. No other facility staff who cared for Resident #152 in September 2024 continued to be employed by the facility at the time of the investigation and/or were unavailable for interview. This concern was discussed at the pre-exit meeting on 06/11/2026 at 1:36 PM, with the Administrator, Director of Nursing, and Regional Nurse. The Regional Nurse stated they do not have a policy for accuracy of documentation. No further information was provided prior to exit on 06/11/2026.