STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parham Health Care & Rehab Center	2400 E Parham Road Richmond, VA 23228

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify the responsible party (RP) of a change in condition for one of forty-three residents (R) 119. The findings included:The facility staff failed to notify the RP of a fall that resulted in R119 being sent to the emergency room (ER). R119's diagnoses included vascular dementia, stridor, cerebral infarction, and dysphagia.Section C (cognitive patterns) of R119's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/26/25 included a brief interview for mental status (BIMS) score of 2 out of a possible 15 points, indicating R119 was severely impaired in cognitive skills for daily decision making.R119's face sheet listed a family member as being the RP and emergency contact #1. R119's clinical record included a progress note documented by the nursing staff on 01/12/26 at 4:39 a.m. indicating R119 was .on the floor in his room.sustained a small bruise to his orbital area.On 01/12/26 at 1:29 p.m., the nursing staff documented R119 was sent to the ER.During the clinical record review, the surveyor was unable to locate any documentation that the RP had been notified of the fall or transfer to the ER.On 02/11/26 at approximately 4:20 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), and Regional Director of Clinical Services the surveyor requested evidence that the RP had been notified of the fall and transfer to the ER on [DATE]. On 02/11/26 the facility staff provided the survey team with a copy of their policy titled, Significant Change of Condition effective date 01/29/24. This policy read in part, Procedure.Responsible party will be notified of a change of condition.On 02/12/26 at 2:35 p.m., the DON stated they were unable to find any notification to the RP of R119's fall. The DON stated the RP should have been notified when the resident fell and was stabilized. No further information regarding this issue was provided to the survey team prior to the exit conference.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, staff interview, and facility documentation review, the facility staff failed to maintain resident clinical records in a manner to ensure privacy and confidentiality of records, on two of three nursing units (Central and [NAME] wings). The findings included:The facility staff failed to maintain resident's clinical record access in a manner to safeguard and protect the content of information from authorized disclosure by allowing facility staff to use personal computers for daily tasks on two nursing units. On 2/12/26 at 9:30 AM, observations were conducted on each of the units. Observations revealed that six of the facility nurses working on the central and west wings, were utilizing their own personal laptop computers to access resident clinical records and documents. On 2/12/26 at 9:30- 10 AM, interviews were conducted with the facility staff about the use of their personal computers. The staff reported, They don't have enough computers, there is only one on this unit and there is no charger for it. They are missing chargers, so I bring my own computer. They aren't charged and it makes me late on passing medications, so I bring my own. The employees/nurses reported that they cannot access the clinical records of residents when they are offsite using their personal computers. On 2/12/26 at 2:46 PM, during a meeting with the facility administrator, director of nursing and regional director of clinical services (RDCS), the above concerns were shared. The RDCS stated that facility staff were not to use their personal computers. The RDCS stated that the staff were not able to access the electronic health record of residents when they are not on the facility's network. The discussion was held that there was no system to ensure that facility staff did not save residents' personal medical information or personal identifying information on personal computers for later use. The RDCS went on to state that the management staff could provide the nursing staff with their facility issued laptop computers to use versus staff utilizing their personal computers. During the above meeting, the facility administrator stated that she had sent nine computers back recently and had ordered nine more. When asked what the turnaround time on that was and when the replacement computers would be received, the administrator stated she did not know. According to a facility document titled, Technology & Information Systems Acknowledgement which was updated 09/2023, it read in part, . Employees should use company computers and information systems primarily for company business only. No additional information was provided.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to respond to grievances for one resident (Resident #121-R121) in a survey sample of 43 residents. The findings included:On 2/10/26, a clinical record review was conducted of R121's chart. Review of the progress notes and care plan revealed no documentation regarding a request for R121's family to provide clothing. On 2/10/26 at 3 PM, an interview was conducted with R121. R121 reported he recalled getting some new clothes a few months ago but couldn't recall what he received and said his memory wasn't perfect. On 2/10/26, attempts were made to reach R121's family, designated representative, but were not successful. On 2/12/26 the facility was asked to provide any grievances they had on file regarding R121. On 2/13/26, the facility provided a grievance that was filed by R121's family member dated 9/26/25. According to the grievance form it read, RP sent clothes to facility they were left at front desk, resident never received the clothes. The summary of investigation read, Facility searched but unable to locate. Resident sister will be reimbursed $119.34. Summary of Actions taken: Facility to reimburse missing items and spoke with family on labeling clothes. Attached was a receipt of delivery to the facility and a receipt for the clothes purchased. On 2/13/26 at 10:54 AM, during a phone call with R121's family member, they reported they had never received the reimbursement. On 2/13/26 at 12:02 PM, the facility administrator confirmed that the reimbursement was pending approval with the business office. The administrator stated she had requested it to be expedited and sent out that day. On 2/13/26 at 12:15 PM, during an end of day meeting with the facility administrator, director of nursing and regional director of clinical services the above concerns were discussed regarding that lack of responding to a grievance filed on behalf of R121. No further information was provided.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to respect resident's right to be free from misappropriation of property for one resident (Resident #121-R121) in a survey sample of 43 residents. The findings included:For R121, the facility staff failed to protect the residents' right to be free from misappropriation of property when clothes were delivered to the facility and the resident never received the items. On 2/10/26, a clinical record review was conducted of R121's chart. Review of the progress notes and care plan revealed no documentation regarding a request for R121's family to provide clothing or that clothing was received. On 2/10/26 at 3 PM, an interview was conducted with R121. R121 reported he recalled getting some new clothes a few months ago but couldn't recall what he received, who gave them to him, and said his memory wasn't perfect. On 2/12/26 the facility was asked to provide any grievances they had on file regarding R121. On 2/13/26, the facility provided a grievance that was filed by R121's family member dated 9/26/25. According to the grievance form it read, RP sent clothes to facility they were left at front desk, resident never received the clothes. The summary of investigation read, Facility searched but unable to locate. Resident sister will be reimbursed $119.34. Summary of Actions taken: Facility to reimburse missing items and spoke with family on labeling clothes. Attached was a receipt of delivery to the facility and a receipt for the clothes purchased. On 2/13/26 at 10:54 AM, during a phone call with R121's family member, they reported they had never received the reimbursement despite speaking with the facility leadership on several occasions. On 2/13/26 at 12:02 PM, the facility administrator confirmed that the reimbursement had not been sent to the family member despite the grievance indicating it had been and the administrator said, it [the reimbursement] was pending approval with the business office. The administrator stated she had requested it to be expedited and sent out that day. On 2/13/26 at 12:15 PM, during an end of day meeting with the facility administrator, director of nursing and regional director of clinical services the above concerns were discussed. No further information was provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, family interview, staff interview, clinical record review, and facility document review, the facility staff failed to implement a person-centered comprehensive care plan (CCP) for one of forty -three residents, Resident (R) 119.The findings included:The facility staff failed to consistently implement R119's CCP regarding their puree diet and weekly weights. R119's diagnoses included dysphagia, vascular dementia, stridor, and cerebral infarction.Section C (cognitive patterns) of R119's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/26/25 included a brief interview for mental status (BIMS) score of 2 out of a possible 15 points, indicating R119 was severely impaired in cognitive skills for daily decision making. Section K (swallowing/nutritional status) was coded to indicate the resident was on a mechanically altered diet. R119's CCP included the focus area at risk for weight loss or malnutrition related to chronic disease, cognitive impairment, requiring assistance to eat and dysphagia requiring puree diet. Interventions included weekly weights (date initiated 12/22/25).R119's clinical record included a provider order dated 12/19/25 for a Regular diet, Dysphagia Advanced texture, Thin Liquids consistency. On 12/22/25 this diet order was changed to include downgrade to puree per recommendations from hospital.During the clinical record review, the surveyor was only able to locate two documented weights the first being obtained on12/31/25 (158 pounds) and the second weight on 01/30/26 (157.3 pounds).On 02/11/26 at 1:10 p.m., the surveyor observed R119 eating lunch. Certified Nursing Assistant (C.N.A.) #4 was standing beside R119 and stated she was not allowing R119 to eat their chicken as she had a question about the consistency. Per request of the surveyor the Dietician and Speech Language Pathologist (SLP) observed the meal tray. The dietician stated the chicken could use more liquid and the SLP stated the chicken was a mixture of mechanically altered and pureed. When asked if it would be safe for R119 to consume the chicken the SLP stated that knowing this resident it would not be safe for them to eat. During a family interview on 02/11/26 at 1:20 p.m., this family member expressed concerns over R119 not receiving their correct diet and stated that on Super Bowl Sunday (02/08/26) R119 was provided with a milkshake that contained Oreo cookies and Reese's Pieces and on three occasions the facility staff had provided R119 with the wrong meal trays. On 02/11/26 the administrative staff terminated C.N.A. #5 for providing R119 the wrong texture milkshake.The issues with R119's person-centered CCP not being consistently implemented were reviewed with the Administrator, Director of Nursing (DON), and Regional Nurse on 02/12/26 at 3:01 p.m. and again on 02/13/26 at 12:00 p.m.The facility policy titled, Care Planning with an effective date of 11/01/19 read in part, A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient.No further information regarding these issues was provided to the survey team prior to the exit conference.

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F 0805 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, family interview, staff interviews, and clinical record review, the facility staff failed to provide a provider ordered mechanically altered diet for one of forty-three sampled residents (R)119 resulting in harm. R119 developed pneumonia and required antibiotic treatment.The findings included:R119's diagnoses included dysphagia, vascular dementia, stridor, and cerebral infarction.R119's hospital Discharge summary dated [DATE] included dietary orders for a pureed diet.Section C (cognitive patterns) of R119's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/26/25 included a brief interview for mental status (BIMS) score of 2 out of a possible 15 points, indicating R119 was severely impaired in cognitive skills for daily decision making. Section K (swallowing/nutritional status) was coded to indicate the resident was on a mechanically altered diet.R119's comprehensive care plan (CCP) included the focus area at risk for weight loss or malnutrition related to chronic disease, cognitive impairment, requiring assistance to eat and dysphagia requiring puree diet. Date initiated 12/22/25.R119's clinical record included a provider order dated 12/19/25 for a Regular diet, Dysphagia Advanced texture, Thin Liquids consistency. On 12/22/25 this diet order was changed to include downgrade to puree per recommendations from hospital.On 02/11/26 at 1:10 p.m., the surveyor observed R119 eating lunch. Certified Nursing Assistant (C.N.A.) #4 was standing beside R119 and stated she was not allowing R119 to eat their chicken as she had a question about the consistency. Per request of the surveyor the Dietician and Speech Language Pathologist (SLP) observed the meal tray. The dietician stated the chicken could use more liquid and the SLP stated the chicken was a mixture of mechanically altered and pureed. When asked if it would be safe for R119 to consume the chicken the SLP stated that knowing this resident it would not be safe for them to eat. The tray ticket that accompanied this meal listed puree crispy chicken thigh as an entree.During a family interview on 02/11/26 at 1:20 p.m., this family member expressed concerns over R119 not receiving their correct diet and stated that on super bowl Sunday (02/08/26) R119 was provided with a milkshake that contained Oreo cookies and Reese's Pieces and on three occasions the facility staff had provided R119 with the wrong meal trays. On 02/11/26 the administrative staff terminated C.N.A. #5 for providing R119 the wrong texture milkshake on 02/08/26. This milkshake was described as a milkshake with Oreo's. The facility administrative staff provided the surveyor with emails regarding this incident. In the first email C.N.A. #5 stated she apologized for the mistake involving providing a milkshake with Oreos to a resident who is on a puree diet. The second email stated they would like to clarify that there was a mistake and misunderstanding regarding the milkshake. The milkshake the patient received was safe and appropriate for him to consume on his puree diet. The Oreo milkshake was not given to the patient.R119 was seen by the provider at the facility on 02/11/26 this provider documented .seen today for SNF [skilled nursing facility] follow-up. Chest radiograph obtained today revealed infiltrate consistent with recurrent aspiration pneumonia. It was reported that he recently received a milkshake containing candy pieces, which likely contributed to this aspiration episode. Given this represents his second pneumonia treatment course in recent weeks, he has been initiated on Augmentin and doxycycline antibiotic therapy. Following discussion with son, prednisone dosage has been increased to 10 mg daily for a seven-day course, after which it will be reduced back to his baseline dose of 5 mg daily. Additionally, a probiotic has been ordered to prevent Clostridioides difficile infection given the recurrent antibiotic exposure.On 02/11/26 at 4:23 p.m., during an interview with R130 this resident confirmed he had door dashed on super bowl Sunday and obtained a cookies and cream milkshake for R119. R130 stated he had told the person who was taking his order (continued on next page)

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F 0805 Level of Harm - Actual harm Residents Affected - Few	to grind up the pieces because the resident was on a puree diet. When asked if he was sure R119 had consumed the item R130 stated Oh yeah I saw him later he said it was good and his son was picky about what he ate. The above issues were reviewed with the Administrator, Director of Nursing (DON), and Regional Nurse on 02/12/26 at 3:01 p.m. and again on 02/13/26 at 12:00 p.m.In addition to R119 being served the milkshake with candy pieces on 02/08/26 and non-pureed chicken on 02/11/26, the DON provided documentation which indicated R119 also received the wrong diet during the weekend of 12/20/25-12/21/25 and provided the survey team with an AD HOC (as needed) quality assurance and performance improvement plan (QAPI) for R119 dated 12/22/25 with a date of compliance of 01/26/26. The plan addressed The resident had the wrong diet served to him which the resident did eat, over the weekend. A chest X ray was ordered and obtained on 12/23/25 with the findings reading Patchy densities are noted involving the perihilar regions.Bilateral perihilar atelectasis/infiltrate. On 12/24/15 the provider ordered the antibiotic Avelox 1 tablet by mouth one time a day for pneumonia. No further information regarding this issue was provided to the survey team 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, staff interview, and facility documentation review, the facility staff failed to follow infection control standards during medication administration on one of three units (west wing), involving four residents. The findings included:On the west wing licensed practical nurse #3 (LPN #3) failed to follow infection control standards during medication administration to prevent the spread of infection. Continuous observations revealed in a 42-minute period and following administration of medications to four residents, LPN #3 failed to perform any hand hygiene and failed to perform any cleaning/disinfecting of a glucometer. On 2/12/26 at 10:40 AM, observations of medication administration were conducted with a licensed practical nurse (LPN #3). The surveyor notified the nurse that the surveyor wanted to do a narc count when she was at a stopping point. LPN #3 was observed to have long artificial nails. Resident #132 (R132) came out of his room and the nurse (LPN #3) said she wanted to give him his medication and check his blood sugar before he left the unit. The nurse pulled two OTC medications out of a bottle by inserting her finger into the bottle and using her fingernail to scoop the pill out of the bottle. LPN #3 removed packages of medications that were pre-packaged by the pharmacy, LPN #3 then proceeded to remove the medication from the card into her bare hand then placed the pills into the medication cup. During this process, one of the pills fell onto the top of medication cart, LPN #3 then proceeded to pick up the pill with her barehand and place the pill into the medication cup. LPN #3 entered R132's room, put on gloves and checked the resident's blood sugar using a glucometer and provided the medication. LPN #3 returned to the medication cart, disposed of the lancet, medication cup, and gloves and placed the glucometer onto the top of the medication cart and began documenting on the computer, without performing any hand hygiene. On 2/12/26 at 10:52 AM, Resident #133 (R133) exited her room and approached LPN #3 at the medication cart in the hall and said that she had an appointment, her ride was waiting and she needed her medication. LPN #3 then proceeded to retrieve R133's medications. LPN #3 removed medications from the packages by putting them into the palm of her bare hand, before placing them into the medication cup. LPN #3 then placed the glucometer into the medication cart drawer, without any disinfecting of it and entered R133's room to administer medications. LPN #3 then exited the room and returned to the medication cart without performing any hand hygiene. On 2/12/26 at 10:57 AM, LPN #3 and the surveyor conducted a narcotic count and no concerns were noted. LPN #3 had still not performed any hand hygiene. On 2/12/26 at 11:03 AM, LPN #3 began medication pass for Resident #134 (R134). LPN #3 again putting medications into the palm of her hand before placing them into the medication cup. LPN #3 again removed medications from the bottle by putting her finger into the bottle and scooping the medication out with her fingernail then placed into the medication cup. While in R134's room to provide medication, while talking to the resident, LPN #3 was observed touching the footboard of the bed with her hands while talking to the resident. LPN #3 then exited the room and returned to the medication cart and started documenting via the computer, without performing hand hygiene. On 2/16/26 at 11:12 AM, LPN #3 began pulling medications for R134's roommate, resident #106 (R106). LPN #3 again placed the medications into the palm of her hand when removing them from the medication card before putting them into the medication cup. LPN #3 entered the room of R106, provided the medications and exited the room. On 2/16/26 at 11:14 AM, LPN #3 pushed the medication cart to the nursing station, removed her laptop computer from the medication cart, and placed it on the nursing station desk and sat down behind the nursing station and began working on the computer. On 2/16/26 at 11:17 AM, LPN #3 returned to the medication cart, prepared a dose of MiraLAX and then took it to R134, who remained in their room. LPN #3 exited the room and returned to the nursing station without performing any hand hygiene. LPN #3 then approached the treatment (continued on next page)

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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. Based on observation, resident interviews, staff interviews and facility documentation review, the facility staff failed to provide a functional, sanitary and comfortable environment for residents on 3 of 3 units.The findings included:1.On all three units, the facility failed to provide enough linen, including wash cloths, towels, and bed linens to care for residents. On 2/10/2026 at 2:45 p.m., an interview was conducted with Resident # 122 who resided on the East Wing. Resident # 122 was alert and oriented with a BIMS score of 15/15 indicating no cognitive impairment. Resident # 122 stated she often had to wait long periods of time for the staff to provide incontinence care because they do not have enough linen. Resident # 122 stated she sometimes had to wait hours until linen was available so that incontinence care could be provided On 2/10/2026 at approximately 2:55 p.m., observations were made on all Resident care units. The linen carts on all three units/halls contained a scarce amount of linen. On 2/12/2026 at 3:10 p.m., an observation was made on the East Wing, revealing a scarce amount of linen available. The linen cart on the East Unit contained only 4 blankets, 8 gowns, wash cloths, 4 towels and 2 fitted sheet, 1 blue incontinence pad, two light weight blankets, and 2 pillow cases. Staff interviews with CNAs (certified nursing assistants) 1,2 and 6 all revealed that frequently they do not have enough linen. When asked what they do if a Resident has an incontinence episode, each of the CNAs reported they must go to other units to see if they can find linen. One of the CNAs, who asked to remain anonymous, stated that the facility just doesn't have adequate linens to provide for Resident care needs. That CNA also said that the linen carts would be stocked for the night shift but the day or evening shift might need linens prior to the start of the night shift to clean Residents. She stated, it's like that all the time. On 2/11/2026 at 2:45 p.m., an interview was conducted with the Housekeeping Director who stated there were issues with the linen. He stated he did not have staff to launder them. Stated he was going to check the Par levels- pull the information On 2/12/2026 at 2:03 p.m., the Housekeeping Director provided the survey team with a copy of the Monthly Linen Inventory Sheet evidence of linen being ordered. The Housekeeping Director stated the facility was going to place their monthly order. He stated we already placed a supplementary order for 600 towels on 2/7/2026 after review of the back-up linen supply. On 2/12/2026 during the end of day debriefing, the Administrator, Director of Nursing and Regional Director of Clinical Services were informed of the findings. They stated that it was important to have sufficient linen to provide care to meet the needs of the Residents. On 2/12/2026 during the end of day debriefing, the Administrator, Director of Nursing and Regional Director of Clinical Services were informed of the findings. They stated that it was important to have sufficient linen to provide care to meet the needs of the Residents. No further information was provided. 2. During the initial tour of the East Wing, the floors of the hallways were observed to be dirty. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parham Health Care & Rehab Center	2400 E Parham Road Richmond, VA 23228

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was debris and build-up of dirt noted in the corners. During tour of the East Wing, there were several observations of the facility being unclean The observations included: dirty floors, dirty towels under bins in one resident's room (Resident # 143) and gnats in the dirty water fountain. There were floors in the corridors that were dirty with debris in the corners. Three hand sanitizing dispensers outside of resident rooms were observed to be dirty with white debris caked on the bottom dish. Some dispensers were empty but with dirty casings. On 2/10/2026 at 11:45 a.m. during the initial tour of Resident # 143's room, observed wet towels with dark orangish-brown stains on the floor under bins by the window. On 2/10/2026 at 2:07 p.m., the stains appeared to be getting bigger on the towels. On 2/11/2026 at 10:45 a.m., the situation was noted to be the same. On 2/11/2026 at 11:00 a.m., an interview was conducted with the housekeeping Director. He stated that the housekeeping staff were expected to clean the residents' rooms, clean the floors and spills but they do not move the personal belongings of the residents. On 2/12/2026 during an afternoon tour of the unit, observed the Water fountain located near the East Wing nurses station -soiled near the drain- approximately 5-inch brownish stain noted around the drain-gnats came out of the drain when the button was pressed to have water flow. Water did flow from the spigot, and several gnats came out of the drain. The Unit Manager for East Wing and the Regional Director of Clinical Services were standing in the hallway directly in front of the nurses station approximately 4 feet from the surveyor. They both saw the gnats and came over to the water fountain. The Unit Manager stated the stain looked like the Med Pass Nutritional supplement that nurses administer during medication pass and pour. She pointed to the container of Med Pass located on top of the medication cart that was located in the hallway near the nurse's station. When asked if the nurses pour the medication or supplement down the drain, the Unit Manager stated no but it's the residents. The Unit Manager was asked if nurses were expected to ensure residents consume medications and/or supplements during the medication administration pass. She stated yes. The Activities Coordinator immediately came over with cleaner and started cleaning the water fountain drain. Gnats were flying over the water fountain and landing on the walls. There were no Housekeeping staff noted in the area. There were residents in the corridor near the nurses station. The Regional Director of Clinical Services asked the staff to put a plastic bag over the water fountain. A staff member was observed placing a large clear plastic bag over the water fountain. During the end of day debriefings on 2/12/2026 and 2/13/2026, the Administrator, Regional Director of Clinical Services and the Director of Nursing were informed of the findings. They stated residents should have a clean, safe and comfortable environment. They also stated nurses should ensure that residents swallow the medication or supplement and do not pour down the water fountain drain. No further information was provided. 3. For R125, the residents' room was observed by the surveyor to have clothes piled up on the floor, dirty dishes on the over the bed table, debris scattered throughout the floor, and a brown substance on the floor in the bathroom and inside the resident's doorway. R125 diagnoses included metabolic encephalopathy, aphasia, hemiplegia and hemiparesis. (continued on next page)

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	495097	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section C (cognitive patterns) of R125's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/04/26 included a brief interview for mental status (BIMS) score of 6 of a possible 15 points, indicating R125 was severely impaired in cognitive skills for daily decision making. R125's comprehensive care plan included the focus area requires assistance with activities of daily living and resident has behaviors interventions included 1:1 until seen by provider. This resident did not have a roommate at the time of the survey. During initial tour on 02/10/26 R125's room was observed by the surveyor to have clothes on the floor piled up in a corner, debris on the floor, dirty dishes on the over the bed table, and a brown substance on the floor at the doorway and on the bathroom floor. Resident #125 was not in their room. On 02/12/26 at 1:40 p.m., during an interview with the Bench Manager, this staff stated the personal items and dishes should have been cleaned and removed by nursing and housekeeping should have cleaned whatever the brown substance was on the floor. This staff stated housekeeping work from 7:00 a.m. to 4:30 p.m. daily. On 02/13/26 at 12:00 p.m., during a meeting with the Administrator, Director of Nursing (DON), and Regional Nurse #1 and #2 the issues with R125's room were reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Residents #126 and #127, who shared a room on the west wing, the facility staff failed to maintain a sanitary and comfortable environment. On 2/10/26 at 11:41 AM, during a tour of the west wing, Resident #126 and #127's room was observed from the hallway. The room was in disarray with refuse throughout the floor and a pile of paper trash on the floor in front of the bedside tables. The floors were soiled. In the resident's bathroom was debris. On 2/10/26 at 11:42 AM, the surveyor entered the room and interviewed both residents. Resident #126 reported it had been four days since someone came in the clean. Resident #127 stated, They don't clean every day, maybe every other day, but it depends on who is working. 5. In the window across from the therapy gym, the window had an abundance of cobwebs present for the duration of the survey. Throughout each day of the survey, the window across from the therapy gym that looked into an enclosed courtyard had cobwebs in the window. Just below that was a spider web that had also been present throughout the survey. On 2/10/26 an interview was conducted with one of the housekeepers, (housekeeper #1). Housekeeper #1 reported that there are three housekeepers per day for the entire facility and said, it used to be four but it got cut back. Housekeeper #1 went on to explain that each room is to be cleaned daily which included, sweeping and mopping the floor, wiping high touch surfaces, cleaning the bathroom, etc. When asked if the housekeepers are able to get to each room daily, housekeeper #1 said, I am able (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to get to every room, because sometimes I work until 9:30 PM to get it done. Housekeeper #1 went on to say that when she returns from being off on the weekend, it looks like a bomb went off. On 2/12/26 at 1:21 PM, an interview was conducted with the housekeeping bench manager/regional housekeeping director (RHD). When asked about the duties of the housekeepers, the RHD said, housekeepers know their assigned halls and it is color coded for common areas too. They have a binder on their cart with a map and layout of the facility that has rooms assigned with a list of what to do. When asked about the number of housekeepers, the RDH said, lately they have only had 3 housekeepers per day. It is difficult to get staffing; we are using a temporary staffing agency. When asked if he was aware that some residents and staff report cleaning is not occurring on weekends, the RHD said, This weekend there will be a manager covering weekends. I was not aware and not informed of things were not being done. The RHD explained, they [the housekeepers] do general housekeeping in the morning of all the rooms, sweep, mop, dusting, wipe surfaces and after lunch they tidy up and look for spills. The above areas of concern were discussed and the RHD agreed that it was not sanitary or comfortable and said, Absolutely not acceptable. On 2/12/26 at 2:13 PM, an interview was conducted with two additional housekeepers, (housekeepers #4 & #5). Both reported they used to have 5-6 housekeepers per day and now only have three. They reported it changed about six months ago and now only have three to four per day and they team up to get the work accomplished. The facility policy titled, Daily Resident/Patient Room Cleaning was received and reviewed. The policy read in part, .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 disinfectant, clean the 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 in a new liner if necessary. 5. Wet mop the room using disinfectant, ensuring a CAUTION floor sign is in use. On 2/12/26, during an end of day meeting the above findings were discussed with the facility Administrator, director of nursing and regional director of clinical services (RDCS). Following the end of day meeting, the facility administrator and RDCS accompanied a surveyor to the hallway at the therapy gym, some of the resident rooms identified above and was shown some of the findings. No additional information was provided.