STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495093	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrisonburg Hlth & Rehab Cntr	1225 Reservoir Street Harrisonburg, VA 22801

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, resident and staff interview and facility documentation review, the facility staff failed to provide a comfortable environment with internal temperatures affecting two of three units. The findings included: For the east and west wings, the facility staff failed to maintain comfortable temperatures within resident areas when the boiler was not operating properly. On 4/2/25 at 3 p.m., upon the survey team arrival to the facility, it was noted that a portable boiler was set-up in the parking lot. On 4/3/25 at 1:30 p.m., resident #3-R3 was visited in her room and a family member was present visiting. R3 and her family member were interviewed about the temperature in the facility. The family member stated, They have boilers for the heat after all the complaints, it took two to three days to get them up and running. I talked to the police department and requested a welfare check. On 4/3/25 at 1:30 p.m., during the above interview, R3 reported that she recalled saying, My God it's cold in here. I had a couple of sheets on me and my feet was froze! On 4/3/25 at 2:10 p.m., an interview was conducted with the maintenance assistant/other employee #7 (OE#7). OE #7 reported he was not working at the facility when the boilers went out, but said, They are replacing the boilers, they boilers quit. The only thing I can tell you is it was time to replace them. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/3/25 at 3:59 p.m., an interview was conducted with the facility administrator. The administrator was asked about the heat in the facility and said that they are in the process of replacing boilers that provide heat to the east and west units. When asked about the heat issues and what had prompted the replacement of the boiler and the temporary boiler noted in the parking lot, the administrator stated that on 12/20/24, 72 heaters were delivered that evening. They were here and I had them in all the rooms by midnight. We started with boiler issues when I got here November 4, 2024. [Name of contractor company redacted] was cleaning the boilers for a month and a half, and they said they were ordering parts. I was thinking the plan was to get parts, in the meantime they would come clean it and take parts off one to fix the other one. I called the manufacturer of the boiler, who is no longer in business, but we ran against a wall waiting on parts. It ran two weeks without a single problem, but then they came and said it was going to go out, they said it may not make it much longer and we needed to come up with a back-up plan, so we ordered heaters. The administrator reported that the boiler would trip shut off and someone would have to come out and reset it. He reported he had some staff that lived close by that would come and reset it or he would come. On 4/3/25, the facility provided the survey team with documentation from the contracted company regarding boiler maintenance/repairs. According to the service logs and invoices provided, on 12/20/24, seventy-two heaters were delivered to the facility. On 12/24/24, two spot coolers with heating capability were delivered, which the facility administrator reported were used to heat the hallways. According to the service logs notes dated 11/5/24 at 6:13 p.m., the service technician noted, . Found boiler one running and occasionally tripping off on startup, found boiler 2 completely unable to start and tripping out on startup repeatedly . On 11/10/24, the service notes read in part, . Gained access to boiler room and site administrator [name of administrator redacted] stated issue was large water leak on hot water pump for boiler. Found pump leaking from both shaft seal and flange seal . found valves passing by and not working. Attempted to close gate valves further back to shut off entire pump station, found valves also passing by, unable to isolate leak to make repairs. Presented option to [Administrator's name redacted] to allow pumps to leak or shut off all hot water for building and to get space heaters for residents and leave building without hot water . opted to allow leak to continue . According to the boiler contractor's service reports and notes, an entry dated 11/13/24 at 12 noon read, Drove to the site called and talked to maintenance he told me what was going on I noticed that when we arrived the boiler was off on a low water fault, I reset it and the boiler fired up started running we then started looking at the pumps that were bad . On 11/13/24 at 1:42 p.m., another note read, .One of the issues is the boiler is not functioning properly and there are 4 recirculating pumps not functioning . We were able to get the boiler back operational again . Service notes dated 11/18/24 at 6:28 p.m., noted, unit has tripped out one time I adjust the damper to be in auto instead of manual this is causing the flame to blow out on start up. On 11/19/24, the notes read, Arrived onsite and checked in with MOD [manager on duty]. Began by resetting the boiler to check operations. Two hours after resetting the boiler, it tripped again . Still a chance of the boiler tripping due to it needs to be cleaned and p.m. [preventative maintenance] properly. On 11/20/24, the notes read, . Found that the boiler was not currently tripped out. Not sure if someone else reset it this morning. If not overhead run all night for the first time in a while . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/25 at 9:50 a.m., an interview was conducted with a service technician from the contracted service provider working to replace the facility's boiler. The service technician indicated that one of the boilers had a cracked heat exchanger and when it would run too long, it would cut off and would have to be reset, causing the facility's two wings to be without heat until the boiler cooled down enough to be reset. When asked if facility staff were resetting the boiler to maintain comfortable temperatures when it would shut off, the technician said, Not that I know of. It was noted that a temporary boiler was put in place and connected on 1/11/25 which provided a consistent heat source for the east and west units. The permanent boilers were installed and went into operation on March 31, 2025. The facility did provide the survey team with evidence that they were monitoring the temperature in resident rooms 12/30/24-1/20/25. On 1/10/25, according to the Data Collection Form eight of the rooms measured between 60-67 degrees Farenheight (F). On 1/11/25, the rooms were consistently measuring above 71 degrees F. The facility achieved complaince on 1/11/25 No additional information was provided.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 2. For Resident #10 (R10), the facility staff neglected to respond to the residents call for assistance to have incontinence care provided, which resulted in R10 being left to sit in feces for fifty minutes, which resulted in psychosocial harm. On 4/3/25 at 9:38 a.m., upon the surveyor's arrival to the south unit, it was noted that several call bells were engaged. A light could be seen outside of the rooms and an auditory sound could be heard beeping in the hallways. On 4/3/25 at 9:41 a.m., the surveyor entered the room of R10, whose call light was on. R10 acknowledged that he had his call light on and reported that he needed to be changed. When asked how long his call light had been on, R10 said, Go look for yourself. R10 then explained that the surveyor could go to the nursing station and observe how long his call light had been on. When asked how often he experiences an extended wait for care, R10 didn't respond. On 4/3/25 at 9:49 a.m., the surveyor went to the nursing station and observed a computer screen that listed three call bells that were engaged. The duration listed for R10's call light was noted to be 50 minutes and 17 seconds. On 4/3/25 at 9:52 a.m., licensed practical nurse (LPN #19) was observed to enter the room, the call light went out, and LPN #19 exited the room. As LPN #19 was coming down the hall, she reported to certified nursing assistant (CNA #4) who passed her in the hall, that R10 needed to be changed. On 4/3/25 at 9:54 a.m., an interview was conducted with LPN #19 and inquired as to what R10 needed. LPN #19 stated, He needs to be changed. When notified that the call light had been engaged for over 50 minutes, LPN #19 was asked if this was common. LPN #19 said, Sometimes it is and sometimes it isn't. I didn't know that was the case this morning. Normally he tells me about it, but he didn't today. On 4/3/25, facility staff were notified of the above concerns related to R10. On 4/9/25, a clinical record review was conducted of R10's chart. This review revealed that R10's diagnosis included, but were not limited to unspecified cord compression, central cord syndrome at C2 level of cervical spinal cord, person injured in unspecified motor-vehicle accident, and quadriplegia. According to R10's most recent minimum data set (MDS - an assessment tool) with an assessment reference date of 3/30/25, R10 was coded as having a BIMS (brief interview for mental status score) of 15 out of 15, which indicated he was cognitively intact. The assessment also noted that R10 was dependent upon the assistance of two staff persons for bed mobility, transfers, and toileting. R10 was also coded on that same assessment as having had no skin impairments. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the care plan, R10 was noted to be at risk for pressure ulcers due to immobility, inability to turn and reposition independently, incontinence, and quadriplegia. Care plan interventions included, Keep skin clean and dry as possible. The care plan also stated, The resident requires assistance with ADLs [activities of daily living] related to chronic health conditions, inability to perform ADLs, weakness, quadriplegia and spinal cord compression. The interventions included, Hoyer lift for all transfers x 2 staff, 2 person assist for bed mobility as needed . Also in the care plan, it was noted that R10 was incontinent of bladder and bowel. The interventions included . provide toileting hygiene with brief changes . According to a skin observation conducted on 3/29/25, R10 was documented with no skin impairments. On 4/1/25, R10 was noted with an incontinence associated dermatitis (iad) to his right buttock that measured 3.5 x 3.5 x 0.1 cm and another area of iad on his left buttock that measured 0.8 x 1 x 0.1 cm. According to the 4/1/25 progress note, the wound care nurse practitioner noted that . wound assessment: location: left buttock, primary etiology: incontinence associated dermatitis (IAD), stage/severity: partial thickness, wound status: new, size: 0.8 cm x 1 cm x 0.1 cm, exposed tissue: dermis, peri wound: fragile, wound base: 100% epithelial; exudate: scant amount of serosanguineous . A second wound was noted on the .right buttock, primary etiology: incontinence associated dermatitis (IAD), stage/severity: partial thickness, wound status: new, size: 3.5 cm x 3.5 cm x 0.1 cm, wound base: 100% epithelial; peri wound: fragile, exudate: scant amount of serosanguineous, exposed tissue: dermis . The progress note went on to give the treatment plan for both areas, which read as: Treatment Recommendations: 1. Cleanse wound with wound cleanser and pat dry. 2. apply Hydrocolloid to base of the wound. 3. change 3 times per week . PREVENTATIVE MEASURES: The patient is incontinent of urine and stool and is at an increased risk of skin breakdown. Recommend continuing ongoing interventions and protocol for swift incontinence management . NEW RECOMMENDATIONS: Staff report new incontinence associated skin breakdown to bilateral buttocks. See new treatment orders. Patient is at high risk for skin breakdown related to decreased mobility, inability to reposition self, comorbidities, incontinence of urine and stool. On 4/9/25 in the morning, a follow up interview was conducted with R10. R10 explained that he is totally dependent on staff for all care, including being fed, and must wait extended periods of time on a routine basis. R10 explained that he doesn't say anything because .what can I do? I have no choice. R10 confirmed that having to sit in his feces for extended periods of times makes him .angry, feel humiliated, and unimportant. I feel all of that but what can I do? R10 then was observed to have tears in his eyes that rolled down his check while talking to the surveyor. On 4/10/25 at 9:15 a.m-9:45 a.m., interviews were conducted with multiple staff, which included licensed practical nurses (LPN #6 & LPN #7) and certified nursing assistants (CNA #1, CNA #4, and CNA #5). All of whom reported that call bells should be answered within five minutes. On 4/10/25, the facility administration reported that they had no policy regarding incontinence care or call bell response times. The facility administration was made aware of the serious concerns related to the above findings. 3. The facility staff neglected to provide incontinent care in a timely manner for Resident #17(R17), which resulted in harm. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R17 was admitted to the facility on [DATE]. Diagnoses for R17 included but are not limited to urinary tract infection, muscle weakness and underweight. R17's Reentry Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 3/3/25 coded R17 with severe cognitive impairment. R17 was dependent on the activity of daily living care. R17 was no longer a resident at the facility, so a closed record review was conducted. On 4/3/25 at 11:00 a.m., an interview was conducted with R17's daughter who was his responsible party. The daughter stated when she visited that she had found her dad in a saturated brief and the bedding was wet. The daughter stated she cleaned him up and took him to therapy. The daughter stated that she had marked R17's brief with a number 12 at 12 o'clock and when she returned to the facility around 8:00 p.m., he was in the same brief she had marked at noon. On 4/3/25 at 4:00 p.m., an interview was conducted with the administrator. The administrator stated that R17 was up and out of bed after doing therapy around 1:00 p.m., sitting at the nurse's station until the daughter came back in around 7:00 p.m., or 8:00 p.m. The administrator stated he spoke with two staff members that came in to work that evening and stated R17's brief did not appear to have been saturated. 4/3/25 at 5:08 p.m., an interview was conducted with certified nursing assistant CNA#18. CNA#18 stated that incontinent rounds should be made every two hours, adding, Sometimes those lines are not accurate. Sometimes those [moisture indicator] lines on the brief are clear and [the resident] will be sitting in a pool of urine. I open the brief to check. 4/3/25 at 5:08 p.m., an interview was conducted with CNA#19. CNA#19 said, I check the residents every two hours unless they use the call bell. Check the strips on the brief and roll them to make sure their bottom isn't wet. I will leave the same brief on for one round but the next round I will change the brief even if dry. I will let the nurse know if the resident goes eight hours without going to the bathroom. On 4/3/25 at 5:30 p.m., an interview with CNA#9 was conducted about the incident that happened on 3/15/25 with R17. CNA#9 said, [R17's] daughter came in at 7:55 p.m. She reported that her father was wearing the same brief she tagged at 12 o' clock. So I went back and looked at the brief and it was marked, like she said. Looking at the brief lines, I would not have changed him, but he was wet. He was wet enough to be changed. CNA#9 showed pictures of the wet brief and the time that was written on the brief. CNA#9 stated that the pictures the daughter had provided were time stamped. On 4/3/25 at 7:20 p.m., an interview was conducted with LPN#5 about the incident that happened on 3/15/25 with R17. LPN#5 stated that R17 had the same brief on that was numbered with a 12 by his daughter. R17's brief was wet, and that cream was applied to his scrotum that LPN#5 said, .was like a flush cheek red. LPN#5 stated that it was understandable why R17's daughter was upset by R17 being in the same brief for eight hours. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/7/25 at 12:10 p.m., an interview was conducted with the assistant director of nursing (ADON). The ADON stated that incontinent care was prn, and the typical standard is every two hours. The ADON said, I would pull back the brief to see if they had a bowel movement. Common sense tells me I would change them, and not leave the brief on for eight hours. The ADON stated that she would expect staff to change a patient's brief every other round, even if the brief lines are clear due to the brief holding moisture, and the patient can sweat, which can cause moisture associated dermatitis. The ADON stated patient's briefs can hold heat causing the patient to sweat, and the brief would need to be changed due to the moisture. On 4/8/25 at 11:00 a.m., an interview was conducted with LPN#13 the unit manager of the south wing. LPN#13 stated that R17's daughter sent her pictures of a saturated brief and a dirty bed pad with dried urine stains on the bed pad. LPN#13 stated that R17's daughter was in the facility around 8:00 p.m., and sent another picture to her with a brief marked with a 12, and of R17 sitting in his wheelchair in his room, and of the wall clock that had 8:00 p.m. On 4/8/25 at 2:00 p.m., a review of R17's clinical record was conducted. On 3/16/25 skin assessment was completed, which documented redness to R17's coccyx area. R17 was getting treatment for MASD (moisture associated skin damage) to sacrum, and groin areas but on 3/16/25 treatment was started to coccyx area. According to the National Institute on Health (NIH) moisture associated skin damage (MASD) is discussed and read in part, . Moisture-associated skin damage (MASD) occurs with exposure to various sources of moisture (bodily secretions or effluents) such as urine or fecal matter, perspiration, wound exudate, mucus, digestive secretions, respiratory secretions, or saliva . Accessed online at: https://pmc.ncbi.nlm.nih.gov/articles/PMC9093722/#fn-group1 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to Wounds International, Moisture-associated skin damage (MASD) represents a significant problem and can have a negative effect on patient wellbeing and quality of life MASD is a complex and increasingly commonly recognized condition. Overexposure of the skin to bodily fluids can compromise its integrity and barrier function, making it more permeable and susceptible to damage (Gray et al, 2001; [NAME] et al, 2017). Individuals with MASD experience persistent symptoms that affect quality of life, including pain, burning and pruritis (Gray et al, 2011; [NAME] et al, 2017). MASD is classified as an irritant-contact dermatitis; see Table 1 (WHO, 2020). Common irritants can include urine, stool, perspiration, saliva, intestinal liquids from stomas and exudate from wounds. As such, MASD is an umbrella term and forms of MASD may be subdivided into four types (see Figure 1): IAD Peristomal dermatitis (relating to colostomy, ileostomy/ ileal conduit, urostomy, suprapu-bic catheter, or tracheostomy) ? Intertriginous dermatitis (intertrigo: where two skin areas may touch or rub together) Peri wound maceration . The article went on to read, .Managing continence As a priority, wherever possible, the cause of incontinence should be identified and eliminated, and treatment options exam-ined if possible - although this may be due to a range of factors including health conditions and mobility issues (Wishin et al, 2008; Beeckman et al, 2020). This should include evaluation of bladder and kidney function regarding urinary incontinence, and that of the intestine and colon in the case of fecal incontinence (Beele et al, 2017). If continence enhancement is not possible, suitable incontinence products should be used and non-invasive behavioral interventions implemented (Beeckman et al, 2018). Behavioral interventions may include nutritional and fluid management, mobility enhancement, and use of different toileting techniques (Wishin et al, 2008; Beeckman et al, 2020). While IAD does not only affect elderly people, evidence from studies involving elderly nursing home residents suggests that structured toileting and exercise interventions can improve incontinence (Bates-[NAME] et al, 2003; Beeckman et al, 2020). The type and frequency of incontinence should be re-assessed on regular basis, in order to tailor incontinence management strategies to the individual and assess the risk of skin-related damage (Beeckman et al, 2018). Wherever possible, indirect risk factors should be mitigated . Accessed online at: https://woundsinternational.com/wp-content/uploads/2023/02/77ece7a46c5c084762956b97f9096e53.pdf On 4/10/25 at 2:40 p.m., following consultation with the SA that verified the existence of IJ, the survey team met with the facility's director of nursing, two regional director of clinical services nurses, and the vice president of operations (VPO) were made aware that the facility was in Immediate Jeopardy (IJ) in the care area of Free from Abuse, Neglect, and Exploitation. On 4/10/25 at 5:43 p.m., the facility administration submitted the following plan of removal for the IJ: F600 Abuse Removal Plan. Plan Corrective Action for those residents found to be affected by the deficient practice: R#10 and R#23 will have a psychosocial assessment completed by the Regional Director of Social Work to determine current state of wellbeing. Corrective Actions taken for residents with potential to be affected by deficient practice: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff will interview residents with a BIMS of 13 or higher about abuse, neglect, timely call bell response, timely incontinence care, psychosocial well-being, and resident rights are upheld. Residents with a BIMS of 12 or less will have their responsible party contacted about concerns related to abuse, neglect, timely call bell response, timely incontinence care, psychosocial well-being, and resident rights are upheld. Skin assessments will also be conducted on the residents with a BIMS of 12 or less. Care plans will be updated based on findings and provider and RP notified as well. The call bell system will be audited for each room to ensure functionality of the call bells. Systemic Changes put into place to ensure the deficient practice does not recur: All facility staff will be educated on the abuse, neglect, timely call bell response, timely incontinence care, psychosocial well-being, and resident rights are upheld. This education will be provided for all new employees as part of new hire orientation to include agency staff. No employee will be allowed to work until they are educated. Audits will be randomly conducted weekly to assess call bell response times, timely incontinence care, and abuse and neglect by a member of the Interdisciplinary Team. The [NAME] President of Operations to conduct an ADHOC Quality Assurance Performance Improvement Meeting on 4/10/25 including the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Regional Director of Social Work, Activities Director, Dietary Manager, Business Office Manager, Director of Housekeeping and Laundry, and Unit Managers to review the abuse policy to include neglect, reporting of abuse and neglect, call bell response time, and the importance of timely incontinence care Monitoring of corrective action to ensure the deficient practice does not recur. The Administrator or designee will monitor call bell response times to ensure they are answered within 15 minutes. Residents with BIMS of 13 or higher will be interviewed at random weekly to validate the timeliness of their incontinence care, call bell response time, abuse and neglect, and psychosocial well-being. Residents with a BIMS of 12 or less will have their responsible party contacted about concerns related to abuse, neglect, timely call bell response, timely incontinence care, psychosocial well-being, and resident rights are upheld. All residents will have a skin assessment completed weekly. Completion of removal plan 4/10/25 at 11:00pm. The [NAME] President of Operations made the Medical Director aware of the Immediate Jeopardy via telephone on 4/10/25 at 3:26 pm. Following review with the SA, the removal plan was accepted. On 4/11/25, the survey team returned to verify that the facility had fully implemented their removal plan. The survey team verified that R10 and R23 had a psychosocial assessment completed by the regional director of social work. The facility's documentation of resident interviews for all residents with a brief interview for mental status (BIMS) score of 13 or higher was reviewed. The survey team conducted a sample of resident interviews to ensure they had been interviewed, and any concerns were shared. The survey team verified that the facility staff had documentation of family interviews being conducted for residents with a BIMS score of less than 13. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The survey team reviewed the staff education regarding abuse/neglect, including psychosocial well-being, timely call bell response, and timely incontinence care. The sign-in sheet for the education was compared to the schedule of staff working to ensure all staff had received education. A sample of staff across all departments was interviewed to verify they had received education and had knowledge of abuse/neglect, how to report such allegations, timely call bell response, timely incontinence care, and psychosocial well-being. No concerns noted. The survey team conducted observations on each of the three resident care units and monitored staff's response to call bells. Calls for assistance were responded to within 15 minutes of the call bells being initiated. The facility provided evidence of a call bell audit that was conducted. According to the facility documentation, they identified several residents whose call-bells were noted to not be operational. The survey team then went to those selected rooms and verified that the call bell was working. The surveyor identified two resident rooms, four residents affected, that the call bell was not working when checked. The facility's VPO was made aware of the above findings regarding the in operatable call bells and that they would not be able to abate the IJ. On 4/11/25 at 9:25 a.m., the survey team was made aware that the call bells in two rooms were replaced and functioning, while the residents in one other room had been distributed hand bells to use to notify staff if assistance was needed. The survey team verified this with no further concerns noted. On 4/11/25 at 10:15 a.m., the facility's administration and regional team were made aware that the survey team needed evidence that the facility was responding to concerns and/or allegations of abuse/neglect shared by residents and families during the interview process. The facility provided the survey team with evidence that three allegations of abuse/neglect were being investigated, and all other concerns were being addressed through the facility's grievance procedure. On 4/11/25 at 12 noon, after having verified that the removal plan had been fully implemented and that facility actions had eliminated the likelihood of serious injury, harm, impairment, or death, the facility was notified that the immediacy had been removed. The scope and severity of the remaining noncompliance was lowered to a level three, isolated. Based on observation, resident and staff interviews, clinical record review and facility documentation review, the facility failed to protect the residents' right to be free from neglect for three residents (Resident #17-R17, Resident #23-R23, and Resident #10- R10) in a survey sample of 26 residents, which resulted in harm for two residents (Resident #10- R10 and Resident #23-R23) and the identification of Immediate Jeopardy (IJ) and substandard Quality of Care. The findings included: 1. The facility staff neglected to provide timely incontinence care for Resident #23 (R23), which resulted in skin injury and psychosocial harm. (continued on next page)

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	495093	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrisonburg Hlth & Rehab Cntr	1225 Reservoir Street Harrisonburg, VA 22801

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to clinical record review, R23 was admitted to the facility on [DATE]. Diagnoses for R23 included but were not limited to chronic diastolic heart failure, muscle weakness and chronic respiratory failure with hypoxia. R23's Quarterly Minimum Data Set (an assessment protocol), with an Assessment Reference Date of 3/25/25, coded R23 with no cognitive impairment. This assessment also documented that R23 was dependent on staff for toileting and required moderate to maximal assistance with bed mobility, transferring, and bathing. On 4/9/25 at 6:35 p.m., upon entering R23's room, it was noted that the privacy curtain had been pulled. When addressing the resident through the curtain, R23 replied, She's changing me. I'll talk to you in just a minute, she almost done. From behind the curtain, R23 was then heard saying, Ouch, Ouch! Be gentle, it burns. The CNA was heard to say, Ok, I'm being gentle. I'm almost done. On 4/9/25 at 6:45 p.m., an interview was conducted with R23. When questioned about care, R23 said, There have been several times that I have had to sit in my urine or feces for long periods of time. R23 said, Last Thursday [4/3/24], I was wearing the wrong size brief, and I sat in my own feces for two hours. When I rang for help, the aide came in at 8:30 a.m., and I told her I needed to be changed, that I had a bowel movement, and that it leaked out of my brief. The aide turned the call bell off, said that state was here, so she had to take care of other residents first, and then she would come back to change me. R23 stated that approximately 10:10 a.m., .another certified nursing assistant [CNA# 7] came to the door, asked how I was doing, and if I needed anything. R23 stated that she told CNA#7 that she needed to be changed, had been sitting in a bowel movement for almost two hours, and that (CNA#6's name redacted) was supposed to come back to do it but had not been back. R23 stated that CNA#7 indicated that she would provide the needed care but had to go get all the supplies she needed. R23 stated that CNA#7 came back at 10:30 a.m. and provided the care. R23 said, My bottom was burning me as she was cleaning me up, and [CNA#7 name redacted] pointed out to me that it was some bad spots down there. R23 said, This made me feel others were more important to me. Made me feel like crap. I have never been treated like this before. R23 stated that CNA#6 had been her aide several times but had never left her waiting that long before. R23 stated that she had reported the incident to someone from Adult Protective Services who came to see her yesterday. When questioned if she had told anyone else, R23 stated that she reported this incident to CNA#7 on Thursday (4/3/25), she told the ADON on Friday (4/4/25), and told the administrator on Saturday (4/5/25). R23 then showed pictures that she stated had been taken that day. One photo showed that fecal material was outside of the incontinent brief, on both sides of her thighs, on the incontinent bed pad, and with a large brown stain on the lower bed sheet. R23 then displayed another picture on her cell phone that she had taken after care was provided, which showed bright red appearance of her groin area and thighs. When questioned if the areas were better, R23 stated that she was suffering with burning to her peritoneal area and thighs. Displaying her inner thighs and groin area, it was observed that R23's mid to inner thighs appeared deep beefy red in color, while the groin area was bright red. On 4/9/25 at 7:30 p.m., an interview was conducted with the assistant director of nursing (ADON). When questioned about R23's complaint, the ADON said, I talked to her sometime on Friday. She hollered at me from her bed. She told me it took [CNA#6's name redacted] a long time to get in here to take care of me. The ADON stated that she told R23 that she would look into it and check the assignment sheet. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/9/25 at 7:45 p.m., the ADON, the director of nursing (DON) and the regional director of clinical services (RDCS) were made aware of the above findings related to R23, during a meeting. The response was that they had not been aware that R23 was sitting in feces for two hours until this meeting. When the RDCS stated that the change in skin condition could be related to yeast, a joint observation was suggested and agreed upon. 4/9/25 at 8:00 p.m., an observation was conducted with the RDCS. R23 retold how she had been left in feces on 4/3/25 to the RDCS. When the RDCS asked to see the affected area, R23 consented and showed her. When the RDCS attempted to move R23's legs apart, R23 began grimacing, wincing, and moving away from the contact. The RDCS asked if she needed something for pain, R23 stated, No, I handle pain well. The RDCS asked R23 if the area itches, and R23 said, No, it burns! The RDCS asked R23 if she had ever had cream applied in that area before, and R23 said, Under my abdomen but never down there. I have never had anything down there until Thursday. On 4/9/25 about 8:10 p.m., an end-of-day meeting was conducted with the administrator, director of nursing and corporate staff, during which they were made aware of the above concerns and the potential for neglect. On 4/10/25 at 9:50 a.m. an interview with CNA#7 was conducted via phone call. CNA#7 stated that when she went to do her rounds, she asked R23 is she needed help or anything. That was when she told me she was needing to be changed and she had been sitting in it for a while. CNA#7 said, She was upset. [R23's name redacted] was sitting in a mess. The feces were up the front of the brief, down the sides of legs, on the chuck pad, on the sheets, and I had to change all bed linen. CNA#7 said, After cleaning her up, the creases of her thighs were red. CNA#7 stated that R23 was upset and mad because CNA#6 was supposed to come back to change her and never came back. CNA#7 stated that she did not report to anyone how she found R23, nor that R23 had reported that she had been laying there for 2 hours in feces waiting on CNA#6 to come back and change her. On 4/10/25 at 10:15 a.m., an interview with CNA#6 was conducted via phone call. CNA#6 stated that when she entered R23's room, she was needing to be changed. CNA#6 stated that she had been asking for help, but no one would come help her with answering the call bell lights. CNA#6 stated that she had another resident that she had to get ready for an appointment, who needed to bathed, dressed, transferred with a lift, and to the lobby for her pick up time or she would miss the appointment. CNA#6 stated that when CNA#7 showed up, she was taking care of R23. CNA#6 stated that she had taken care of R23 several times, and that R23 had no skin issues or red areas. CNA#6 stated that she did not mention state being her in the facility, but she did turn off the call light. CNA#6 stated that the administrator, and APS had talked with her about the incident. On 4/11/25, a review of Resident #23 clinical record was conducted. Resident #23 was seen by the nurse practition-er (NP) on 4/10/25. The progress note read in part, .patient was seen per nursing request for redness to groin/inner thighs. The NP note read in part, .MASD [moisture-associated skin damage], inner thighs/groin. The NP ordered .zinc bid [twice daily] until Greers goo arrives. Greers goo bid until healed. No additional information was provided prior to exit.

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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 the facility documentation and staff interview the facility staff failed to implement abuse policy regarding reporting to the Department of Health Professionals (DHP) for two residents (Resident #17 and Resident #23) out of a survey sample of 26 residents. The findings included: The facility staff failed to report an allegation of abuse and neglect to DHP that involved license staff. On 4/3/25 at 11:00 a.m., the facility provided a synopsis report for R17 for review. In this report dated 3/24/25 it was reporting an allegation of abuse/neglect. During the review there were fax forms and confirmation to adult protective services (APS), the ombudsman, and the Virginia Department of Health (VDH). The allegation involved a certified nursing assistant, CNA#15. There was no evidence of the DHP being notified of the allegation against CNA#15. On 4/3/25 at 4:47 p.m., an interview with the administrator was conducted. The administrator said, I did send to DHP, here is what happened: I sent it and it had incomplete on it. I called DHP last Thursday and resent the form. I have everything in there and last Thursday I called DHP. I talked to them, and they said it was fine. The administrator was asked why it was not in the investigation file, and he said, Well, that is an error on my part. On 4/3/25 at 5:00 p.m., the administrator brought in evidence that the incident was faxed to DHP last Thursday, as confirmation of the notification to DHP. However, The administrator showed the form, it was noted that it was addressed to VDH and not to DHP. When questioned about this, the administrator said, I don't fax DHP unless it is substantiated, then I will. I have never faxed the allegation to DHP. On 4/9/25 at 8:00 p.m., a review of a facility incident report of R23 was conducted. During the review there was faxed conformations for APS, VDH, and ombudsman. The allegation involved CNA#6. There was no evidence of DHP being notified of the allegation against CNA#6. On 4/9/25 at 8:30 p.m., a review was conducted of a facility document. The policy titled, Abuse/Neglect/Misappropriation/Crime, read in part, .Notify within 24 hours the Department of Health Professions (DHP) for incidences involving nurse aides, RN's, LPN's, Physicians, or others licensed or certified by DHP. No other information was provided prior to exit.

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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 the facility documentation and staff interviews, the facility staff failed to report an allegation of abuse and neglect timely for two residents (Resident #17 and Resident #23) out of a survey sample of 26 residents. The findings included: 1. The facility staff failed to report an allegation of abuse and neglect timely to the regulatory agencies for R17. On 4/3/25 at 5:30 p.m., an interview was conducted with CNA #9. CNA#9 said, [R17's name redacted] daughter came into the facility about 7:55 p.m., on 3/15/25, and he had the brief on she tagged at 12 o'clock. He was wet enough to be changed. CNA#9 stated his bottom was red, and cream was applied. CNA#9 stated she would be concerned with a brief being left on for eight hours. CNA#9 did report this to charge nurse LPN#5 but no evidence of reporting this to upper management. On 4/3/25 at 7:20 p.m., an interview was conducted with LPN#5. LPN#5 stated that he saw the brief that was changed around 8:00p.m., and it was marked with a number 12 on the brief. LPN#5 stated he understood why the daughter was upset if R17 was in the same brief for that long of a time. LPN#5 stated that he applied cream to R17's scrotum area. LPN#5 said, scrotum was like a flushed cheek red color. LPN#5 did not report this incident to anyone but did write a witness statement for the administrator two days after the incident. LPN#5 wrote on the witness statement that R17's daughter came to him upset about patient not being changed. LPN#5 stated that on 3/15/25 at 12:00 p.m., she wrote the time on the patients brief and at 8:00 p. m., I went with the daughter and saw the brief with a number 12 on the brief which indicated R17 had not been changed since 12:00 p.m. On 4/8/25 at 10:40 a.m., an interview was conducted with the unit manager on South wing, LPN#13. LPN#13 stated that R17's daughter sent a message to me and stated that CNA#15 had told her that her dad was showered. LPN#13 stated that the daughter sent pictures to me of him in the bed with a gown on, a saturated brief, dried urine ring on the bed pad, not groomed and hair was greasy looking. LPN#13 stated that the daughter stated she would be having a meeting about this on Monday with me and the administrator. LPN#13 stated that on the evening of 315/25 that the daughter sent another message to her stating that the daughter had marked R17's brief with a 12 and when she arrived around 8:00 p.m. R17 still had the same brief on. LPN#13 had pictures of the brief with a #12 wrote on the brief and of the wall clock showing 7:58 p. m. LPN#13 stated that the pictures were taken from R17's room and the pictures were time stamped. LPN#13 stated she called to the facility and LPN# 5 stated that the daughter had approached him and CNA#9, and they had already cleaned him up. On 3/16/25 the daughter messaged LPN#13 and stated that she had told CNA#15 not to enter her dad's room or go near her dad anymore. LPN#13 stated that she did not report this allegation to anyone at this time and waited until Monday to make the administrator aware of the pictures and the daughters conversation. 2. The facility staff failed to report an allegation of abuse and neglect timely to the regulatory agencies for R23. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/25 at 6:45 p.m., R23 stated that approximately 10:10 a.m., that CNA# 7 came to the door, and asked how I was doing, and if I needed anything. R23 stated she told CNA#7 that she needed to be changed and had been sitting in my bowel movement for almost two hours, and CNA#6 was supposed to come back to change me but has not been back. R23 stated that CNA#7 was going to change her but had to go get all the supplies she needed. R23 stated that CNA#7 came back at 10:30 a.m. to change me. R23 said, my bottom was burning me as she was cleaning me up, and [CNA#7 name redacted] pointed out to me that it was some bad spots down there. R23 stated that she told the assistant director of nursing (ADON) after CNA#7 had cleaned her up. R23 stated that the ADON was going to have the physician to order some new cream today because the zinc ointment they were using was not helping. R23 said, this made me feel others were more important to me. It made me feel like crap I have never been treated this. R23 stated CNA#6 was her aide several times but never left me waiting that long before. R23 stated that someone from Adult Protective Services came to see her yesterday. R23 stated that she reported this incident to CNA#7 on Thursday (4/3/25), she told the ADON on Friday (4/4/25), and the administrator on Saturday (4/5/25). R23 showed the surveyor a picture she had taken that day. Feces were out of her brief, on both sides of her thighs, on the incontinent bed pad, and down to the sheet on the bed. R23 showed the surveyor a picture she had taken of her groin area, and thighs after being cleaned up. On 4/9/25 at 7:30 p.m., an interview was conducted with ADON. ADON said, I talked to her sometime on Friday. She hollered me from her bed. She told me it took [CNA#6's name redacted] a long time to get in here to take care of me. ADON stated she told R23 that she would look into it and check the assignment sheet. On 4/9/25 at 8:10 p.m., an end-of-day meeting was held with the administrator, the director nursing and corporate staff were held, and they were made aware of the above concerns. No additional information was given prior to the 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. For Resident #12 (R12) who was presumed to have ingested a body wash, which resulted in hospitalization, the facility staff failed to have credible evidence of a thorough investigation being conducted. On 4/4/25, a closed record review was conducted of R12's chart. This review revealed a progress note written by a licensed practical nurse (LPN #5) dated 3/17/25 at 5:45 a.m., that was titled, eInteract SBAR Summary for Providers. This note read in part, Blood pressure: 173/98- 3/17/2025 at 5:50 a.m., Position: Sitting r/arm [right arm]. Pulse: 110, R 22 [respirations] Temp 97.5- 3/14/25 23:00 route: Forehead non-contact . Pulse Oximetry: O2 90%- 3/17/2025 at 5:49 a.m Outcomes of Physical Assessment: . Respiratory Status Evaluation: Shortness of breath, abnormal lung sounds (rales, rhonchi, wheezing), Cardiovascular Status Evaluation: Resting pulse greater than 100 or less than 50 . Nursing observations, evaluation, and recommendations are patient grabbed and ingested unknown specific amount of soap. patient bubbling from mouth with wheezing heard from lung sounds. tachycardia noted as well as hypertension. patient decreased response to stimuli. on call contacted, MD and NP [medical doctor and nurse practitioner] no answer. emergency contact was reached, and patient was sent to ER [emergency room] via 911. report [sic]. On 3/17/25 at 6:15 a.m., another nursing progress note entry by LPN #5 was entered into R12's chart that read, patient grabbed and ingested unknown specific amount of soap. patient bubbling from mouth with wheezing heard from lung sounds. tachycardia noted as well as hypertension. patient decreased response to stimuli. on call contacted, MD and NP no answer. emergency contact was reached, and patient was sent to ER via 911 at 0615. report called to [name redacted] ER nurse at [hospital name redacted]. On 3/17/25 at 12:38 p.m. an entry noted as a Late Entry was entered by the regional director of clinical services (RDCS) that read, Per investigation, staff statements, patient was not witnessed grabbing or ingesting shower gel. According to hospital records dated 3/17/25, and titled, Pulmonary & Critical Care Specialist- ICU intake note read in part, . In summary this [AGE] years old female with severe dementia who is functionally limited . found to be hypoxic with change in mental status but also the staff noticed that she has ingested liquid body wash of 20 cc which has not been witnessed but patient was smelling fruity like the body wash in the room. When EMS arrived, she was hypoxic and confused unresponsive. She came to ER on nonrebreather. She is found to have a new airspace disease involving the right lung, metabolic acidosis with anion gap, lactic acidosis, venous blood gas shows metabolic as well as respiratory acidosis . Assessment: 1. Acute hypoxic and hypercapnic respiratory failure- currently on high flow 2. Accidental ingestion poisoning of liquid body wash/unknown amount and duration at the nursing home . According to hospital records dated 4/1/25, titled, Physician Discharge Summary which read in part, . brought to the emergency room where she was hypoxic hypercapnic could not tolerate BiPAP and she was eventually intubated, patient was extubated in March 22 and she did not tolerate and has to be reintubated in March 22 after discussion with the family decision was made for tracheostomy and PEG tube placement . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility provided documents regarding the incident of R12, the facility only talked with and interviewed licensed practical nurse (LPN #12) and a certified nursing assistant (CNA #3). According to the nursing schedule for the overnight shift from 3/16/25-3/17/25, two nursing assistants (CNA #3 and CNA #2) worked the unit where R12 was a resident, and two licensed practical nurses (LPN #12 and LPN #11) worked the unit. LPN #5, who made the entries into R12's chart had been assigned to another unit. According to a facility synopsis dated 3/24/25, which was signed by the facility administrator, it noted that interviews were conducted with the nurse and CNA assigned to R12 and they did not witness her drink shower gel. The document went on to state, Due to the results of this investigation, including staff interviews [facility name redacted] is unable to substantiate resident ingested shower gel, based on available information and the incident not being witnessed On 4/4/25 at 9:40 a.m., an interview was conducted with resident #2 (R2), who was R12's roommate. R2 was asked about the day R12 was sent to the hospital, R2 stated, I remember hearing coughing, it sounded like she was choking. I kept ringing the buzzer, I heard her drinking something, I didn't know that kind of stuff was over there, she must have been thirsty. When asked what she drank, R2 said, body wash. When asked how she knew this, R2 stated, I heard them [facility staff] say she drank body wash, they said they could tell by her poop. She had a major blow out. It sounded like she was choking. R2 stated she couldn't see R12 because the privacy curtain was pulled. On 4/7/25 at 4:30 p.m., an interview was conducted with licensed practical nurse #11 (LPN #11), who also worked the unit where R12 was a resident the night of the incident. LPN #11 stated, I was fairly new, I was only working there two weeks, but she would grab you when you walk by. I was working night shift and the nurse assigned came and told me she swallowed soap. She had aspirated, she had soap coming from her nose and mouth, it was tan colored. The nurse from the other side came to help. She was having massive diarrhea. When asked if she thought R12 had drank shower gel, LPN #11 said, Definitely! I was a CNA for 20 years and I know for sure it was bath and body works, maroon colored, I saw the bottle when the EMTs [emergency medical technicians] came and most likely the CNA left it on the bedside table. She would grab things. It was a bunch of CNAs trying to help. [LPN #5's name redacted] was helping, [LPN #12's name redacted] was on the phone with the doctor and we got vitals. I saw her aspirating from her nasal, she sounded like she was under water. She was struggling to breathe. She was not at her baseline. She had a lot of fluid sounds. LPN #11 went on to report that when the EMT's came they had four trainees, and they were getting instructions on how to lift R12. They applied oxygen, she was in the wheelchair, and I was doing something and remember [LPN #11's name redacted] saying this isn't good. I dropped what I was doing to go help. I was present. When asked if any of the facility administration had attempted to reach her to get information about what had happened, she stated, They never called or reached out. The next day they had a whole protocol on keeping stuff out of reach. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/25 at 8:10 p.m., an interview was conducted with CNA #3. CNA #3 was asked about the night R12 was sent to the hospital. CNA #3 stated, I was working with one other CNA, we had 40-60 residents. The CNA working with me would not finish a full round. The only resident she got cleaned up was [R12's name redacted]. They let her sit from 3-11 p.m. in the chair. The CNA on the prior shift said she was acting crazy because she had been refusing medications and several days. The CNA [CNA #2] washed her up and changed her into her gown. I helped hold her up while she was washing her and got her in bed. I was walking by and on the bedside table I noticed soap was missing from the bottle. I went and told the nurse that on the table was a bottle of soap and it was soap missing out of it. I told the nurse. I think she went to check on her. I went back about 20 minutes later to check on her and she was still sitting there, she had diarrhea and was breathing heavy. The other CNA was sitting at the station. We were both working the floor together because she was new. [R12's name redacted] was sitting up with soap missing and the top off, it was something the family provided, it said black cherry, she had taken her gown off the reason I went in the room, and I noticed she was breathing weird. I told [LPN #12], and she wanted to know how much she had drank. I told her a good amount and she said she will probably just puke it out. When asked if she had worked with R12 previously and what she was like. CNA #3 said, I had worked with her. She was always reaching out, that night she was aggressive and hitting, we kept her at the nursing station until she was ready to go to bed. The other CNA was a new agency person. CNA #3 went on to report that the rescue squad staff took the soap with them. She had red stuff in her mouth, I noticed foaming, we were wiping that off, it was pink tinted. When asked how R12 got the soap, CNA #3 said the other CNA working that night, heard the same things I did. She had dementia and is grabbing at things, she is off her meds. I think it is kind of negligent, why would you leave soap right there on the overbed table, especially that night. On 4/8/25 at 8:47 a.m., an interview was conducted with LPN #5. LPN #5 reported he had walked to the unit where R12 was a resident to get a vital sign machine. LPN #5 reported, The nurses and CNAs looked like something was wrong. They said, 'She grabbed soap and ingested it.' I contacted 911, started her file to send with her. That was between 5-6 a.m. When asked how R12 got the soap, LPN #5 said, I'm not sure, I thought I heard them say she grabbed it off the bedside table. I'm not sure if while getting her cleaned up and stepped away to get a towel or something. One nurse said they thought she drank soap and had suds and bubbles coming out of her mouth and nose, so I started the ball rolling to get EMS there. That soap lines the esophagus and can be aspirated. When asked if she saw or assessed R12, LPN #5 stated, No, usually my role in emergency situations is to get 911 there and do the paperwork. On 4/8/25 at 9:13 a.m., an interview was conducted with LPN #12. LPN #12 reported, I was on my med cart and had been on the hall and walked by the room and saw her [R12] laying sideways, she had a bowel movement, and it was all over her, it was bubbly and pink tinged, it even smelled like it [the soap]. The CNA said 'I think she may have drank it [the soap]' I could hear her in her respiratory, she was very congested. The CNA said she had washed her up. [R12's name redacted] was new to our hall and the CNA is a traveler. When asked if R12 was restless, confused or grabbing at things, LPN #12 said, All the time! When asked if R12 had any clinical symptoms, LPN #12 stated, Her lips were discolored, vitals surprisingly weren't too off baseline for her which, I've learned means nothing. She just looked at you with a stare. Respiratory was bad, I knew she had to go. That facility has a protocol you have to call three people to send someone out and no body answered, so I called on-call back. (continued on next page)

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Harrisonburg Hlth & Rehab Cntr	1225 Reservoir Street Harrisonburg, VA 22801

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #12 was asked if she suctioned R12. LPN #12 said, I didn't suction her because I wiped out of her mouth what was coming from her was deep you could wipe the bubbles and it kept coming, it smelled perfume, it was foamy bubbles with a pink tinge. When asked if anything else could have happened, LPN #12 said, No. I don't think it was intentional but there is no other explanation. On 4/8/25 at 9:32 a.m., an interview was conducted with CNA #2. CNA #2 reported, It was the first time I had worked with her, we gave her a bath, prior to that she was sitting at the nursing station, when I came in at 11 p.m. I think we put her to bed maybe around 4 a.m. When we brought her to the bed, we washed her off and changed her brief. The other aide was doing rounds and called me to come, we saw bubbles coming out of her mouth, she was foaming. We called for the nurse at the desk, I think she said she was aspirated. We sat in the room until the ambulance came. We think she drank the soap on her nightstand. She literally had bubbles coming out. We didn't give her anything to drink, it was bubbles, it was on her nightstand when we brought her in the room. CNA #2 went on to state that she had seen the soap on the bedside table and said, So I didn't think anything about it. It was my first time with her, so I didn't really know her. When asked if she had gotten any kind of report on the residents she was to be assigned, CNA #2 said, I could have, I don't recall. CNA #2 continued the interview and said, She [R12] was demented. It was a nightmare. I feel horrible for her; she had bubbles coming out of her mouth, so I assume she drank the soap. You could hear her gurgling, at that point I'm thinking she aspirated, it was like she was choking. When asked if R12 was having any difficulty breathing, CNA #2 said, Yes, you could hear the sound like gurgling. On 4/8/25 at 11:35 a.m., an interview was conducted with licensed practical nurse #3 (LPN #3), who was a unit manager. When asked about R12, LPN #3 stated, She was a sweet, demented lady. We tried to keep her up here with us to keep an eye on her, she was grabby, she would grab at you as you walk by and would touch other residents' arms if they say by her. She was not oriented, she was total care for everything, was fed by staff, incontinent of bowel and bladder. When asked about her knowledge and involvement the day R12 was sent to the hospital, LPN #3 said, I was on call that morning when [LPN #12's name redacted] called me and said [R12's name redacted] had gotten a hold to some soap and drank it. She called for transport to send her out, she said she was still alert and at her baseline, was coughing up soap bubbles. Following that we put a plan of correction in place to be observant of toiletries being out of reach and stored in closets or bedside drawers. On the afternoon of 4/8/25, an interview was conducted with the facility administrator. The administrator was asked to discuss his investigation and facility summary findings regarding the incident with R12. The administrator asked if he could get some other staff in on the conversation and reported while he had authored the facility summary, he had some help. The administrator returned to the conference room with the regional director of clinical services (RDCS). When asked to explain their investigation and findings/conclusion the RDCS. The RDCS reported that they conducted interviews with the staff that worked with R12, and no one saw the resident drink or swallow soap so therefore they could not conclude that was what happened. The RDCS was asked what else could cause the symptoms R12 was having and reported that congestive heart failure can cause pink tinged foam/bubbles. The RDCS also stated that they never conclude or substantiate an allegation unless they know for sure it happened. During the above interview, the surveyor expressed concern of the lack of a thorough investigation of the incident as they had only reviewed hospital records and talked with two staff, which did not indicate a thorough investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's abuse policy titled, Reporting Requirements/Investigations, which read in part, . 2. The administrator and/or director of nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations . No additional information was provided. Based on facility documents and staff interviews, the facility staff failed to complete a thorough investigation regarding abuse and neglect for two residents (Resident #17, R17 and Resident #12, R12) out of a survey sample of 26 residents. The findings included: 1. The facility staff failed to thoroughly investigate an allegation of neglect for R17. On 4/3/25 at 11:00 a.m., the facility provided a facility synopsis report on R17 for the surveyor to review. R17's daughter was reporting an allegation of neglect. The report was dated 3/17/25, and the allegation read, [R17's name redacted] daughter brought concerns to nursing leadership related to allegation of incontinent care not being provided timely for her father. On 4/3/25 at 11:15 a.m., a review of the witness statements collected by the administrator was completed. The findings of the witness statements were as follows: A certified nursing assistant CNA#9's witness statement dated 3/24/25 read in part, . [CNA#15's name redacted] gave me the verbal report that he [R17] was changed at 6:30 p.m. Around 8 p.m. I went into [R17's name redacted] room with the daughter and she showed me the brief was tagged at 12 (noon) an he still had it on. The witness statement written by licensed practical nurse LPN#5's dated 3/20/25 read in part, .Around 7:30 p.m. [R17's name redacted] daughter came to me upset. She showed me her father's brief, the brief didn't look full, but I understand why she's upset being in brief for 8 hours. The witness statement written by CNA#13's dated 3/19/25 read in part, [CNA#15 name redacted] and I budded up and work together. I didn't check [R17's name redacted] between 8 am and 12 noon. [CNA#15 name redacted] and I both checked [R17's name redacted] at 2:30 and he was dry. I personally did not check him anymore. After 2:30 [CNA#15 name redacted] checked him between 3:30 and 4 o'clock. and probably again around 6:30, The witness statement written by LPN#4's dated 3/19/25 read in part, .The daughter told me at 8 that she tagged the brief but didn't know any other issues existed about the brief before that. [R17's name redacted] was out of his bed from approximately 1 pm until I left at 7 p.m. most of the time he was up he was at the desk. I was watching him. OE#12's written witness statement dated 3/19/25 read in part, .daughter said he was in a wet bed pad and a pad that seemed to have dry urine. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA#16's witness statement was written on 3/17/25 read in part, On 3/16/25, I witnessed [CNA#15's name redacted] come up to the nurse's station. Made the statement that She would look good in orange and that she wanted to knock that bitch out. She was talking about [R17's name redacted] daughter. This all took place in front of three nurses and several residents around the nurses station. On 4/3/25 an interview was conducted with the administrator. The administrator was asked who the abuse coordinator was for the facility, and he said, if you mean the one that investigates, I do the investigations, so I guess I am. The administrator was asked for the definition of neglect, and he said, not taking care of someone needs intentionally. The administrator stated that R17 was up, and out of bed from after doing therapy until 7:00 p.m. He stated that one daughter came in at 3:00 p.m. and the other daughter came in at 5:00 p.m., and found their father wet, and did not tell anyone or change him. He said, I should go to their house to talk to them. The administrator stated he spoke with two staff members that came that evening and stated R17's brief did not appear to have been saturated. On 4/3/25 at 5:30 p.m., an interview with CNA#9 was conducted about the incident that happened on 3/15/25 with R17. CNA#9 said, daughter came in at 7:55 p.m., brief was tagged at 12 o' clock I went back and looked at the brief and it was marked. Looking at the brief lines I would not have changed him, but he was wet. He was wet enough to be changed. CNA#9 showed pictures of the wet brief and the time that was wrote on the brief. CNA#9 stated that the pictures were time stamped. On 4/3/25 at 7:20 p.m., an interview was conducted with LPN#5 about the incident that happened on 3/15/25 with R17. LPN#5 stated that R17 had the same brief on that was numbered with a 12 by his daughter. R17's brief was wet, and cream was applied to his scrotum that LPN#5 said, was like a flush cheek red. LPN#5 stated he was able to understand why R17's daughter was upset due to being in the same brief for eight hours. On 4/8/25 at 9:00 a.m., an interview was conducted with LPN#4. LPN#4 said, CNA#13 changed or toileted him after the daughter being in. [CNA#15 name redacted] was aide on paper technically assigned aid. On 4/8/25 at 11:00 a.m., an interview was conducted with LPN#13 the unit manager of the south wing. LPN#13 stated that R17's daughter sent her pictures of a saturated brief and a dirty bed pad with dried urine stains on the bed pad. LPN#13 stated that R17's daughter was in the facility around 8:00 p.m., and sent another picture to her with a brief marked with a 12, of R17 sitting in his wheelchair in his room, and of the wall clock that had 8:00 p.m. LPN#13 said, Based on the nurses' statements there was some truth to this. Based on allegations that was how we came up with neglect. On 4/8/25 at 10:40 a.m., an interview was conducted with CNA#13. CNA#13 said, On Sunday when I seen the daughter is when she had [CNA#15's name redacted] cornered in hallway yelling at her. Telling [CNA#15's name redacted] that she didn't give him a shower, didn't change him, didn't do her job, and [CNA#15's name redacted] wasn't allowed back in his room. CNA#13 stated R 17 was on CNA#15's assignment that day, and the nurse switched out a room with another aide. CNA#15 stated that R17's daughter had a history of tagging his brief, but no one knew his brief was tiffed that day. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/25 at 2:00 p.m. a review of the facility document was conducted. The policy titled, Abuse/Neglect/ Misappropriation/Crime, read in part, .the administrator and/or director of nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations. On 4/3/25 at 5:23 p.m., an end of day meeting was conducted with the director of nursing and corporate staff, and they were made aware of the above concerns. No additional information was provided prior to the 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 observation, staff interview, clinical record review and facility documentation review, the facility staff failed to review and revise care plan with fall interventions for one resident (Resident #11, R11) out of a survey sample of 26 residents. The findings included: The facility staff failed to revise the care plan to include R11's fall interventions. On 4/4/25 at 10:10 a.m., an observation on the [NAME] wing was conducted. In the room that R11 was in when at the facility nonskid strips were observed on the floor by the bedside. On 4/4/25 at 10:15 a.m., an interview was conducted with a licensed practical nurse LPN#17. LPN#17 stated that R11 did not have nonskid strips by his bedside for a fall intervention. LPN#17 stated R11 was moved closer to the nurse's station and had a concave mattress for his fall interventions. LPN#17 stated that the resident in the room now was a fall risk, and the nonskid strips was for her. On 4/4/25 at 10:40 a.m., an interview was conducted with the certified nursing assistant, CNA#1. CNA#1 said, fall interventions should be on the [NAME] and care plan for us to implement the interventions. CNA#1 stated that he does not remember if R11 had nonskid strips by the bedside. CNA#1 stated that housekeeping was responsible for taking up the nonskid strips in the rooms when they flip the room after a resident discharge. On 4/4/25 at 10:50 a.m., an interview was conducted with LPN#10. LPN#10 stated that she thought R11 had nonskid strips at his bedside. LPN#10 said, fall interventions are on the care plan. The aides are made aware by the nurses, being on the care plan and on their [NAME]. LPN#10 stated there was standard interventions that we use for falls and the supervisor will let us know what interventions was put in place. On 4/7/25 at 12:00 p.m., an interview was conducted with CNA#16. CNA#16 stated that floor technicians put the nonskid strips on the floor and remove the strips when the room is flipped after a resident discharge. CNA#16 stated that she does not recall if R11 had nonskid strips by his bedside. On 4/7/25 at 2:00 p.m., a review of the clinical record was conducted. The [NAME] was reviewed and there was no intervention for the nonskid strips by R11's bedside. A progress note was reviewed that was written on 1/20/25. The progress note was a fall note for R11 and the new interventions that were on the note were for nonskid strips by bedside. The care plan was reviewed and the interventions for nonskid strips by the bedside were not on R11's care plan. A device assessment was reviewed. This note was signed on 1/23/25 by LPN#20 that the intervention for nonskid strips to ensure stability with transfers was added to the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/25 at 2:30 p.m., a review of facility documents was conducted. The policy titled, Fall Management Program, read in part, .incorporate any identified interventions into the care plan as applicable. A licensed nurse will review, revise, and implement interventions to the care plan based on: Post fall investigation findings, Review of Device Assessment, Review of fall Risk scoring tool. The policy titled, Care Planning, read in part, .care plans will be updated on an ongoing basis as changes in the patient occur and reviewed quarterly with the quarterly assessment. On 4/9/25 at 5:23 p.m., an end of the day meeting was conducted with the administrator, director of nursing and corporate staff, and they were made aware of the above concerns. No additional information was provided prior to the exit conference.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical reviews and facility documents, the facility staff failed to provide activity of daily living (ADL) care for one resident (Resident #17, R17) out of a survey sample of 26 residents. The findings included: The facility staff failed to provide grooming and shower for R17. R17 was admitted to the facility on [DATE]. Diagnoses for R17 included but are not limited to urinary tract infection, muscle weakness and underweight. R17's Reentry Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 3/3/25 coded R17 with severe cognitive impairment. R17 was dependent on the activity of daily living care. Because Resident #17 was no longer a resident at the facility, a closed record review was conducted. On 4/3/25 at 11:15 a.m., a review of the facility incident summary was conducted. A written statement by licensed practical nurse, LPN#4 (LPN4) read in part, . [R17 name redacted] was not wanting to get up, so I said he could sleep a little longer. It was around 7:30 to 8'ish. I know that he did not get a shower in the morning. [R17's name redacted] was out of his bed from approximately 1 pm until I left at 7 pm most of the time he was up he was at the desk I was watching him. LPN#4 was the charge nurse on the south unit on 3/15/25 when this incident took place. A physical therapist assistant other employee #12 (OE#12) written statement was reviewed and read in part, .I went to pick up [R17's name redacted] at 8:30 a.m. he was in bed and in gown and not ready. [CNA# 15's name redacted] said she would finish up bed baths and then get back to him. I checked back on [R17's name redacted] between 9 and 12 and he was in bed the entire time. He did not appear showered at 8:30 am and did not appear to be showered between 8:30 and noon. I saw [CNA#15's name redacted] passing trays at 8:14 am. CNA#15 statement was reviewed, which noted that she clocked in at 7:05 a.m. on 3/15/25, received a quick report, and did a dry round check on her assigned group of residents. CNA#15 stated after doing her dry round check that she showered R17 then laid him down after the shower because he was sleepy. CNA#15 stated she placed him in a clean gown, brief, and clean sheets. On 4/3/25 at 4:00 p.m., an interview was conducted with the administrator. The administrator stated that CNA#15 attempted that morning to take R17 into the shower. He stated that R17 had a difficult night and not an easy morning. He stated R17 refused his breakfast, and the nurse had to work with him to give him his morning medication. He stated the daughter came in around noon. The administrator said, The shower wasn't successful. On 4/8/25 at 9:00 a.m., an interview was conducted with LPN#4. LPN#4 said, I know [CNA#15's name redacted] didn't give him a shower. LPN#4 stated that R17 was hard to wake up, I instructed CNA#15 to let him rest. When R17 gets a shower, he is up out of bed, dressed, and in his wheelchair. LPN#4 said, I talked with the daughter on Sunday. [R17's name redacted] hadn't had a shower. LPN#4 stated that CNA#15 did not give R17 a shower on Saturday, adding, I gave a shower on Sunday and shaved him myself. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/25 at 10:40 a.m., an interview was conducted with the unit manager on South wing, LPN#13. LPN#13 stated that R17's daughter sent a message to me and stated that CNA#15 had told her that her dad was showered. LPN#13 stated that the daughter stated her dad was not groomed and hair was greasy looking. LPN#13 said that the daughter reported to her that her dad was not showered and did not appear showered. LPN#13 said, If [LPN#4's name redacted] was saying that [R17's name redacted] did not get a shower and [CNA#15's name redacted] didn't do the shower I would take that to the bank. [LPN#4 name redacted] was a very thorough nurse. On 4/9/25 at 11:00 a.m., a review of R17's clinical record was conducted. The documentation for activities of daily living (ADL) was reviewed. On 3/15/25 in the ADL documentation, 7:00 a.m. to 7:00 p.m. for CNA#15's shift she documented care provided as a bed bath, a shower, not applicable for a bowel movement, and that she had transferred him two times during her shift. On the shower sheet for 3/15/25 CNA#15 had signed her initials that a shower was given. On 4/9/25 at 11:45 a.m., a request for ADL policy was requested and the facility stated that there was no policy for ADL's. On 4/9/25 at 5:23 p.m., an end of day meeting was conducted with the administrator, director of nursing and corporate staff. The facility staff were made aware of the above concerns. No additional information was provided prior to the exit conference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on resident interview, clinical record review, and facility documentation review, the facility staff failed to administer medications as ordered by the physician for one resident (Resident #8-R8) in a survey sample of 26 residents. The findings included: For R8, the facility staff failed to administer Latanoprost eye drops as ordered. On 4/3/25 at 5 p.m., an interview was conducted with R8. During the interview R8 expressed concerns that frequently he doesn't receive his eye drops for glaucoma. On 4/3/25 and 4/4/25, a clinical record review was conducted of R8's chart. According to the physician orders, R8 was to receive Latanoprost Ophthalmic Solution 0.005%. Instill 1 drop in both eyes at bedtime for glaucoma. The order for the eye drops was originally written 2/14/24 and remained an active order at the time of survey. On 4/8/25 at 5:49 p.m., an interview was conducted with the facility's director of nursing (DON). When asked what a blank on the MAR indicated, she said, I would assume it was not administered and something should have been written. The DON acknowledged that she expected residents to receive medications as ordered. On 4/10/25 at 3:30 p.m., interviews were conducted with two of the licensed practical nurses (LPN #16 & LPN #18). When asked what they do when administering medications and a medication is not available. LPN #16 and LPN #18 both stated if the medication is scheduled, they message the pharmacy and if it is not available in the Omnicell they call the provider for alternate orders. When asked why a medication would not be available, both LPN #16 and LPN #18 explained that perhaps someone didn't order the medication, or being an eye drop since they have a lot of agency staff that work maybe they didn't know the overstock/extra bottles are stored in the fridge in the medication room. LPN #16 stated, I do remember them saying he [R8] didn't have drops, but the DON [director of nursing] can override that for them [the pharmacy [to send it. According to the medication administration record (MAR), R8 did not receive the eye drops on 1/17/25 and 1/18/25. There was no documentation regarding the scheduled administration on 1/17/25, the MAR was blank and on 1/18/25, there was an indication that the medication was held. The nursing progress notes gave no details as to why the medication was not administered either day. According to the facility policy titled, General Guidelines for Medication Administration it read, . II. Administration . 2. Medications are administered in accordance with written orders of the prescriber . IV. Documentation. 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given On 4/9/25, during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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Harrisonburg Hlth & Rehab Cntr	1225 Reservoir Street Harrisonburg, VA 22801

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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, clinical record review and facility documentation review, the facility staff failed to provide adequate supervision and an environment free of accident hazards to prevent injury to residents, that resulted in two instances of injury/harm to Resident #12 (R12) and one occurrence of harm for Resident #18 (R18). Having the potential to affect multiple residents residing on three of three nursing units, the noncompliance resulted in the identification of immediate jeopardy (IJ) and substandard quality of care. The findings included: 1. The facility staff failed to ensure the environment was free of accident hazards, which resulted in R12 ingesting body wash, requiring hospitalization for respiratory failure and intubation, and the subsequent placement of a trach and a feeding tube. On 4/4/25, a closed record review was conducted of R12's chart. This review revealed a progress note written by a licensed practical nurse (LPN #5) dated 3/17/25 at 5:45 a.m., that was titled, eInteract SBAR Summary for Providers. This note read in part, Blood pressure: 173/98- 3/17/2025 at 5:50 a.m., Position: Sitting r/arm [right arm]. Pulse: 110, R 22 [respirations] Temp 97.5- 3/14/25 23:00 route: Forehead non-contact . Pulse Oximetry: O2 90%- 3/17/2025 at 5:49 a.m Outcomes of Physical Assessment: . Respiratory Status Evaluation: Shortness of breath, abnormal lung sounds (rales, rhonchi, wheezing), Cardiovascular Status Evaluation: Resting pulse greater than 100 or less than 50 . Nursing observations, evaluation, and recommendations are patient grabbed and ingested unknown specific amount of soap. patient bubbling from mouth with wheezing heard from lung sounds. tachycardia noted as well as hypertension. patient decreased response to stimuli. on call contacted, MD and NP [medical doctor and nurse practitioner] no answer. emergency contact was reached, and patient was sent to ER [emergency room] via 911. report [sic]. On 3/17/25 at 6:15 a.m., another nursing progress note entry by LPN #5 was entered into R12's chart that read, . patient grabbed and ingested unknown specific amount of soap. patient bubbling from mouth with wheezing heard from lung sounds. tachycardia noted as well as hypertension. patient decreased response to stimuli. on call contacted, MD and NP no answer. emergency contact was reached, and patient was sent to ER via 911 at 0615. report called to [name redacted] ER nurse at [hospital name redacted]. According to hospital records dated 3/17/25, and titled, Pulmonary & Critical Care Specialist- ICU intake note read in part, . In summary this [AGE] years old female with severe dementia who is functionally limited . found to be hypoxic with change in mental status but also the staff noticed that she has ingested liquid body wash of 20 cc which has not been witnessed but patient was smelling fruity like the body wash in the room. When EMS arrived, she was hypoxic and confused unresponsive. She came to ER on nonrebreather. She is found to have a new airspace disease involving the right lung, metabolic acidosis with anion gap, lactic acidosis, venous blood gas shows metabolic as well as respiratory acidosis . Assessment: 1. Acute hypoxic and hypercapnic respiratory failure- currently on high flow 2. Accidental ingestion poisoning of liquid body wash/unknown amount and duration at the nursing home . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to hospital records dated 4/1/25, titled, Physician Discharge Summary which read in part, . brought to the emergency room where she was hypoxic hypercapnic could not tolerate BiPAP and she was eventually intubated, patient was extubated in March 22 and she did not tolerate and has to be reintubated in March 22 after discussion with the family decision was made for tracheostomy and PEG tube placement . According to the facility provided documents regarding the incident of R12, the facility only talked with and interviewed licensed practical nurse (LPN #12) and a certified nursing assistant (CNA #3). According to the nursing schedule for the overnight shift from 3/16/25-3/17/25, two nursing assistants (CNA #3 and CNA #2) worked the unit where R12 was a resident, and two licensed practical nurses (LPN #12 and LPN #11) worked the unit. LPN #5, who made the entries into R12's chart had been assigned to another unit. On 4/4/25 at 9:40 a.m., an interview was conducted with resident #2 (R2), who was R12's roommate. R2 was asked about the day R12 was sent to the hospital, R2 stated, I remember hearing coughing, it sounded like she was choking. I kept ringing the buzzer. I heard her drinking something . I didn't know that kind of stuff was over there, she must have been thirsty. When asked what she drank, R2 said, Body wash. When asked how she knew this, R2 stated, I heard them [facility staff] saying she drank body wash. They said they could tell by her poop. She had a major blow out . It sounded like she was choking. R2 stated she couldn't see R12 because the privacy curtain was pulled. On 4/7/25 at 4:30 p.m., an interview was conducted with licensed practical nurse #11 (LPN #11), who also worked the unit where R12 was a resident the night of the incident. LPN #11 stated, I was fairly new. I was only working there two weeks, but she would grab you when you walk by. I was working night shift and the nurse assigned came and told me she swallowed soap. She had aspirated; she had soap coming from her nose and mouth, it was tan colored. The nurse from the other side came to help. She [R12] was having massive diarrhea. When asked if she thought R12 had drank shower gel, LPN #11 said, Definitely! I was a CNA for 20 years and I know for sure it was bath and body works, maroon colored. I saw the bottle when the EMTs [emergency medical technicians] came and most likely the CNA left it on the bedside table. She would grab things . It was a bunch of CNAs trying to help. [LPN #5's name redacted] was helping, [LPN #12's name redacted] was on the phone with the doctor and we got vitals. I saw her aspirating from her nasal, she sounded like she was under water. She was struggling to breathe. She was not at her baseline. She had a lot of fluid sounds. LPN #11 went on to report that when the EMT's came they had four trainees, and they were getting instructions on how to lift R12. They applied oxygen, she was in the wheelchair. I was doing something and remember [LPN #11's name redacted] saying this isn't good. I dropped what I was doing to go help. Yes, I was present. When asked if any of the facility administration had attempted to reach her to get information about what had happened, she stated, They never called or reached out. The next day they had a whole protocol on keeping stuff out of reach. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/7/25 at 4:53 p.m., the vice president of operations (VPO) provided the survey team with a plan of correction the facility had implemented in response to R12's incident. The VPO said, We can't tell for certain it happened, but we put a plan in place. The documents included a paper with a grid that noted, . Problem: Toiletry Items: Date of Implementation: 3/17/25. Problem: 1. Toiletry items not stored correctly in pt [patient] bedrooms. Immediate response- what was done at the time: 1. 100% audit of all rooms to ensure toiletry items stored correctly. How to identify other residents: 1. All residents have the potential to be affected. What measures were put in place to prevent reoccurrence: 1. Education to nursing staff, provided by DON [director of nursing], or designee: On ensuring toiletry items are stored in closet, nightstand drawer or with staff. Ensuring all cleaning supplies are locked up. How to monitor to ensure the problem does not reoccurrence [sic] 1. The DON or designee will audit 10 rooms weekly for 4 weeks then 3 rooms weekly for 4 weeks to ensure toiletry item and cleaning supplies are stored correctly. QA: [quality assurance] The results will be reported to the monthly quality committee for review and discussion. To ensure substantial compliance. Once the QA committee determines the problem no longer exists, then review will be completed on a random basis. ADHOC QAPI: 3/24/25. QAPI Meeting: 4/13/25. Date of compliance: 3/27/25. Also included in the documents provided by the VPO was a typed paragraph that read, On 3/17/25 resident #1 [identified as R12 in this survey report] noted with hypertension, tachycardia, wheezing, and secretions from mouth. The medical provider was notified and ordered resident to be sent to ED for further evaluation after it was discovered that the patient may have ingested shower gel that was used for her bed bath previously. The RP [responsible party] was notified. The resident was admitted to the hospital for further evaluation. No staff member witnessed patient grabbing or ingesting the shower gel. A midnight census report dated 3/17/25, which listed all residents in the facility was provided that had a handwritten note across the top that read, 3/17/25 100% audit all rooms. All toiletry items stored correctly. There were no other notes or marks on the forms. Also provided was In-service education records that noted subject: Storage of toiletries, cleaning supplies . Summary of content: All toiletry items for patients will be stored away in their close, nightstand, or with staff. The in-service education records were signed by 145 staff members. There was also evidence of audits that were conducted for three weeks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/7/25 at 8:10 p.m., an interview was conducted with CNA #3. CNA #3 was asked about the night R12 was sent to the hospital. CNA #3 stated, I was working with one other CNA, we had 40-60 residents. The CNA working with me would not finish a full round. The only resident she got cleaned up was [R12's name redacted]. They let her sit from 3-11 p.m. in the chair. The CNA on the prior shift said she was acting crazy because she had been refusing medications for several days. The CNA [CNA #2] washed her up and changed her into her gown. I helped hold her up while she was washing her and got her in bed. I was walking by and on the bedside table I noticed soap was missing from the bottle. I went and told the nurse that on the table was a bottle of soap and it was missing soap out of it. I told the nurse. I think she went to check on her. I went back about 20 minutes later to check on her and she was still sitting there, she had diarrhea and was breathing heavy. The other CNA was sitting at the station. We were both working the floor together because she was new. [R12's name redacted] was sitting up with soap missing and the top off. It was something the family provided; it said black cherry [on the label]. She had taken her gown off . it was the reason I went in the room, and I noticed she was breathing weird. I told [LPN #12], and she wanted to know how much she had drank. I told her a good amount and she said she will probably just puke it out. When asked if she had worked with R12 previously and what she was like. CNA #3 said, I had worked with her. She was always reaching out, that night she was aggressive and hitting. We kept her at the nursing station until she was ready to go to bed. The other CNA was a new agency person. CNA #3 went on to report that . the rescue squad staff took the soap with them. She had red stuff in her mouth, I noticed foaming, we were wiping that off, it was pink tinted. When asked how R12 got the soap, CNA #3 said that the other CNA working that night, . heard the same things I did. She had dementia and is grabbing at things; she is off her meds. I think it is kind of negligent; why would you leave soap right there on the overbed table? On 4/8/25 at 8:47 a.m., an interview was conducted with LPN #5. LPN #5 reported he had walked to the unit where R12 was a resident to get a vital sign machine. LPN #5 reported, The nurses and CNAs looked like something was wrong. They said, 'She grabbed soap and ingested it.' I contacted 911, started her file to send with her. That was between 5-6 a.m. When asked how R12 got the soap, LPN #5 said, I'm not sure, I thought I heard them say she grabbed it off the bedside table. I'm not sure if while getting her cleaned up and stepped away to get a towel or something. One nurse said they thought she drank soap and had suds and bubbles coming out of her mouth and nose. So I started the ball rolling to get EMS there. That soap lines the esophagus and can be aspirated. When asked if she saw or assessed R12, LPN #5 stated, No. Usually my role in emergency situations is to get 911 there and do the paperwork. On 4/8/25 at 9:13 a.m., an interview was conducted with LPN #12. LPN #12 reported, I was on my med cart and had been on the hall and walked by the room and saw her [R12] laying sideways. She had a bowel movement, and it was all over her; it was bubbly and pink tinged, it even smelled like it [the soap]. The CNA said 'I think she may have drank it [the soap]' I could hear her in her respiratory, she was very congested. The CNA said she had washed her up. [R12's name redacted] was new to our hall and the CNA is a traveler. When asked if R12 was restless, confused or grabbing at things, LPN #12 said, All the time! When asked if R12 had any clinical symptoms, LPN #12 stated, Her lips were discolored, vitals surprisingly weren't too off baseline for her, which I've learned means nothing. She just looked at you with a stare. Respiratory was bad, I knew she had to go. That facility has a protocol you have to call three people to send someone out and no body answered, so I called on-call back. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LPN #12 was asked if she suctioned R12. LPN #12 said, I didn't suction her because I wiped out of her mouth what was coming from her was deep you could wipe the bubbles and it kept coming; it smelled perfume, it was foamy bubbles with a pink tinge. When asked if anything else could have happened, LPN #12 said, No. I don't think it was intentional but there is no other explanation. On 4/8/25 at 9:32 a.m., an interview was conducted with CNA #2. CNA #2 reported, It was the first time I had worked with her, we gave her a bath. Prior to that she was sitting at the nursing station, when I came in at 11 p.m. I think we put her to bed maybe around 4 a.m. When we brought her to the bed, we washed her off and changed her brief. The other aide was doing rounds and called me to come. We saw bubbles coming out of her mouth, she was foaming. We called for the nurse at the desk, I think she said she was aspirated. We sat in the room until the ambulance came. We think she drank the soap on her nightstand. She literally had bubbles coming out. We didn't give her anything to drink, it was bubbles, it was on her nightstand when we brought her in the room. CNA #2 went on to state that she had seen the soap on the bedside table and said, So I didn't think anything about it. It was my first time with her, so I didn't really know her. When asked if she had gotten any kind of report on the residents she was to be assigned, CNA #2 said, I could have, I don't recall. CNA #2 continued the interview and said, She [R12] was demented. It was a nightmare. I feel horrible for her; she had bubbles coming out of her mouth, so I assume she drank the soap. You could hear her gurgling, at that point I'm thinking she aspirated, it was like she was choking. When asked if R12 was having any difficulty breathing, CNA #2 said, Yes, you could hear the sound like gurgling. During the survey on 4/3/25, 4/7/25 and 4/8/25, the shower rooms on the east and west units were noted to have the doors open and gallon jugs of shampoo & body wash were noted to be accessible to anyone entering the shower rooms. On 4/7/25, Resident #20 (R20) was noted to be sitting in the hallway near the nursing station. R20 was not able to answer questions and replied unintelligibly. A review of the clinical record revealed that R20 had a BIMS of 3. On 4/7/25 at 1p.m., during an interview with R20's roommate, who was Resident #9 (R9), observations of the room revealed that R9 had aerosol air freshener and two cans of Raid ant and roach spray in the room that was not secured. When questioned, R9 reported that she had the bug spray for ants. On 4/8/25 at 10:35 a.m., observations of R20 's room revealed that the over bed table was located by the sink, with the breakfast tray and a bottle of dove silver shampoo sitting on the table. On 4/8/25 at 11:17 a.m., an interview was conducted with licensed practical nurse #13 (LPN #13), who was the unit manager where R20 resided. When asked about R20, LPN #13 said, Some days are better than others, she does have dementia. Her decision making is impaired, she has very minimal safety awareness and is very impulsive. We try to keep her in high traffic areas, try to keep her busy and she goes to activities. When asked how toiletry items are to be stored, LPN #13 said, In the nightstand or closet. When asked why they are to be stored there, LPN #13 stated, Due to the potential of someone with impaired memory thinking it is something else. LPN #13 accompanied the surveyor to R20's room and confirmed the observation of the bottle of shampoo on the overbed table beside R20's cup of water and breakfast tray. LPN #13 said, This should not be out, and the breakfast tray should have been taken out. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/8/25 at 11:35 a.m., an interview was conducted with licensed practical nurse #3 (LPN #3), who was a unit manager. When asked about R12, LPN #3 stated, She was a sweet, demented lady. We tried to keep her up here with us to keep an eye on her, she was grabby, she would grab at you as you walk by and would touch other residents' arms if they stay by her. She was not oriented, she was total care for everything, was fed by staff, incontinent of bowel and bladder. When asked about her knowledge and involvement the day R12 was sent to the hospital, LPN #3 said, I was on call that morning when [LPN #12's name redacted] called me and said [R12's name redacted] had gotten a hold to some soap and drank it. She called for transport to send her out, she said she was still alert and at her baseline, was coughing up soap bubbles. Following that we put a plan of correction in place to be observant of toiletries being out of reach and stored in closets or bedside drawers. When asked if any consideration had been given to toiletry items in the shower rooms, LPN #3 stated, Nothing is to be left out in the shower rooms. When LPN #3 was notified that the survey team had observed gallon jugs of shampoo and body wash was unsecured on multiple occasions and even sitting on the floor while the shower room doors were open and accessible to anyone coming into the rooms, LPN #3 stated, There is a holder on the wall it should have been placed in. When I walk by, I try to shut the doors. On 4/8/25 at 1:02 p.m., following confirmation of IJ existence by the SA, the facility's administrator, director of nursing, and corporate staff were made aware that the survey team had identified the facility was in Immediate Jeopardy (IJ), which also constituted substandard quality of care. The IJ template was read and a copy emailed to the facility administrator and vice president of operations (VPO). Immediate Jeopardy was identified to have begun on 1/8/25, when R12 was not appropriately assessed for the risk of injury from hot liquids. On 4/8/25 at 4:45 p.m., the facility administration provided the following IJ removal plan: F689 Accidents and Hazards Removal Plan. Plan Corrective Action for those residents found to be affected by the deficient practice: A. R#12 is no longer residing in the facility. B. R#12 is no longer residing in the facility. All items for R#20 and R#9 have been stored appropriately. Corrective Actions taken for residents with potential to be affected by deficient practice: A. All residents who drink hot liquids have the potential to be affected by this deficient practice. Nursing team will conduct hot liquid assessments on all patients to determine an appropriate level of intervention for each patient. Care plans will be updated based on findings. B. All residents who reside in the facility have the potential to be affected by this deficient practice. The interdisciplinary team will audit all resident rooms to ensure items are stored appropriately in resident rooms and shower rooms. The Facility Administrator will conduct a town hall meeting on 4/8/25 at 6:00pm with the resident counsel to review appropriate items that can be in the room and how it can be stored. Those residents not in attendance will be given a handout with this information, and resident families will be called to be educated for patients who are not able to be educated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Systemic Changes put into place to ensure the deficient practice does not recur: A. The Interdisciplinary Team (Administrator, Director of Nursing, Assistant Director of Nursing, Director of Social Work, Activities Director, Dietary Manager, Business Office Manager, Director of Maintenance, Director of Housekeeping and Laundry, Human Resources, and Unit Managers) will be educated by the [NAME] President of Operations on the policy which states the acceptable hot liquid temperatures. Starting 4/8/25 all facility staff will be educated on the hot liquids policy to include the appropriate temperatures to serve to residents before it leaves the kitchen. The kitchen will keep a temperate log of coffee temperatures prior to it leaving the kitchen. A list of residents with hot liquid interventions will be provided to the dietary staff and floor staff to ensure all interventions are in place. This education will be provided to all new employees as part of new hire orientation to include agency staff. No employee will be allowed to work until they have been educated. The [NAME] President of Operations to conduct an ADHOC Quality Assurance Performance Improvement Meeting on 4/8/25 including the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Director of Social Work, Activities Director, Dietary Manager, Business Office Manager, Director of Housekeeping and Laundry, and Unit Managers to review the hot liquids policy and procedure. B. The Interdisciplinary Team (Administrator, Director of Nursing, Assistant Director of Nursing, Director of Social Work, Activities Director, Dietary Manager, Business Office Manager, Director of Maintenance, Director of Housekeeping and Laundry, Human Resources, and Unit Managers) will be educated by the [NAME] President of Operations on what is appropriate to store in resident rooms and how they need to be stored. Starting 4/8/25 all facility staff will be educated on what is appropriate to store in resident rooms and how they need to be stored. This education will be provided to all new employees as part of new hire orientation to include agency staff. No employee will be allowed to work until they are educated. The [NAME] President of Operations to conduct an ADHOC Quality Assurance Performance Improvement Meeting on 4/8/25 including the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Director of Social Work, Activities Director, Dietary Manager, Business Office Manager, Director of Housekeeping and Laundry, and Unit Managers to review the procedure for storing hazardous items in resident rooms and in shower rooms. Monitoring of corrective action to ensure the deficient practice does not recur. A. Facility will monitor the temperature of coffee that is poured for residents to ensure it is following the policy for proper temperature before leaving the kitchen. B. Facility will monitor resident rooms, common areas, and shower rooms to ensure items are stored appropriately. Completion of removal plan 4/8/25 at 10:00pm. The Regional Director of Clinical Services made the Medical Director aware of the Immediate Jeopardy via telephone on 4/8/25 at 3:08pm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Following consultation with the SA, the facility was notified of the acceptance of their IJ removal plan. On 4/9/25, the survey team verified the implementation of the facility's removal plan through clinical record reviews to ensure that all resident's had been assessed for risk of injury from hot liquids by facility staff's completion of a hot liquid safety evaluation. The resident's identified at risk had their care plan reviewed to ensure that the care plan included the risk for injury and interventions to prevent accidents from hot liquids. During the review, one resident was listed on a list titled, List of residents needing intervention for hot liquids that did not match the interventions identified on the hot liquid safety evaluation. There was an additional resident that according to the hot liquid safety evaluation required interventions and that resident was not listed on the list of residents needing interventions for hot liquids. These concerns were brought to the attention of the facility's administrator and corporate staff and were immediately corrected with a revised listing provided to the survey team at 10:03 a.m. On 4/9/25, observations were conducted throughout the facility, in the shower rooms, and in resident rooms to ensure that no potentially hazardous items were readily accessible to cognitively impaired residents. Interviews were conducted with a sample of residents to ensure they had been made aware of how to store toiletry items. Handouts were observed in resident rooms that included the safe storage of potentially hazardous items and the temperature of hot liquids being monitored. On 4/9/25, the survey team was provided with a revised policy titled, Hot Beverage Policy that read, 1. The dining services director will ensure that coffee temperatures of hot beverages will arrive for service at a temperature range of 150 F or less. 2. When beverages have been reheated in a microwave the following must occur: a. Time of microwaving should not exceed 2 minutes. b. Using a sanitized (alcohol wipe) probe thermometer, the temperature must not exceed 140 degrees before deliver of the hot beverage. c. The staff will be provided with a probe thermometer and alcohol wipes to sanitize the thermometer. Staff who take the temperature will have adequate training on the proper sanitizing and use of a probe thermometer. d. If the temperature exceeds 150 degrees the beverage shall remain under the direction of the person reheating until the beverage is less than 150-degree temperature range. 3. The hot beverage should be covered with a lid during transport back to the resident. On 4/9/25, the staff education sign-in sheets were compared to the working schedule to ensure that all present staff, in all departments, had received training regarding the appropriate serving temperature of hot liquids and the storage of potentially hazardous items. No concerns noted. On 4/9/25, the survey team conducted staff interviews with staff across all departments to verify education was provided and to confirm their understanding of the serving temperature for hot liquids and appropriate storage of hazardous items. No concerns noted. On 4/9/25, observations were conducted in the kitchen and noted that a new Hot Beverage Service Temperature Log had been implemented. The dietary staff were observed to be monitoring the temperature of the coffee being put into the thermal dispensers to ensure it was less than 150 degrees, and prior to the beverage carts being delivered to the unit. Dietary staff were interviewed to confirm their knowledge of the appropriate serving temperatures. No concerns noted. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrisonburg Hlth & Rehab Cntr	1225 Reservoir Street Harrisonburg, VA 22801

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/9/25 at 11:15 a.m., after having verified that the removal plan had been fully implemented and that facility actions had eliminated the likelihood of serious injury, serious harm, serious impairment, or death, the facility was notified that the immediacy had been removed. The scope and severity of the remaining noncompliance was then lowered to a level three, isolated. 2. The facility staff did not have a system or protocol to monitor the temperature of hot liquids served to residents, to ensure safety, which resulted in R12 sustaining an injury from spilled coffee that required medical treatment to prevent further severity On 4/4/25, a closed record review was conducted of R12's chart. According to the hot liquid safety evaluation completed on 1/8/25, the questions in section 2B that indicated easily agitated, mood varies, and impulsive acts was not checked as having applied to R12. Section 2A was checked as yes and 2B1g was checked. Section 3 noted, If two or more indicators are checked in safety factors section 2, than the resident is at risk for injury from hot liquids and requires an intervention selected from below. Section 3 was blank and did not indicate R12 was at risk, despite having two areas checked in section 2. According to progress notes dated 1/1/25-1/8/25, the week prior to completion of the hot liquid safety evaluation, there were multiple entries indicating that R12 was agitated, restless, disrobing, and was administered lorazepam on several occasions due to behaviors. The hot liquid safety evaluation did not have the section checked that easily agitated, mood varies, and impulsive acts as being applicable R12, which was inaccurate based on nursing documentation. A progress note dated 3/5/25, was noted to read, During dinner time patient spilled coffee on herself. Slight redness on her thigh noted. NP [nurse practitioner] made aware. patient doesn't seem to be in distressed. No new order. Zinc oxide was applied. Staff will continue to monitor. On 4/7/25 at 11:40 a.m., an interview was conducted with the dietary manager (Other Employee #1- OE#1). OE #1 stated that they do not monitor or measure the temperature of coffee served to residents. OE #1 stated, After it comes out of the machine, it is supposed to go down [the temperature], so we don't scald anyone. When asked if they check the temperature of coffee, OE #1 said, No. Are we supposed to? Because we don't. At another facility I worked, we did check the temperature to make sure it wasn't too hot because someone got burned. We made sure it was 140 degrees Fahrenheit (F) or below before we sent it out of the kitchen. It is not part of the routine here. The kitchen temperature logs were reviewed for the past month and revealed no evidence of the kitchen staff monitoring coffee or other hot liquids temperatures prior to serving to residents. On 4/7/25 at 4:45 p.m., OE #1 accompanied the surveyor to each beverage cart and checked the temperature of the coffee using a digital thermometer. The coffee being served on the East wing was 159 F. After the coffee on the west wing measured 153 F, OE #1 drank the coffee to see how hot it was and said, It's hot. The coffee on the south wing measured 150.8 F. On 4/8/25, the facility administrator provided a policy titled, Hot Beverage Delivery. According to the policy, which read in part, 1. The dining services director will ensure that coffee temperatures from the coffee machine do not exceed 165 degrees. 2. The dining services director will ensure that coffee temperatures of hot beverages will arrive for service at a temperature range of 150 F or less. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/8/25 at 10 a.m., OE #1 was observed in the kitchen to measure the temperature of the coffee after it was brewed, and it was noted to be at 176 F. OE #1 said, When it first brews, it is around 180 degrees F, and we have to let it sit to cool. When asked if he was monitoring the temperatures prior to today, OE #1 said, No, we didn't have a policy that I knew about until today, if I'm being honest with you. 3. T[TRUNCATED]

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F 0690 Level of Harm - 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** 3. For Resident #10 (R10), who suffered from quadriplegia and was totally dependent upon facility staff, the facility staff failed to respond to the call bell to provide incontinence care in a timely manner, resulting in psychosocial harm. On 4/3/25 at 9:38 a.m., upon the surveyor's arrival to the south unit, observations revealed multiple call bells/lights engaged. On 4/3/25 at 9:41 a.m., the surveyor entered the room where one of the call lights was engaged as evidenced by a light being illuminated outside the door in the hallway and a beeping auditory sound being heard. R10 acknowledged that he had his call light on and reported he needed to be changed. When asked how long his call light had been on, R10 said, Go look for yourself. When asked, R10 explained that the surveyor could go to the nursing station and observe how long his call light had been on. When asked if this happens often, R10 didn't respond. On 4/3/25 at 9:49 a.m., the surveyor was at the nursing station and observed a computer screen that listed three call bells that were engaged. The duration listed for R10's call light was noted to be 50 minutes and 17 seconds. On 4/3/25 at 9:52 a.m., licensed practical nurse (LPN #19) was observed to enter the room, reset/disengage the call light and exit the room. As LPN #19 was coming down the hall, she reported to certified nursing assistant (CNA #4) that R10 needed to be changed. The surveyor stopped LPN #19 and inquired as to what R10 needed and again LPN #19 stated, He needs to be changed. When notified that the call light was noted to have been engaged for over 50 minutes, and asked if this is common, LPN #19 stated, Sometimes it is and sometimes it isn't. I didn't know that was the case this morning. Normally he tells me about it, but he didn't today. When the surveyor explained that he had reported to it to the surveyor, LPN #19 said, Oh, maybe that's why he didn't tell me. On 4/3/2025, the facility administration was made aware of the concerns regarding findings that incontinence care was not being provided timely. On 4/9/25, a clinical record review was conducted of R10's chart. This review revealed that R10's diagnosis included, but were not limited to unspecified cord compression, central cord syndrome at C2 level of cervical spinal cord, person injured in unspecified motor-vehicle accident, and quadriplegia. According to R10's most recent minimum data set [MDS, an assessment tool] with an assessment reference date of 3/30/25, coded R10 as having required the assistance of two staff persons for bed mobility, transfers, and toileting. R10 was also coded on that same assessment as having had no skin impairments. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	According to R10's care plan, he was noted to be at risk for pressure ulcers due to immobility, inability to turn and reposition independently, incontinence and quadriplegia. One intervention was noted to read, Keep skin clean and dry as possible. The care plan also noted, The resident requires assistance with ADLs [activities of daily living] related to chronic health conditions, inability to perform ADLs, weakness, quadriplegia and spinal cord compression. The interventions included, Hoyer lift for all transfers x 2 staff, 2 person assist for bed mobility as needed . Also in the care plan, it was noted that R10 was incontinent of bladder and bowels. The interventions included, . provide toileting hygiene with brief changes . According to a skin observation conducted on 3/29/25, R10 was noted with no skin impairments. On 4/1/25, R10 was noted with iad [incontinence associated dermatitis] to his right buttock that measured 3.5 x 3.5 x 0.1 cm and another area of iad on his left buttock that had measurements of 0.8 x 1 x 0.1 cm. According to a progress note written by the wound care nurse practitioner on 4/1/25, it noted, . wound assessment: location: left buttock, primary etiology: incontinence associated dermatitis (IAD), stage/severity: partial thickness, wound status: new, size: 0.8 cm x 1 cm x 0.1 cm, exposed tissue: dermis, peri wound: fragile, wound base: 100% epithelial; exudate: scant amount of serosanguineous . A second wound was noted on the right buttock, primary etiology: incontinence associated dermatitis (IAD), stage/severity: partial thickness, wound status: new, size: 3.5 cm x 3.5 cm x 0.1 cm, wound base: 100% epithelial; peri wound: fragile, exudate: scant amount of serosanguineous, exposed tissue: dermis . The progress note went on to give the treatment plan for both areas, which read as: Treatment Recommendations: 1. Cleanse wound with wound cleanser and pat dry. 2. apply Hydrocolloid to base of the wound. 3. change 3 times per week . PREVENTATIVE MEASURES: The patient is incontinent of urine and stool and is at an increased risk of skin breakdown. Recommend continuing ongoing interventions and protocol for swift incontinence management . NEW RECOMMENDATIONS: Staff report new incontinence associated skin breakdown to bilateral buttocks. See new treatment orders. Patient is at high risk for skin breakdown related to decreased mobility, inability to reposition self, comorbidities, incontinence of urine and stool. On 4/9/25 in the morning, a follow up interview was conducted with R10. R10 explained that he is totally dependent on staff for all care, including being fed and must wait extended periods of time on a routine basis. R10 explained that he doesn't say anything because What can I do? I have no choice. R10 confirmed that having to sit in his feces for extended periods of times makes him . angry, feel humiliated and unimportant. I feel all of that but what can I do? R10 then was observed to have tears in his eyes that rolled down his check while talking to the surveyor. On 4/10/25 at 9:15 a.m-9:45 a.m., interviews were conducted with multiple staff, which included, licensed practical nurses LPN #6 & LPN #7, certified nursing assistants, CNA #1, CNA #4, and CNA #5. All of whom reported that call bells should be answered within five minutes. On 4/10/25, the facility administration reported that they had no policy regarding incontinence care or call bell response times. The facility administration was made aware of the above findings, potentially constituting harm. No additional information was provided. Based on observation, resident interviews, staff interviews, facility documentation, clinical record review the facility staff failed to provide timely incontinence care to three residents (Resident #17, Resident #23 and Resident #10) out of a survey sample of 26 residents, resulting in harm. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The findings included: 1. The facility failed to provide incontinent care timely for Resident #23 (R23). R23 was admitted to the facility on [DATE]. Diagnoses for R23 included but are not limited to chronic diastolic heart failure, muscle weakness and chronic respiratory failure with hypoxia. R23's Quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 3/25/25 coded R23 with no cognitive impairment. R23 was dependent for toileting and required moderate to maximal assistants with bed mobility, transferring, and bathing. On 4/9/25 at 6:35 p.m., an observation was made of R23 having incontinence care being provided. The surveyor was standing on the roommate's side of the room, and the curtain was pulled, and the surveyor heard R23 stated to be gentle, it hurts when you are cleaning me to the aide. R23 was saying ouch and making whimpering noises during her incontinence care. On 4/9/25 at 6:45 p.m., an interview was conducted with R23. R23 stated that there had been several times that I have had to sit in my urine or feces for long periods of time. R23 stated that last Thursday (4/3/25) I was wearing the wrong size brief, and I sat in my own feces for two hours. R23 said, the aide came in at 8:30 a.m., and I told her I needed to be changed, that I had a bowel movement, and it leaked out of my brief. R23 stated that the certified nursing assistant CNA #6 turned the call off and stated that state was here so she had to take care of the other residents first, and then she would come back to change me. R23 stated that approximately 10:10 a.m., that CNA# 7 came to the door, and asked how I was doing, and if I needed anything. R23 stated she told CNA#7 that she needed to be changed and had been sitting in my bowel movement for almost two hours, and CNA#6 was supposed to come back to change me but has not been back. R23 stated that CNA#7 was going to change her but had to go get all the supplies she needed. R23 stated that CNA#7 came back at 10:30 a.m. to change me. R23 said, my bottom was burning me as she was cleaning me up, and [CNA#7 name redacted] pointed out to me that it was some bad spots down there. R23 stated that she told the assistant director of nursing (ADON) after CNA#7 had cleaned her up. R23 stated that the ADON was going to have the physician to order some new cream today because the zinc ointment they were using was not helping. R23 said, this made me feel others were more important to me. Made me feel like crap I have never been treated like this was. R23 stated CNA#6 was her aide several times but never left me waiting that long before. R23 stated that someone from Adult Protective Services came to see her yesterday. R23 stated that she reported this incident to CNA#7 on Thursday (4/3/25), she told the ADON on Friday (4/4/25), and the administrator on Saturday (4/5/25). R23 showed the surveyor a picture she had taken that day. Feces were out of her brief, on both sides of her thighs, on the incontinent bed pad, and down to the sheet on the bed. R23 showed the surveyor a picture she had taken of her groin area, and thighs after being cleaned up. On 4/9/25 at 7:00 p.m., an observation was made of R23 inner thighs, and groin area. Observed both inner thighs were dark red in color, and the groin area was red. R23 had some areas on her thighs had white cream that was applied. On 4/9/25 at 7:30 p.m., an interview was conducted with ADON. ADON said, I talked to her sometime on Friday. She hollered me from her bed. She told me it took [CNA#6's name redacted] a long time to get in here to take care of me. ADON stated she told R23 that she would look into it and check the assignment sheet. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 4/9/25 at 7:45 p.m., there is a meeting with ADON, the director of nursing (DON) and the regional director of clinical services (RDCS). The ADON, DON, and RDCS were made aware of the concerns with R23. They were not aware that R23 was sitting in feces for two hours until the surveyor informed them at this meeting. 4/9/25 at 8:00 p.m., an observation was conducted with the RDCS. The surveyor and the RDCS went into R23's room, and R23 stated what had happened on 4/3/25 to the RDCS. The RDCS asked R23 if it was alright for her to look at her inner thighs, and R23 showed her. The RDCS put on gloves, and moved her legs apart, and when she did this R23 began sliding up in the bed, grimacing, and whelping. The RDCS asked her if she needed something for pain, R23 stated no that she handled pain well. The RDCS asked R23 if the area itches, and R23 said, no it burns. The RDCS asked R23 if she had ever had cream in that area before, and R23 said, under my abdomen but never down there. I have never had anything down there until Thursday. On 4/3/25 at 8:10 p.m., an end-of-day meeting was conducted with the administrator, director of nursing and corporate staff, and they were made aware of the above concerns. On 4/10/25 at 9:50 a.m. an interview with CNA#7 was conducted via phone call. CNA#7 stated when she went to do her rounds, she asked R23 is she needed help or anything, and that is when R23 told me she was needing to be changed because she had been sitting in it for a while. CNA#7 said, She was upset. [R23's name redacted] was sitting in a mess. The feces were up the front of the brief, down the sides of legs, on the chuck pad, on the sheets, and I had to change all bed linen. CNA#7 said, after cleaning her up the creases of her thighs were red. CNA#7 stated that R23 was upset and mad because CNA#6 was supposed to come back to change her and, never came back. CNA#7 stated that she did not report to anyone how she found R23, and that she had been laying there for 2 hours in feces waiting on CNA#6 to come back and change her. On 4/10/25 at 10:15 a.m. an interview with CNA#6 was conducted via phone call. CNA#6 stated when she entered R23's room that she was needing to be changed. CNA#6 stated she was asking for help, and no one would come help her with the call bell lights. CNA#6 stated she had a resident that had an appointment, and she had to put in the lobby for her pick up time or she would miss the appointment. CNA#6 stated that when CNA#7 showed up she was taking care of R23. CNA#6 stated she had taken care of R23 several times, and that R23 had no skin issues or red areas. CNA#6 stated that she did not mention state being her in the facility, and she did turn off the call light. CNA#6 stated that the administrator, and APS had talked with her about the incident. According to the National Institute on Health (NIH) moisture associated skin damage (MASD) is discussed and read in part, . Moisture-associated skin damage (MASD) occurs with exposure to various sources of moisture (bodily secretions or effluents) such as urine or fecal matter, perspiration, wound exudate, mucus, digestive secretions, respiratory secretions, or saliva . Accessed online at: https://pmc.ncbi.nlm.nih.gov/articles/PMC9093722/#fn-group1 (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	According to Wounds International, Moisture-associated skin damage (MASD) represents a significant problem and can have a negative effect on patient wellbeing and quality of life MASD is a complex and increasingly commonly recognized condition. Overexposure of the skin to bodily fluids can compromise its integrity and barrier function, making it more permeable and susceptible to damage (Gray et al, 2001; [NAME] et al, 2017). Individuals with MASD experience persistent symptoms that affect quality of life, including pain, burn-ing and pruritis (Gray et al, 2011; [NAME] et al, 2017). MASD is classified as an irritant-contact dermatitis; see Table 1 (WHO, 2020). Common irritants can include urine, stool, perspira-tion, saliva, intestinal liquids from stomas and exudate from wounds. As such, MASD is an umbrella term and forms of MASD may be subdivided into four types (see Figure 1): ? IAD ? Peristomal dermatitis (relating to colostomy, ileostomy/ ileal conduit, urostomy, suprapu-bic catheter, or tracheostomy) ? Intertriginous dermatitis (intertrigo: where two skin areas may touch or rub together) ? Peri wound maceration . The article went on to read, .Managing continence As a priority, wherever possible, the cause of incontinence should be identified and eliminated, and treatment options exam-ined if possible - although this may be due to a range of factors including health conditions and mobility issues (Wishin et al, 2008; Beeckman et al, 2020). This should include evalua-tion of bladder and kidney function regarding urinary incontinence, and that of the intestine and colon in the case of fecal incontinence (Beele et al, 2017). If continence enhancement is not possible, suitable incontinence products should be used and non-invasive behavior-al interventions implemented (Beeckman et al, 2018). Behavioral interventions may in-clude nutritional and fluid management, mobility enhancement, and use of different toilet-ing techniques (Wishin et al, 2008; Beeckman et al, 2020). While IAD does not only affect elderly people, evidence from studies involving elderly nursing home residents suggests that structured toileting and exercise interventions can improve incontinence (Bates-[NAME] et al, 2003; Beeckman et al, 2020). The type and frequency of incontinence should be re-assessed on regular basis, in order to tailor incontinence management strategies to the individual and assess the risk of skin-related damage (Beeckman et al, 2018). Wherev-er possible, indirect risk factors should be mitigated . Accessed online at: https://woundsinternational.com/wp-content/uploads/2023/02/77ece7a46c5c084762956b97f9096e53.pdf. No additional information was provided prior to exit. 2. The facility staff failed to provide incontinence care timely to Resident#17 (R17). R17 was admitted to the facility on [DATE]. Diagnoses for R17 included but are not limited to urinary tract infection, muscle weakness and underweight. R17's Reentry Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 3/3/25 coded R17 with severe cognitive impairment. R17 was dependent on the activity of daily living care. On 4/3/25 at 4:00 p.m., an interview was conducted with the administrator. The administrator stated that R17 was up, and out of bed after doing therapy around 1:00 p.m., sitting at the nurse's station until the daughter came back in around 7:00 p.m., or 8:00 p.m. The administrator stated he spoke with two staff members that came in to work that evening and stated R17's brief did not appear to have been saturated. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	4/3/25 at 5:08 p.m., an interview was conducted with certified nursing assistant CNA#18. CNA#18 stated that incontinent rounds should be made every two hours, CNA#18 said, sometimes those lines are not accurate, sometimes those lines on the brief are clear and will be sitting in a pool of urine. I open the brief to check. 4/3/25 at 5:08 p.m., an interview was conducted with CNA#19. CNA#19 said, I check the residents every two hours unless they use the call bell. Check the strips on the brief and roll them to make sure their bottom isn't wet. I will leave the same brief on for one round but the next round I will change the brief even if dry. I will let the nurse know if the resident goes eight hours without going to the bathroom. On 4/3/25 at 5:30 p.m., an interview with CNA#9 was conducted about the incident that happened on 3/15/25 with R17. CNA#9 said, daughter came in at 7:55 p.m., brief was tagged at 12 o' clock I went back and looked at the brief and it was marked. Looking at the brief lines I would not have changed him, but he was wet. He was wet enough to be changed. CNA#9 showed pictures of the wet brief and the time that was wrote on the brief. CNA#9 stated that the pictures were time stamped. On 4/3/25 at 7:20 p.m., an interview was conducted with LPN#5 about the incident that happened on 3/15/25 with R17. LPN#5 stated that R17 had the same brief on that was numbered with a 12 by his daughter. R17's brief was wet, and cream was applied to his scrotum that LPN#5 said, .was like a flush cheek red. LPN#5 stated that it was understandable why R17's daughter was upset due to being in the same brief for eight hours. 4/7/25 at 12:10 p.m., an interview was conducted with the assistant director of nursing (ADON). The ADON stated that incontinent care was prn, and the typical standard is every two hours. The ADON said, I would pull back the brief to see if they had a bowel movement. Common sense tells me I would change them and not leave the brief on for eight hours. The ADON stated she would expect staff to change a patient's brief every other round even if the brief lines are clear due to the brief holding moisture, and the patient can sweat, and cause moisture associated with dermatitis. The ADON stated patient's briefs can hold heat causing the patient to sweat, and the brief would need to be changed due to the moisture. On 4/8/25 at 11:00 a.m., an interview was conducted with LPN#13 the unit manager of the south wing. LPN#13 stated that R17's daughter sent her pictures of a saturated brief and a dirty bed pad with dried urine stains on the bed pad. LPN#13 stated that R17's daughter was in the facility around 8:00 p.m., and sent another picture to her with a brief marked with a 12, and of R17 sitting in his wheelchair in his room, and of the wall clock that had 8:00 p.m. On 4/8/25 at 2:00 p.m., a review of R17's clinical record was conducted. On 3/16/25 skin assessment was completed and had redness to coccyx noted. R17 was getting treatment for MASD (moisture associated skin damage) to sacrum, and groin areas but on 3/16/25 was being applied to coccyx area.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure residents maintain acceptable parameters of nutritional status for one resident (Resident #5) in a survey sample of 26 residents. The findings included: For Resident #5 (R5), who was admitted with a known significant weight loss, then lost 18 pounds in the first nine days at the facility, and lost 24 pounds in 5 weeks, the facility staff failed to implement interventions timely to prevent further significant weight loss. On 4/4/25 at 7:50 a.m., an interview was conducted with R5. R5 had his breakfast tray and observations revealed he had all items in bowls. There was a bowl of broth, two bowls of oatmeal, two bowls of Jello, a bowl of pudding and a yogurt cup. According to R5's meal/tray ticket it noted R5 was to receive clear liquid, large portions. On 4/7/25 at 11:56 a.m., observations were conducted of R5's lunch meal. According to the meal ticket, R5 was to have received ice cream, which was not present on his tray. When asked, R5 stated that he liked ice cream. R5 was asked about the food and his meals and reported, It's always the same. On 4/7/25 a clinical record review was conducted of R5's chart. According to the hospital Discharge summary dated [DATE], it documented that R5 . presents to ER with 1 day history of generalized weakness and inability to walk, patient has been trying to lose weight and did not eat over the last couple of weeks. He has been drinking water since then. Pt [patient] says that he lost 40 lbs . Diagnosis included: history of bipolar disorder, lactic acidosis, starvation ketosis, generalized weakness and achalasia. According to the hospital discharge summary, it noted, Discharge recommendations and follow-up: . 3. Follow up with [hospital name redacted] gastroenterology . Diet: full liquid . According to the census tab, R5 was admitted to the facility on [DATE], from the hospital. According to the weights and vitals tab of the chart, R5's weight on admission was recorded as 205.5 lbs. Additional weights revealed that on 2/23/25 and 2/24/25, R5 had a recorded weight of 205.5 lbs. On 3/4/25, R5's weight was 187.1 lbs., on 3/18/25, his weight was 185.5 lbs, and on 4/2/25, R5 weighed 181.3 lbs. According to the physician orders, R5's diet was noted as Full liquid diet, full liquid texture, thin liquids consistency. A supplement order was initiated on 3/28/25, which read, 2.0 House Supplement, three times a day for To Prevent Malnutrition/Additional Nutritional Intake Give 90 ml via PO TID [by mouth, three times a day] [sic]. There was also an order entered 3/31/25, that read, Appointment with Digestive Health Dr [physician's name redacted] [hospital name, address and phone number redacted]. According to a Malnutrition Universal Screening Tool completed 2/28/25, by a registered dietician, the resident was at low risk (routine clinical care). According to the progress notes, the registered dietician didn't have any further documentation regarding R5. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	According to a progress note from a surgical consultant physician dated 3/5/25, R5 was seen for follow-up of asymptomatic cholelithiasis. The note read in part, . Patient likely has achalasia based on GI work up. He and his nurse state they have not heard from [hospital name redacted] about an appointment. I have reached out to Dr. [name redacted] to make sure everything was placed correctly since the patient has currently been restricted to a full liquid diet for this reason . On 4/2/25, a registered dietician made an entry into R5's chart and added fortified pudding three times daily and ice cream twice daily noted R5 had a 11.8% weight loss. According to a progress note by the facility's nurse practitioner dated 4/4/25, R5 was seen Patient seen per nursing request for weight loss. The note read in part, . Assessment and Plan: Weight Loss: start large portions of full liquid diet, c/w [continue with] 2.0 house supplement TID [three times daily], Start CBC, CMP, TSH [complete blood count, complete metabolic panel, and thyroid stimulating hormone] [labs], start referral to Dr [name redacted of gastrointestinal doctor] at [hospital name redacted] for achalasia to see if can get sooner appointment than the one at [hospital name redacted] . On 4/7/25 at 1:56 p.m., an interview was conducted with other employee #8 (OE#8), who handled appointments. OE #8 stated, I make all the appointments. OE #8 was asked about an appointment with the doctor the nurse practitioner noted in her note on 4/4/25, for R5. OE #8 said, I have not received any information regarding a need for an appointment with Dr. [name redacted]. OE #8 asked the surveyor if she could write down the doctor's name and location. OE#8 accessed the records for R5 and noted he had an appointment on 7/29/25 with a digestive health doctor. On 4/7/25 at 2:45 p.m., an interview was conducted with the nurse practitioner (NP) (Other employee #3- OE #3), who was the primary care provider for R5 in the facility. The NP was asked about R5's weight loss and what was being done. The NP said, Apparently there are only two GI [gastrointestinal] doctors in the state that manage achalasia. He [R5] was sent to us without already having an appointment. The unit secretary called, and they wanted his records to review . On my end its not popping up on the alerts that he is eating less but I am doing weekly labs to ensure he is not going into malnutrition. If the labs start showing malnutrition we may have to send him to the hospital for a feeding tube. On 4/7/25 at 3:00 p.m., an interview was conducted with other employee #4 (OE#4), who was the unit secretary. When asked about appointments for R5, OE #4 said, We have a pending appointment, but it is so far out, I have sent his discharge summary to this digestive doctor in [alternate hospital location noted in the NP's note dated 4/4/25], I need to touch base with them in the morning. OE #4 went on to state that she was back and forth with the other location where the appointment is scheduled for July, trying to get an appointment sooner. OE #4 showed the surveyor a document titled, appointment and transportation form for R5 that was dated 3/31/25 and noted the scheduled appointment for 7/29/25. When asked if she had any evidence of working to get the appointment prior to 3/31/25, OE #4 stated that was all they had. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 4/7/25 at 3:41 p.m., an interview was conducted with the registered dietician (RD), other employee #2-(OE #2). The RD reported that they are currently looking for an RD for the facility who can provide 24 hours per week coverage. She went on to report that the previous RD was moving cross country and was going to continue to work remotely, but she [OE #2] noticed the prior RD went off the grid, so I stepped in the 3rd week of March and had to terminate her [the prior RD]. When asked about R5 and the accuracy of the malnutrition screening completed for R5 by the prior RD, OE #2 explained that I don't know why she didn't include weight loss, and it is my expectation that they attach an assessment in a progress note. When the surveyor stated she had not seen a note with an assessment by the RD, OE #2 confirmed there was no evidence or progress note to indicate it had been completed. OE#2 went on to say, I talked to his home health dietician on Friday [4/4/25]. When the surveyor explained that R5 was admitted to the facility with a known history of significant weight loss as documented in the hospital records, was on a liquid diet only, there was a lack of any intervention documented until 3/28/25 and no evidence that the facility had attempted to make the follow-up GI appointment until 3/31/25. OE #2 said, I'm right there with you, when I caught this, I about fell out of my chair, and I immediately notified the nurse practitioner. He has wounds . there was a period of about three weeks that he fell through the cracks . OE #2 stated that she had reached out to the home health dietician trying to get R5 into the GI doctor sooner because, he is too high risk. I wanted to get him on pureed food, but the hospital says he can't be upgraded whatsoever until seen by GI. I spoke to the nurse practitioner on Wednesday [4/2/25] and his nutritionist on Friday [4/4/25], he is very much on our radar, we added ice cream to come on his meal trays at lunch and dinner. The surveyor explained that she had conducted observations of two of R5's meals, one breakfast and one lunch, neither of them had ice cream. OE #2 went on to say, I hate it, it went three weeks for us to figure this out. I was taking drinks from a fire hydrant; I've never had someone just leave a job and that's when I terminated her. I hate it, I'm so mad. I don't know what I could have done differently, she kept saying she was going to work on the laptop while traveling, so I don't understand. I'm so disappointed to say the least. On 4/7/25 at 4:08 p.m., a follow-up interview was conducted with R5. When asked about ice cream, he stated he liked ice cream but has only received it 1-2 times since he has been at the facility. R5 said he was not aware of what was going on with why he had to be on a liquid diet. On 4/7/25 at 5:15 p.m., observations of R5's meal revealed he did not have ice cream on his meal tray. On 4/7/25 at 5:20 p.m., an end of day meeting was held with the facility administrator, director of nursing and corporate staff. The above findings were discussed, and the facility was asked to provide any evidence they had regarding attempts to get R5 an appointment with the GI doctor prior to 3/31/25 and/or any other interventions that were put in place. On 4/8/25, the survey team was notified that R5 was going to the gastroenterologist that day. The facility reported that the office where R5 had an appointment for 7/29/25 had called and had a cancellation. On the afternoon of 4/8/25, the surveyor was able to obtain the documents that returned with R5 from the appointment. The notes indicated, plan for manometry, increase to omeprazole 40 mg BID [twice daily], daily weight, calorie count if possible, and f/u [follow-up] in 3 months. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	According to the facility policy titled, Transportation and Appointments, which read in part, 1. The center will schedule a provider appointment when a consult recommendation is received . The facility was asked to provide any policy they had with regards to weight management. The facility provided a policy titled, Weight Monitoring and Tracking. According to this policy, it read, 1. The director of nursing is responsible for ensuring patients are weighed in an acceptable timeframe, using proper technique. Nursing staff are responsible for recording weight in the medical record. 2. Patients will be weighed on admission/readmission and weekly x 4 weeks thereafter, or until the interdisciplinary team determines weight is stable, then monthly thereafter. 3. Weights will be verified when a weight variance of 5 pounds from the last weight and/or when a significant weight change is identified. 4. Significant weight changes will be identified and discussed by the interdisciplinary team using the table below: 5%=1 month, 7.5%=3 months, 10%=6 months. 5. Members of the team may include, but are not limited to, director of nursing or designee, other members of nursing administration and/or nursing team, and the registered dietician as available. 6. Weekly weights should continue greater than 4 weeks if one or more of the following criteria are met: significant unplanned weight change, identified trends in weight change, new or unstable enterally or parenterally fed patients, patients with pressure ulcers or wounds for 4 weeks or greater, patients <100 pounds if < UBW/IBW [usual body weight/ideal body weight], provider ordered. 7. The team can determine the frequently of weight measurement needed or may discontinue weekly weight monitoring and change to monthly monitoring on any patient that is deemed stable. 8. The team will notify the provider and responsible party of significant weight changes, investigate possible causes of the weight change, discuss interventions, and document a progress note. No additional information was provided prior to the survey conclusion on 4/11/25.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on resident interview, clinical record review and facility documentation review, the facility staff failed to ensure medications were available for administration in accordance with physician orders for one resident (Resident #8-R8) in a survey sample of 26 residents. The findings included: For R8, the facility staff failed to have Latanoprost eye drops available for administration as ordered by the physician. On 4/3/25 at 5 p.m., an interview was conducted with R8. During the interview R8 expressed concerns that frequently he doesn't receive his eye drops for glaucoma. On 4/3/25 and 4/4/25, a clinical record review was conducted of R8's chart. According to the physician orders, R8 was to receive Latanoprost Ophthalmic Solution 0.005%. Instill 1 drop in both eyes at bedtime for glaucoma. The order for the eye drops was originally written 2/14/24 and remained an active order at the time of survey. On 4/10/25 at 3:30 p.m., interviews were conducted with two of the licensed practical nurses (LPN #16 & LPN #18). When asked what they do when administering medications and a medication is not available. LPN #16 and LPN #18 both stated if the medication is scheduled, they message the pharmacy and if it is not available in the Omnicell they call the provider for alternate orders. When asked why a medication would not be available, both LPN #16 and LPN #18 explained that perhaps someone didn't order the medication, or being an eye drop since they have a lot of agency staff that work maybe they didn't know the overstock/extra bottles are stored in the fridge in the medication room. LPN #16 stated, I do remember them saying he [R8] didn't have drops, but the DON [director of nursing] can override that for them [the pharmacy [to send it. According to the medication administration record (MAR), R8 did not receive the eye drops on 1/16/25. The nursing progress note written on 1/16/25 at 21:40 noted, eye gtts [drops] reordered. The MAR indicated that on 3/2/25 and 3/4/25, R8 did not receive the eye drops as ordered. According to the nursing progress notes the drops were not administered and the following was documented, awaiting from pharmacy and awaiting supply, pharmacy contacted per mediprocity to send asap [as soon as possible], np [nurse practitioner] aware rp [responsible party] aware. According to the facility policy titled, Medication unavailability it read, A licensed nurse discovering a mediation on order that is unavailable will initiate appropriate steps to ensure medical treatment is provided as ordered. 1. A licensed nurse will notify the provider of the unavailability of medication and discuss an alternative order, if necessary. 2. If alternate medication is ordered and is not available, the licensed nurse will activate the backup pharmacy process and procedures . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the facility policy titled, General Guidelines for Medication Administration it read, . I. Preparation: . 11. If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit . II. Administration . 2. Medications are administered in accordance with written orders of the prescriber . IV. Documentation. 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given On 4/9/25, during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. For Resident #12 (R12), the facility staff failed to accurately complete a hot liquid safety evaluation. On 4/7/25 a closed record review of R12's chart was conducted. It was noted that in the progress notes in the week prior to completion of the hot liquid safety evaluation there were multiple entries indicating that R12 was agitated, restless, disrobing, and was administered lorazepam on several occasions due to R12's behaviors. According to the hot liquid safety evaluation completed on 1/8/25, the questions in section 2B that indicated, easily agitated, mood varies, and impulsive acts was not checked as having applied to R12. Section 2A was checked as yes and 2B1g was checked. Section 3 noted, If two or more indicators are checked in safety factors section 2 than the resident is at risk for injury from hot liquids and requires an intervention selected from below. Section 3 was blank and did not indicate R12 was at risk, despite having two areas checked in section 2. On 4/9/25 at 11:12 a.m., the above concerns were shared with the Director of Nursing (DON). The DON was shown R12's hot liquid safety evaluation and concern about the accuracy of the form and the DON said, I would agree, she should have had other factors checked. The DON went on to say that staff were not counting the checks in section 2 appropriately and therefore they made a revision to the hot liquid safety evaluation on 4/8/25. No additional information was provided. Based on facility documentation, staff interviews and clinical record review, the facility staff failed to maintain an accurate clinical record for two residents Resident #17 (R17) and Resident #12 (R12) in a survey sample of 26 residents. The findings included: 1. The facility staff failed to accurately document a shower for R17. R17 was admitted to the facility on [DATE]. Diagnoses for R17 included but are not limited to urinary tract infection, muscle weakness and underweight. R17's Reentry Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 3/3/25 coded R17 with severe cognitive impairment. R17 was dependent for activities of daily living care. On 4/3/25 at 11:00 a.m., the facility provided a synopsis report to the surveyor for review. In this report dated 3/24/25 it read in part, first rounds [certified nursing assistant, CNA#15's (CNA15) name redacted] had to shower him because he was soiled and then laid him back down after. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25 at 11:15 a.m., a review of the facility incident summary was conducted. A written statement by licensed practical nurse, LPN#4 (LPN4) read in part, . [R17 name redacted] was not wanting to get up, so I said he could sleep a little longer. It was around 7:30 to 8'ish. I know that he did not get a shower in the morning. [R17's name redacted] was out of his bed from approximately 1 pm until I left at 7 pm most of the time he was up he was at the desk I was watching him. LPN#4 was the charge nurse on the south unit on 3/15/25 when this incident took place. A physical therapist assistant other employee #12 (OE#12) written statement was reviewed and read in part, .I went to pick up [R17's name redacted] at 8:30 a.m. he was in bed and in gown and not ready. [CNA# 15's name redacted] said she would finish up bed baths and then get back to him. I checked back on [R17's name redacted] between 9 and 12 and he was in bed the entire time. He did not appear showered at 8:30 am and did not appear to be showered between 8:30 and noon. I saw [CNA#15's name redacted] passing trays at 8:14 am. CNA#15 statement was reviewed. CNA#15 wrote she clocked in at 7:05 a.m. on 3/15/25, received a quick report, and did a dry round check on her assigned group of residents. CNA#15 stated after doing her dry round check that she showered R17 then laid him down after the shower because he was sleepy. CNA#15 stated she placed him in a clean gown, brief and clean sheets. On 4/3/25 at 4:00 p.m., an interview was conducted with the administrator. The administrator stated that CNA#15 in the morning hours she attempted to take R17 into the shower. He stated that R17 had a difficult night and not an easy morning. He stated R17 refused his breakfast, and the nurse had to work with him to give him his morning medication. He stated the daughter came in around noon. The administrator said, shower wasn't successful. On 4/8/25 at 9:00 a.m., an interview was conducted with LPN#4. LPN#4 said, I know [CNA#15's name redacted] didn't give him a shower. LPN#4 stated that R17 was hard to wake up, I instructed to CNA#15 to let him rest and when R17 gets a shower he is up out of bed, dressed and in his wheelchair. LPN#4 said, I talked with the daughter on Sunday. [R17's name redacted] hasn't had a shower. LPN#4 stated that CNA#15 did not give R17 a shower on Saturday and I gave a shower on Sunday and shaved him myself. On 4/8/25 at 10:40 a.m., an interview was conducted with the unit manager on South wing, LPN#13. LPN#13 stated that R17's daughter sent a message to me and stated that CNA#15 had told her that her dad was showered. LPN#13 stated that the daughter sent pictures to me of him in the bed with a gown on, a saturated brief, dried urine ring on the bed pad, not groomed and hair was greasy looking. LPN#13 said that the daughter reported to her that her dad was not showered and did not appear showered. LPN#13 said, [LPN#4 name redacted] saying that [R17's name redacted] did not get a shower and [CNA#15's name redacted] didn't do the shower I would take that to the bank. [LPN#4 name redacted] was a very thorough nurse. On 4/8/25 at 11:00 a.m., an interview was conducted with CNA#13. CNA#15 stated that around 7:15 a.m. on Saturday, March 15, 2025, that CNA#15 told me that she had already given R17 a shower this morning because he had a bowel movement. CNA#13 said, I didn't see him get a shower. CNA#13 stated on that day CNA#15 and I worked together as a team on our assignment for the day. On 4/9/25 at 11:00 a.m., a review of R17's clinical record was conducted. The documentation for activities of daily living (ADL) was reviewed. On 3/15/25 in the ADL documentation, 7:00 a.m. to 7:00 p.m. for CNA#15's shift she documented a bed bath, a shower, not applicable for a bowel movement and that she had transferred him two times during her shift. On the shower sheet for 3/15/25 CNA#15 had signed her initials that a shower was given. (continued on next page)

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	495093	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrisonburg Hlth & Rehab Cntr	1225 Reservoir Street Harrisonburg, VA 22801

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/25 at 11:45 a.m., a request for ADL policy was requested and the facility stated that there was no policy for ADL's. On 4/9/25 at 5:23 p.m., an end of day meeting was conducted with the administrator, director of nursing and corporate staff. The facility staff was made aware of the above concerns. No additional information was provided prior to 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 and staff interviews, the facility staff failed to follow infection control standards on three of three units. The findings included: The facility staff failed to handle soiled linen and disposing of incontinent briefs according to infection control standards. On 4/2/25 at 3:10 p.m., an observation was made during the initial tour of the facility. On the south wing an employee (other staff#11, OS11) was observed transporting dirty linen that was not in a bag, carrying it up against her body and without wearing gloves. On the [NAME] wing the shower room was observed with dirty linen laying on the floor and a soiled incontinent brief in the trash can without a liner. On 4/2/25 at 3:40 p.m., an interview was conducted with a certified nursing assistant CNA#1 (CNA1). CNA1 said, absolutely not should dirty linen be on the floor or that brief in that trash can like that. CNA1 stated that he was going to take care of this as soon as possible. He stated dirty linen should be bagged up and taken to soiled utility room. He also stated the brief was to be bagged and put in soiled brief barrel. On 4/7/25 at 12:10 p.m., an interview was conducted with the assistant director of nurses (ADON). The ADON stated that dirty linen was to be bagged up and transported to the soiled utility room. On 4/7/25 at 1:00 p.m., an interview was conducted with the director of nurses (DON), The DON stated dirty laundry was to be transported in a bag in the hallways to the soiled linen room. On 4/9/25 at 9:00 a.m., an observation was made of dirty linen being thrown on the floor in a resident's room during morning care. The certified nursing assistant CNA #14 (CNA14) was observed throwing dirty linen to the floor during morning care. CNA14 was observed with a pile of towels, wash cloths and bed linen in the floor during morning care in a resident's room. CNA14 was interviewed about the linen being on the floor and she picked up the pile and stated it should be in a bag. On 4/9/25 at 9:50 a.m., observations were conducted on the East wing. It was noted that in one room on the first hall of the east wing the privacy curtain was pulled for the A bed resident and a staff member's legs and feet could be seen at the bedside. An abundance of linen was noted on the floor that included bed linen and a hospital gown, and a linen cart was noted to be at the doorway. The surveyor stood in the hallway observing for a few minutes and then the staff member came from behind the curtain and closed the door. On 4/9/25 at 10:00 a.m., the unit manager on the south wing was interviewed about the proper handling of dirty linen. The unit manager stated she had a bag placed at the foot of the bed, and during bathing she would place the dirty linen in the bag. The unit manager stated that it was not acceptable to place dirty linen on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/9/25 at 10:43 a.m., an interview was conducted with a certified nursing assistant (CNA #10). CNA #10 confirmed that she had been providing care to the residents in the room observed in the earlier observation on the east wing. When asked about handling linen CNA #10 said, I put it in a trash bag and put it, so it doesn't touch the floor, or I have my buggy I put it in [referring to a linen cart]. CNA #10 reported that the residents have a habit of throwing linen on the floor. CNA #10 confirmed that she had not made any attempts to pick up the soiled linen off the floor until she was done with care. On 4/9/25 at 11:00 a.m., a review of facility documentation was conducted. The facility policy titled, Contaminated Laundry, read in part, .contaminated laundry is bagged at the generation site, placed in biohazard bags or containers labeled or color coded, and transported to laundry. handling and sorting soiled or contaminated laundry must wear protective gloves, fluid repellant gowns, and any other appropriate protective equipment On 4/9/25 at approximately 5:23 p.m., the above findings were reviewed with the facility administrator, director of nursing and corporate staff. No additional information was provided prior to exit conference.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 2. In a resident room on west wing the facility staff failed to clean the bathroom to remove brownish/black substances from the wall and trashcan. On 4/3/25 at 9:38 a.m., during observations within the facility, a resident room on the west unit was noted to have a brownish/black substance in the bathroom wall in two places around the trash can and on the trash can. On 4/3/25 at 7:30 p.m., an additional observation was made of the resident room/bathroom on the west wing. The previously observed brownish/black substances were noted to remain on the wall and bathroom. On 4/4/25 at 11:33 a.m., an interview was conducted with the housekeeping supervisor. The housekeeping supervisor explained that all resident rooms and bathrooms are cleaned daily except on the weekends. When asked what the daily cleaning included, she explained that cleaning the sinks, toilets, and floors was performed daily and a deep cleaning was done on each room about once a month. Following the above interview with the housekeeping supervisor, she was asked to accompany the surveyor to the room on the west wing that the surveyor had observed on 4/3/25. When shown the bathroom, the housekeeping supervisor said, It looks like poop. When asked if she would have expected that to have been cleaned since it was observed on 4/3/25 at 9:38 a.m., she stated she would have. 3. For a resident room on the east wing, the facility staff failed to maintain the bathroom in a sanitary and functional manner. On 4/8/25 at 9:45 a.m., following a family interview, the surveyor conducted observations of the bathroom that resident #21 shared with three other residents. Upon opening the bathroom door, it was an obvious odor that was musty and damp smelling. The wall behind the commode and the adjacent wall was noted to have plaster missing and a gray discoloration with black spots throughout. On 4/8/25 at 10 a.m., an interview was conducted with R21. When asked about the bathroom, R21 stated, It's been like that as long as I remember, it's been like that the whole time I've been here. On 4/8/25 at 11:10 a.m., the maintenance assistant was asked to accompany the surveyor to R21's bathroom. When shown, the maintenance assistant stated, it's wet, looks like it's done that before, that's joint compound that has been put there. I will cut all that mold out of there, there is something going on. The maintenance assistant reported he had worked at the facility for two months and was not aware of any problems prior to the surveyor bringing it to his attention. He added that the maintenance director position was vacant. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/8/25 at 1:50 p.m., certified nursing assistant (CNA #13) accompanied the surveyor to the bathroom shared by four residents, which included R21. When asked about the bathroom, CNA #13 said, they are all bad, it's been like that for months. CNA #13 continued stating, that Corporate came and put new floors and that's all they did, they didn't come back. They promised us they were going to renovate all the bathrooms and did the floors and that's all. It was noted that none of the bathrooms observed on the east wing had cove base around the wall, which left a gap between the sheetrock walls and the floors. A licensed practical nurse (LPN #18) explained that it was the prior company that was going to perform renovations of all the bathrooms, but since the new company took over several years ago, they have done nothing towards repairs. On 4/9/25 at 11:40 a.m., the facility administrator was made aware of the above concern regarding the bathroom shared by R21 and other residents. The administrator accompanied the surveyor to the room, and it was noted that the maintenance assistant was actively working to remove the wall and had pieces in a bucket and said, I'm getting all that mold out. The administrator agreed that all the bathrooms are in poor repair and in need of work. The administrator confirmed that the maintenance department had open positions that had been challenging to fill. 4. For resident #9 (R9) and resident #20 (R20), who shared a room, the facility staff failed to maintain the room in a sanitary manner. On 4/7/25 at approximately 1 p.m., an interview was conducted with R9 in her room. The surveyor observed that the room floor was very soiled and dirty. The floor was sticky and as the surveyor stepped her shoes stuck to the floor to the point her foot came out of her shoe that was stuck to the floor as she stepped. R9 reported ongoing concerns regarding the cleanliness of her room and the supply of paper towels. R9 showed the surveyor a roll of paper towels she had to get her spouse to bring in because the paper towel dispenser in the room had been empty since 4/4/25. The surveyor did note that no paper towels were present in the dispenser by the sink. During the above interview with R9, she verbalized concern over the lack of cleaning in her room and said, I'm scared to put my feet on the floor. I've never had all these infections; I'm getting sicker in this place and I'm paying for it! R9 reported that the housekeeper comes in but doesn't speak English, so she doesn't really clean and doesn't understand what the resident is saying. On 4/8/25 at 10:40 a.m., R9 was visited in her room again. It was noted that paper towels had been placed in the paper towel dispenser, but the floor had the same black marks and dirty appearance noted the day before. The floor was still noted to be sticky where shoes stuck to the floor as you walked across the room. According to a document provided by the facility titled, Daily Resident/Patient Room Cleaning, it read, . The room cleaning tasks should be performed in the following order: 1. Straighten up the resident's room. 2. Dust all flat surfaces with a cloth and disinfectant, clean air vent covers, and spot clean all necessary areas. 3. Dust mop the floor and sweep all trash and debris to the door and pick it up with the dustpan. 4. Empty and clean the trashcans and put a new liner if necessary. 5. Wet mop the room using disinfectant, ensuring a CAUTION floor sign is in use. On 4/10/25, during an end of day meeting, the facility administration and corporate staff were made aware of the above findings with regards to the lack of sanitary and comfortable environment for residents. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided. Based on observation, resident interview, staff interview and facility document the facility staff failed to maintain a sanitary environment for rooms on three of three units. The findings included: 1. The facility staff were not maintaining a sanitary environment in two rooms, one room on the south wing and one on the west wing. On 4/2/25 an observation was made in the room on the south wing. The bathroom commode had brownish colored stains on the commode seat and down on the sides of the commode. The floor on both sides of the commode had brownish colored stains. On 4/2/25 an observation was made in the room on the west wing. The bathroom had brownish colored stains on the wall behind the commode, brownish colored stains on the floor on both sides of the commode and in the front of the commode. The wall had tears and areas were peeling with white chalk like material exposed. On 4/2/25 an interview was conducted with Resident #26 (R26). R26 said, look in my bathroom, it's a mess. My roommate sits to far back on the seat and gets a mess on the seat and runs down the sides and housekeeping doesn't clean it up like they should. They don't clean every day and sometimes days. On 4/2/25 an interview was conducted with Resident #25 (R25). R25 said, my bathroom is nasty, and it has stuff all over the walls and floors. It is disgusting. On 4/4/25 an interview was conducted with the housekeeping supervisor. She stated that the resident's room was supposed to be cleaned daily except on the weekends. On the weekends half of the residents' rooms was cleaned on Saturday and the other half were cleaned on Sunday. The housekeeping supervisor stated that rooms were to have toilets cleaned, sink cleaned, wipe down all the tables in the room and clean window seals daily. She stated floors were to be swept and mopped daily. The housekeeping supervisor was in the rooms and observed the bathrooms. She said, no I don't expect it to be this dirty, it should be cleaned daily and we just talked about cleaning the sides of the toilets. On 4/4/25 a facility documentation was reviewed. The policy reviewed was titled, Daily Resident/Patient Room Cleaning, read in part, .dust all flat surfaces with a cloth and disinfectant, clean the air vent covers, and spot clean all necessary areas; dust mop the floor and sweep all trash and debris to the door and pick it up with the dustpan. Wet mop the room using disinfectant, ensuring a Caution floor sign is in use. On 4/4/25 an end of day meeting was conducted with the administrator, director of nursing and corporate staff. They were informed of the above concerns. No additional information was provided prior to the exit conference.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, staff interviews and facility documents, the facility staff failed to maintain an effective pest control program that affected three of three units. The findings included: The facility staff did not maintain an effective pest control program for the center. On 4/2/25 at 3:00 p.m., a tour of the facility's nursing units was conducted, and no concerns were noted. On 4/3/25 at 9:26 a.m., an interview was conducted with a licensed practical nurse LPN#17. LPN#17 said, If we see an ant in the room, I will put gloves on and kill all I see, fill out form on PCC (point click care), and that goes to maintenance man. Then I report it to the administrator and director of nursing. On 4/4/25 at 11:45 a.m., an interview was conducted with the administrator. The administrator presented the invoices from the pest control company from October 2024, November 2024, December 2024 and March 2025. The administrator shrugged his shoulders when asked about no pest control being in the building for the months of January and February 2025. The administrator stated that pest control was not in the building in January 2025 or February 2025. The administrator explained that he was changing pest control companies and said, I guess I am at fault, and it fell through the cracks. On 4/4/25 at 12:30 p.m., a review of facility documents was completed. The work orders from January 2025 and February 2025 were reviewed. During the months the facility was without pest control on 1/7/25 a work order was filled out and read in part, .cockroaches observed on and in a nightstand in a resident's room on [NAME] wing. On 2/20/25 on the [NAME] wing a work order was filled out and read in part . a resident saw roaches in her bathroom. On 4/7/25 at 9:15 a.m., a review of a facility document was completed. The policy titled, Pest Control, read in part, .center environment will be inspected monthly and treated for pests by a corporate-approved contractor. On 4/9/25 at 5:23 p.m., an end of day meeting was conducted with the administrator, director of nursing and corporate staff and they were informed of the above concerns. No additional information was provided prior to the exit conference.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on staff interviews and facility documentation the facility staff failed to ensure staff had abuse training for two certified nursing assistants, CNA#11 (CNA11) and CNA#12 (CNA12) out of eight employee records reviewed. The findings included: The facility staff failed to have credible evidence of abuse training for CNA11 and CNA12. On 4/9/25, a sample of eight employees was selected for a review of training requirements as part of the extended survey. The list of employees was given to the facility administrator, and they were asked to provide evidence of staff training to include the area of abuse. On 4/9/25, the employee records were reviewed. It was noted that CNA11 and CNA12 had no evidence of having received training for abuse. On 4/9/25 at approximately 5:23 p.m., the above findings were reviewed with the facility administrator, director of nursing and corporate staff. The facility administrator provided the survey team with the percentage of the overall Relias completion record. The [NAME] President of operations stated that the surveyor was correct, and he was unable to find the training for this staff. No additional information was provided prior to the exit conference.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on staff interviews and facility documentation the facility staff failed to provide infection control training for two certified nursing assistants, CNA#11 (CNA11) and CNA#12 (CNA12) out of eight employee records reviewed. The findings included: The facility staff failed to have credible evidence of infection control training for CNA11 and CNA12. On 4/9/25, a sample of eight employees was selected for review of training requirements as part of the extended survey. The list of employees was given to the facility administrator, and they were asked to provide evidence of staff training to include the area of infection control. On 4/9/25, the employee records were reviewed. It was noted that CNA11 and CNA12 had no evidence of having received training for infection control. On 4/9/25 at approximately 5:23 p.m., the above findings were reviewed with the facility administrator, director of nursing and corporate staff. The facility administrator provided the survey team with the percentage of the overall Relias completion record. The [NAME] President of operations stated that the surveyor was correct, and he was unable to find the training for this staff. No additional information was provided prior to the exit conference.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on staff interviews, staff record review and facility documentation review, the facility staff failed to provide behavioral health training to five of eight employees. The findings included: For other staff #9 (OS9), other staff #10 (OS10), certified nursing assistant, CNA#11 (CNA11), CNA#12 (CNA12) and CNA#13 (CNA13) the facility staff had no credible evidence of the employees having received behavioral health training. On 4/9/25, a sample of eight employees was selected for review of educational requirements as part of the extended survey review. The facility administrator was given the list of employees selected for review and was asked to provide evidence of their educational training to include behavioral health training. On 4/9/25, the facility provided the surveyor with the employee training records. This review revealed no evidence that OS9, OS10, CNA11, CNA12 or CNA13 received any behavioral health training. According to the facility assessment, which was last reviewed on 8/6/25, the facility provides for residents with mental health and behavioral needs. According to section 2: Services and Care We Offer Based on Residents' Needs, it read in part, . Mental Health and Behavior: Manage the medial conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities. According to section 3 of the facility assessment, it noted, Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies. This section included a statement that read in part, . We utilize the following competencies: This is not an all-inclusive list . Behavioral Health-Memory care units. OS9, OS10, CNA11, CNA12 or CNA13 had evidence of having completed the behavioral health training. On 4/9/25, the above findings were reviewed with the facility administrator, director of nursing and corporate staff. They reported they had nothing additional to provide. The facility administrator provided the survey team with the percentage of the overall Relias completion record. The [NAME] President of operations stated that the surveyor was correct, and he was unable to find the training for this staff. No additional information was provided prior to the exit conference.