

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495102	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Carlin Springs Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 550 South Carlin Springs Road Arlington, VA 22204	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to develop and/or implement the comprehensive care plan for three of 52 residents in the survey sample, Residents #9, #13, and #20. The findings include: 1. For Resident #9 (R9), the facility staff failed to monitor the resident for side effects (bleeding) from the anticoagulant (blood thinning) medication Eliquis. R9's comprehensive care plan dated 7/16/25 documented, ANTICOAGULANTS: the resident is at risk for bleeding and bruising related to use of an anticoagulant for diagnosis of Atrial Fibrillation (a heart condition). Observe for s/s (signs and symptoms) of abnormal bleeding or bruising and or black tarry stools and report to MD (Medical Doctor) as indicated. A review of R9's clinical record revealed a physician's order dated 5/15/26 for Eliquis 5mg (milligrams)-one tablet every 12 hours for atrial fibrillation. Further review of R9's clinical record for May 2026 through July 2026 failed to reveal any physician's orders for or documentation that the resident was monitored for anticoagulant side effects (bleeding). On 7/22/26 at 3:17 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #6. LPN #6 stated the care plan demonstrates what staff are doing for the resident and what the resident's goals are moving forward. LPN #6 stated a lot of interventions in residents' care plans are captured in physician's orders and nurses evidence the interventions, such as anticoagulant monitoring, are implemented by signing them off on the medication administration record or treatment administration record. On 7/22/26 at 4:45 p.m., the Administrator and Director of Nursing were made aware of the above concern. The facility policy titled, Care Planning-Comprehensive Person-Centered documented, SPECIFIC PROCEDURES/GUIDANCE- 2. The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was presented prior to exit. 2. For Resident #13 (R13), the facility staff failed to implement the comprehensive care plan to provide pain medication as ordered on 1/27/2026. The comprehensive care plan for R13 dated 5/11/2025 documented in part, OPIOIDS: the resident is at risk for complications related to the use of opioid secondary to arthritis, chronic back pain , chronic pain unrelieved by analgesics, unrelieved joint pain. Under Interventions it documented in part, Administer medications as ordered. The physician orders for R13 documented in part, - Hydromorphone HCl (1) Oral Tablet 8 MG (milligram) (Hydromorphone HCl). Give 1 tablet by mouth every 4 hours for Pain. - Methadone HCl (2) Oral Tablet 10 MG (Methadone HCl). Give 3 tablet by mouth three times a day for chronic pain. The progress notes for R13 documented in part, - 01/27/2026 10:13 (AM) Note Text: At about 0600 (6:00 AM), the nurse was going to administer Methadone 10MG three tablets by mouth to the resident, but erroneously gave three tablets of Hydromorphone (Dilaudid) 8MG Tablets by mouth for pain. Resident was informed and advised to call immediately if feels any drowsiness, dizziness, or any thing. Resident is stable, alert and oriented X4 (to person, place, time and situation) at this moment, V/S (vital signs) obtained include BP (blood pressure):146/79, P (pulse):68, O2 SAT (oxygen saturation): 98%, T (temperature) 97.9, R (respiration): 18.Staff informed the incoming nurse and Unit Manager about the medication error. NP (nurse practitioner) [Name of NP] was notified via phone at about 0839 (8:39 AM) and ordered to put an hold on the Hydromorphone 8MG tablet for all the three scheduled doses. The daughter [Name of daughter] was also informed via phone at about 0844 (8:44 AM). Monitor is in progress as ordered. On 7/22/2026 at 1:50 PM, an interview was conducted with LPN (licensed practical nurse) #2 who stated that the purpose of the care plan was to guide the care of the resident and show the specific needs of each resident. She stated that the interventions should be implemented. LPN #2 stated that the night shift nurse had reported to her when she arrived around 7:00 AM that he had administered three Dilaudid instead of three Methadone tablets to R13. She stated that she had immediately gone to assess R13, obtained vital signs, contacted the nurse practitioner and R13's daughter. She stated that R13 had told her that she was fine and the vital signs were stable, so she had made sure that they checked on her more often and monitored her more often. On 7/27/2026 at 1:20 PM, the Administrator and the Director of Nursing were made aware of the concern. No further information was provided prior to exit. (continued on next page)		

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/22/26 at 4:30 PM, the Administrator and Director of Nursing were made aware of the findings. No further information was provided prior to exit.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services to meet professional standards for four of 52 residents in the survey sample, Residents #154, #145, #173, and #13. The findings include: 1. For Resident #154 (R154), the facility staff failed to administer medications in a timely manner on multiple dates in December 2022. A review of R154's MAR (medication administration record) for December 2022 revealed that on the following dates/times. Omeprazole Delayed Release (1) was administered more than an hour after the time it was scheduled (scheduled time/administered time): 12/20/22 Omeprazole Capsule Delayed Release 40 mg (milligrams) give one capsule two times a day: 5:00 p.m./7:27 p.m.; 12/21/22 Omeprazole 5:00 p.m./7:32 p.m.; 12/22/22 Omeprazole 5:00 p.m./7:22 p.m.; 12/23/22 Omeprazole 5:00 p.m./7:48 p.m.; 12/26/22 Omeprazole 5:00 p.m./not given; 12/28/22 Omeprazole 5:00 p.m./11:35 p.m.; 12/28/22 12/31/22 Omeprazole 5:00 p.m./8:48 p.m. On 7/22/26 at 11:45 a.m., RN (registered nurse) #1, a unit manager, was interviewed. She stated that medications should be administered within one hour before or after the medication is scheduled. She stated this is a standard practice for all nurses and that she learned this in nursing school. She added: No one has to tell us this. We have just always known since we were learning to be nurses. She explained that the timing of administration can have an effect on the medication's effectiveness for a resident. On 7/23/26 at 10:36 a.m., the Director of Nursing was interviewed. She stated that the acceptable timeframe for a medication to be administered is one hour before through one hour after the medication is scheduled. She stated that if medications are not administered on time, the resident's condition could change, depending on the severity of the resident's condition. She stated she learned about the one hour before and after timeframe when she was in nursing school. She explained: It is a nursing standard of practice. On 7/23/26 at 4:42 p.m., the Administrator and Director of Nursing were informed of these concerns. A review of the facility policy, Conformity With Laws and Professional Standards, revealed, in part: Our facility operates and provides services in compliance with current federal, state, and local laws, regulations, codes, and professional standards of practice that apply to our facility and types of services provided. Our facility's policies, procedures, and operational practices are developed and maintained in accordance with current commonly accepted health standards. A review of the facility policy, Medication Administration Policy, revealed, in part: This policy establishes the guidelines for the safe and effective administration of medications. All medications administered within the facility are subject to these guidelines. The 5 Rights (right resident, right medication, right dose, right route, right time) must be confirmed during medication administration. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided prior to exit. Reference(1) Prescription omeprazole is used alone or with other medications to treat the symptoms of gastroesophageal reflux disease (GERD), a condition in which backward flow of acid from the stomach causes heartburn and possible injury of the esophagus (the tube between the throat and stomach) in adults. This information is taken from the website https://medlineplus.gov/druginfo/meds/a693050.html. 2. The facility staff failed to meet professional standards by administering fluid restrictions not as ordered for Resident #145. Resident #145 (R145) was admitted to the facility on [DATE] with diagnosis that included but were not limited to metabolic encephalopathy, pulmonary edema, congestive heart failure and ESRD (end stage renal disease) The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/18/26, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score indicating the resident is oriented to person, place and time and has unimpaired immediate recall. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assist with bathing and set up for eating/hygiene and dressing. A review of the comprehensive care plan dated 7/14/26 revealed, FOCUS: the resident has a fluid restriction of (1000) ml's of total fluids per day related to End Stage Renal Disease (ESRD). INTERVENTIONS: Resident to receive (400) ml's fluid per meal tray per day. Nursing to administer (140)ml's with med pass per day. No refillable water cups kept at bedside. Observe and document any instances of extra fluid intake consumed by the resident. A review of the physician's order dated 6/2/26 revealed, Fluid restriction 1 Liter (1000mls), No canned fruit or juice, no fruit cup, no tomato soup, no tomato puree; 360 mL (12 oz) PO TID (three times a day) with meals; 140 mL per shift nursing allowance. An interview was conducted on 7/21/26 at 3:35 PM with LPN (licensed practical nurse) #2, the unit manager. Asked to read and clarify the fluid restriction order for R145, LPN #2 stated, there is an order for fluid restriction of 1000 mls with 360 mL (12 oz) PO TID with meals; 140 mL per shift nursing allowance. Asked to calculate the amount of fluid as written in the order, LPN #2 stated, the resident is getting more fluid than ordered. Asked if the order is clear, LPN #2 stated, it comes to 1500 mls. Asked if the order should have been clarified, LPN #2 stated, yes, it should have been clarified with the provider. Asked if professional standards of practice had been followed, LPN #2 stated, no, since the order was not clarified. On 7/22/26 at 4:30 PM, the Administrator and Director of Nursing were made aware of the findings. No further information was provided prior to exit. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. For Resident #173 (R173), the facility staff failed to follow professional standards of practice during medication administration. Resident #173 (R173) was admitted to the facility with diagnoses that included but were not limited to hypertension (1), lymphedema (2), generalized muscle weakness, and shortness of breath. On the most recent minimum data set (MDS), quarterly assessment with an assessment reference date (ARD) of 3/6/2024, the resident's BIMS (brief interview for mental status) score was assessed as 14 out of fifteen, indicating the resident was cognitively intact for daily decision making. Review of the physician's orders for R173 document in part, Benazepril (3) HCL tablet 10mg. Give one tablet by mouth one time a day for hypertension. Start Date 1/31/2024 (0900). Discontinued Date 4/27/2024. Review of the April MAR (medication administration report) demonstrated the administration of Benazepril to the resident but failed to code in the MAR that the medication was not administered at the time ordered by the physician as evidence in the medication administration audit report. The medication administration audit report evidence that on 4/1/2024, 4/21/2024 and 4/22/2024, R173's Benazepril was administered over two hours late. On 7/22/2026 at 11:45 AM, an interview was conducted with RN #1, who stated that medications can be administered up to one hour before or one hour after the scheduled time. On 7/23/2026 at 9:55AM, an interview was conducted with LPN #1, who stated that scheduled medications should be administered at the scheduled time or within a one hour range from the time it is ordered. When asked how does a nurse evidence that they have given a medication, LPN #1 stated in the MAR. When asked what is the process for documenting the administration of late medication, LPN #1 stated three attempts should be made to administer the medication, explain to the resident why it is important to take the medication and the benefit of taking the medication, notify the physician and the resident's family and document in the MAR that the medication was late. LPN #1 continued to explain that the MAR will take the nurse to a progress note where they document the reason the medication was late. On 7/24/2026 at 10:43 AM, an interview was conducted with the DON, who stated that scheduled medication should be administered within one hour of the time they are due. When asked why is it important to administer medication as ordered, the DON stated because depending on the medication it could potentially cause a change in a resident's condition. When asked is there a way to know if the medication was not given, the DON stated only if it is documented. A review of the facility's Conformity With Laws and Professional Standards policy, effective 10/01/2021, revealed, Our facility operates and provides services in compliance with professional standards of practice that apply to our facility and types of services provided. Our facility's policies and procedures are developed and maintained in accordance with current accepted professional standards and principles as well as current commonly accepted health standards established by (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	national organizations, boards and councils. A review of the facility policy, Medication Administration Policy, revealed, in part: This policy establishes the guidelines for the safe and effective administration of medications. All medications administered within the facility are subject to these guidelines. The 5 Rights (right resident, right medication, right dose, right route, right time) must be confirmed during medication administration. On 7/23/2026 at 11:30 AM, the Administrator and Director of Nursing were notified of the findings. No further information was provided prior to exit. Reference: Hypertension- High blood pressure, also called hypertension, is when blood puts too much pressure against the walls of your arteries. https://medlineplus.gov/bloodpressuremedicines.html Lymphedema- Lymphedema is the name of a type of swelling. It happens when lymph builds up in your body's soft tissues. Lymph is a fluid that contains white blood cells that defend against germs. It can build up when the lymph system is damaged or blocked. It usually happens in the arms or legs. https://medlineplus.gov/lymphedema.html Benazepril- Benazepril is used alone or in combination with other medications to treat high blood pressure. Benazepril is in a class of medications called angiotensin-converting enzyme (ACE) inhibitors. It works by decreasing certain chemicals that tighten the blood vessels, so blood flows more smoothly. https://medlineplus.gov/druginfo/meds/a692011.html 4. For Resident #13 (R13), the facility staff failed to follow professional standards of practice after a medication error on 1/27/2026. On the most recent minimum data set (MDS), a significant change assessment with an assessment reference date (ARD) of 5/11/2026, the resident was assessed as receiving scheduled and as needed pain medications, having occasional pain, and receiving an opioid medication. The physician orders for R13 documented in part, - Hydromorphone HCl (1) Oral Tablet 8 MG (milligram) (Hydromorphone HCl). Give 1 tablet by mouth every 4 hours for Pain. - Methadone HCl (2) Oral Tablet 10 MG (Methadone HCl). Give 3 tablet by mouth three times a day for chronic pain. The progress notes for R13 documented in part, - 01/27/2026 10:13 (AM) Note Text: At about 0600 (6:00 AM), the nurse was going to administer Methadone 10MG three tablets by mouth to the resident but erroneously gave three tablets of (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hydromorphone (Dilaudid) 8MG Tablets by mouth for pain. Resident was informed and advised to call immediately if feels any drowsiness, dizziness, or anything. Resident is stable, alert and oriented X4 (to person, place, time and situation) at this moment, V/S (vital signs) obtained include BP (blood pressure):146/79, P (pulse):68, O2 SAT (oxygen saturation): 98%, T (temperature) 97.9, R (respiration): 18.Staff informed the incoming nurse and Unit Manager about the medication error. NP (nurse practitioner) [Name of NP] was notified via phone at about 0839 (8:39 AM) and ordered to put a hold on the Hydromorphone 8MG tablet for all the three scheduled doses. The daughter [Name of daughter] was also informed via phone at about 0844 (8:44 AM). Monitor is in progress as ordered. - 01/27/2026 12:30 (PM) SNF (skilled nursing facility) follow up [Name of NP] . seen today at the skilled nursing facility for accidental overdose. Per staff, patient was scheduled to receive 3 10mg tablets of methadone (30mg total). Patient instead received 3 8mg tablets of dilaudid (24mg total) at 6 a.m. Staff notified provider of incident at 8:30 a.m. and reported patient remained alert and awake, overall stable. Vital signs remained stable. Narcan PRN (as needed) was ordered but not administered due to patient being stable. Afternoon dose of dilaudid was held. Methadone dose due at 12 p.m (30mg) was held, and one time dose of 20mg was ordered at 2 p.m. Orders were placed to reassess hourly and to assess for appropriate administration of dilaudid dose due at 4 p.m. Continue with frequent monitoring of status and vitals, with orders to monitor patient hourly for any change in condition and monitor vitals closely. Discussed incident with daughter [Name of daughter] over the phone . Plan: Naloxone 4 mg intranasal spray ordered PRN for opioid overdose; not administered as patient remained clinically stable. - Afternoon hydromorphone dose was held. - Scheduled methadone 30 mg dose due at 12 p.m. was held; ordered one-time reduced dose of methadone 20 mg at 2 p.m. - Ordered hourly monitoring of vital signs and clinical status. - Ordered reassessment before next hydromorphone dose due at 4 p.m. to determine appropriateness of administration. - Incident discussed with daughter [Name of daughter] via telephone. - Continue close monitoring for delayed respiratory depression or change in mental status . Review of the medication error report dated 1/27/2026 documented in part, .At about 0600, the nurse was going to administer Methadone 10MG three tablets by mouth to the resident but erroneously gave three tablets of Hydromorphone (Dilaudid) 8MG Tablets by mouth for pain. Resident was informed and advised to call immediately if feels any drowsiness, dizziness, or anything. Resident is stable, alert and oriented X4 at this moment, V/S obtained include BP :146/79, P :68, O2 SAT : 98%, T 97.9, R : 18.Staff informed the incoming nurse and Unit Manager about the medication error. NP [Name of NP] was notified via phone at about 0839 (8:39 AM) and ordered to put an hold on the Hydromorphone 8MG tablet for all the three scheduled doses. The daughter [Name of daughter] was also informed via phone at about 0844 (8:44 AM). Monitor is in progress as ordered. Resident Description: When asked, if feels anything, resident said, I am fine for now . No injuries observed at the time of incident . No injuries post incident . Attached to the medication error report was a telephone order dated 1/27/2026 at 9:11 AM to Monitor vital signs every 4 hours starting 1/27/2026 at 12:00 PM and ending 1/28/2026 at 12:00 AM, a vital sign summary which documented blood pressures on 1/27/2026 at 9:00 AM, 11:45 Am, 5:02 PM, and 8:33 PM, oxygen saturations on 1/27/2026 at 12:30 PM and 10:54 PM, pulses checked on 1/27/2026 at 9:00 AM, 11:45 AM, 5:02 PM, and 8:33 PM and respirations assessed on 1/27/2026 at 11:45 AM, 5:02 PM and 8:33 PM. The clinical record failed to evidence documentation of the hourly monitoring of vital signs and clinical (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	status documented in the NP note, or notification of the provider of the medication error until the night nurse informed the unit manager upon her arrival. On 7/22/2026 at 1:50 PM, an interview was conducted with LPN (licensed practical nurse) #2 who stated that the night shift nurse had reported to her when she arrived around 7:00 AM that he had administered three Dilaudid instead of three Methadone tablets to R13. She stated that she had immediately gone to assess R13, obtained vital signs, contacted the nurse practitioner and R13's daughter. She stated that R13 had told her that she was fine and the vital signs were stable, so she had made sure that they checked on her more often and monitored her more often. She stated that if she had made the medication error she would immediately notify the resident, assess them, check the vital signs, ensure they had the call light in reach, check on them frequently, call the provider to get orders, and notify the family. LPN #2 stated that she would have expected the night nurse to have called the provider prior to her arrival and had interventions in place prior to when she arrived to the facility around 7:00 AM because there was always a provider on call. According to Lippincott Nursing Procedures, 7th Edition, pg. 680, documented in part, .Report all medication errors and adverse effects; this includes preventable ADEs (adverse drug effects), close calls, and hazardous conditions . On 7/27/2026 at 1:20 PM, the Administrator and the Director of Nursing were made aware of the concern. No further information was provided prior to exit. Reference: (1) Hydromorphone is used to relieve severe pain. Hydromorphone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain . This information was obtained from the website: Hydromorphone: MedlinePlus Drug Information (2) Methadone is used to relieve severe pain. Methadone also is used to treat opioid addiction (physical and psychological reliance on a chemical found in prescription and street drugs). Methadone is in a class of medications called opiate (narcotic) analgesics. Methadone works to treat pain by changing the way the brain and nervous system respond to pain. It works to treat people who were addicted to opiate drugs by producing similar effects and preventing withdrawal symptoms . This information was obtained from the website: Methadone: MedlinePlus Drug Information		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide a clean and homelike environment for three of 52 residents in the survey sample, Residents #6, #112, and #38. The findings include: 1. For Resident #6 (R6), the facility staff failed to provide a clean and homelike environment. On the most recent minimum data set (MDS), an annual assessment with an assessment reference date (ARD) of [DATE], the resident scored 15 out of 15 on the brief interview for mental status (BIMS) assessment, indicating they were cognitively intact for making daily decisions. On [DATE] at 4:46 PM, an observation was made of R6's room. Observation revealed an approximately four feet tall white plastic storage bin to the right side of R6's bed. The plastic storage bin was observed to have a dried brown colored material on the lower right side of the bin. Observation of the privacy curtain revealed two stained areas on the curtain, one area approximately quarter-sized and one approximately six inches long. At that time, an interview was conducted with R6 who stated that someone came in almost every day to mop the floor and clean up but he did not know if they ever changed the curtain. Additional observations were made on [DATE] at 10:30 AM and 4:18 PM. The findings remained the same. On [DATE] at 12:41 PM, an interview was conducted with the Director of Housekeeping who stated that privacy curtains were inspected during daily cleaning and he was notified by his staff if they needed to be changed. He stated that furniture was cleaned as needed and if staff noticed something on the furniture his staff would clean it. At 12:52 PM, the Director observed R6's privacy curtain and the plastic furniture and stated that it needed cleaning and the curtain needed to be changed. The facility policy Homelike Environment, documented in part, Residents will be provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible . On [DATE] at 4:34 PM, the Administrator and the Director of Nursing were made aware of the concern. No further information was provided prior to exit. 2. For Resident #112 (R112), the facility staff failed to provide a clean and homelike environment. On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of [DATE], the resident scored 15 out of 15 on the brief interview for mental status (BIMS) assessment, indicating they were cognitively intact for making daily decisions. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:47 PM, an observation was made of R112's room. During the observation dead roaches were observed on the floor along the headboard of the resident bed and behind the dresser and TV stand. At that time an interview was conducted with R112 who stated that there had been an ongoing roach problem in the room for a while and the room was last treated about two weeks prior. He stated that the dead roaches had been on the floor for awhile and housekeeping had not cleaned them all up. Additional observations were made on [DATE] at 4:45 PM and [DATE] at 4:00 PM. The findings remained the same. Review of the pest control logs documented the most recent pest control treatment to R112's room on [DATE]. On [DATE] at 10:00 AM, an interview was conducted with the maintenance director who stated that after the room was treated housekeeping went in and deep cleaned the rooms to pick up any dead roaches before the resident went back in the room. He stated that nursing was responsible for cleaning the residents belongings prior to putting them back in the residents room after the intensive treatment and housekeeping cleaned the room prior to the resident going back in the room. He observed the dead roaches on the floor in R112's and stated that the room had been treated a couple of weeks ago for roaches and housekeeping must have missed the dead roaches. On [DATE] at 12:41 PM, an interview was conducted with the Director of Housekeeping who stated that when rooms were treated for pests they moved everything out of the room and the furniture was moved away from the walls. He stated that after the pests died the housekeeping staff went in and swept the floor and mopped. The Director stated that housekeeping went back to follow up because the roaches kept dying so they wanted to get them up. He stated that daily floor care also included cleaning behind the bed and under the bed and dressers. The Director stated that residents personal belongings would be cleaned by nursing because housekeeping did not touch personal belongings only furniture. He stated that housekeeping had already cleaned R112's room because maintenance had informed him of the dead roaches on the floor. On [DATE] at approximately 4:34 PM, the Administrator and the Director of Nursing were made aware of the findings. No further information was provided prior to exit. 3. For Resident #38 (R38), the facility staff failed to clean rodent droppings off the resident's floor. On [DATE] at 5:02 p.m., an observation of R38 and the resident's room was conducted. R38 was lying in bed. There was approximately one foot of space (in width) between the resident's bed and the wall. In this area, approximately 25 rodent droppings were observed on the floor. On [DATE] at 8:38 a.m., [DATE] at 3:40 p.m., and [DATE] at 7:45 a.m. R38 was observed lying in bed and the rodent droppings remained on the floor. On [DATE] at 12:52 p.m., an interview was conducted with the Director of Environmental Services. (continued on next page)		

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Environmental Services stated resident room floors should be swept and mopped every day and disinfected if rodent droppings are observed. The Director of Environmental Services stated rodent droppings on the floor are not clean or homelike. On [DATE] at 4:45 p.m., the Administrator and Director of Nursing were made aware of the above concern. No further information was presented 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 facility document review and staff interview, it was determined that the facility staff failed to implement their abuse policy for protection of the resident during the investigation of an abuse allegation for one of 52 residents in the survey sample, Resident #162. The findings include: For Resident #162 (R162), the facility staff failed to implement their abuse policy for protection of a resident during the investigation of an abuse allegation reported on 11/11/2025. The facility policy Abuse documented in part, .When specific staff is identified as being allegedly involved in the abuse allegation, the staff may be re-assigned or suspended during the investigation .Review of the facility synopsis of events documented an initial report date of 11/11/2025 for the incident date unknown documenting in part, On November 11, 2025, the administrator received an email from the resident's wife alleging abuse and neglect. Investigation initiated . The facility internal investigation documented a completion date of 11/18/2025. Review of the investigation folder documented Summary of Issues at [Name of facility] which documented in part, .Safety Incidents and Physical Harm . Nurse [Name of LPN (licensed practical nurse) #10] has been verbally abusive and mocking toward [Name of R162], including making fun of him in front of other staff and residents. He cried after several of these incidents and is afraid of her . The final five-day investigation summary documented an abuse investigation with notification of the police and interview of R162 who voiced no concerns regarding nursing staff however failed to evidence re-assignment LPN #10 or suspension during the investigation. Review of the clinical record documented LPN #10 caring for R162 on 11/12/2025, 11/15/2025 and 11/16/2025. On 7/22/2026 at 4:06 PM, an interview was conducted with the Director of Nursing (DON), who stated that the former Administrator had received an email from R162's spouse with concerns regarding care and an abuse allegation so they had reported it and investigated. She stated that she did not think there was any specific staff identified. The DON reviewed the Summary of Issues at [Name of facility] which documented LPN #10 named in the allegation of abuse and stated that normally they would have suspended the employee when they were named in an abuse allegation. On 7/23/2026 at 11:05 AM, the Administrator and the Director of Nursing were made aware of the concern. No further information was provided prior to exit.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to ensure medications were available for administration for one of 52 residents in the survey sample, Resident #156. The findings include: For Resident #156 (R156), the facility staff failed to ensure Gabapentin (1) was available for two doses on 10/14/2022. Review of the eMAR (electronic medication administration record) for R156 dated 10/1-10/31/2022 documented in part, Gabapentin Capsule 100 MG (milligram). Give 1 capsule by mouth every 8 hours for Neuropathy. On 10/14/2022 the scheduled 6:00 AM dose and 10:00 PM dose were documented as not given saying to see the nurse notes. The 10:00 PM dose on 10/13/2022 and 2:00 PM dose on 10/14/2022 were documented as administered. The nursing notes for R156 documented the 10/14/2022 6:00 AM dose not administered due to it was not delivered from the pharmacy and the 10:00 PM dose not administered due to a prescription needed. On 7/22/2026 at 1:50 PM, an interview was conducted with licensed practical nurse (LPN) #2 who stated that medication orders were faxed to the pharmacy on admission and any medications that they were able to pull from their in house medication stock they pulled out and started them when the pharmacy gave them the code. She stated that there was a new pharmacy and she was not sure if the medications were the same back in 2022 but if the medication was not available they could call the pharmacy to send it over stat. The facility was owned by another company during 2022, and it could not be determined if Gabapentin was kept in house at the time of R156's stay. The facility policy Unavailable Medications dated 8/2020 documented in part, .The nursing staff shall: Notify the attending physician (or on-call physician when applicable) of the situation and explain the circumstances, expected availability, and alternative therapy(ies) available .On 7/27/2026 at 1:20 PM, the Administrator and the Director of Nursing were made aware of the concern. No further information was provided prior to exit. Reference: (1) Gabapentin capsules, tablets, and oral solution are used along with other medications to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). Gabapentin extended-release tablets (Horizant) are used to treat restless legs syndrome (RLS; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or lying down). Gabapentin is in a class of medications called anticonvulsants. Gabapentin treats seizures by decreasing abnormal excitement in the brain. Gabapentin relieves the pain of PHN by changing the way the body senses pain. It is not known exactly how gabapentin works to treat restless legs syndrome . This information was obtained from the website: Gabapentin: MedlinePlus Drug Information		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to ensure one of 52 residents were free of a significant medication error, Resident #13. The findings include: For Resident #13 (R13), the facility staff failed to ensure correct dosing of Dilaudid (1) and Methadone (2) on 1/27/2026. R13 was admitted to the facility with diagnoses that included but were not limited to Cauda Equina syndrome (3) and chronic pain syndrome (4). On the most recent minimum data set (MDS), a significant change assessment with an assessment reference date (ARD) of 5/11/2026, the resident was assessed as receiving scheduled and as needed pain medications, having occasional pain, and receiving an opioid medication. The physician orders for R13 documented in part, - Hydromorphone HCl Oral Tablet 8 MG (milligram) (Hydromorphone HCl). Give 1 tablet by mouth every 4 hours for Pain.- Methadone HCl Oral Tablet 10 MG (Methadone HCl). Give 3 tablet by mouth three times a day for chronic pain. Review of the eMAR (electronic medication administration record) for R13 dated 1/1-1/31/2026 documented the Hydromorphone HCL 8mg scheduled to be administered at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM and the Methadone HCL 10mg 3 tablets scheduled to be administered at 7:00 AM, 3:00 PM and 11:00 PM. The comprehensive care plan for R13 dated 5/11/2025 documented in part, OPIOIDS: the resident is at risk for complications related to the use of opioid secondary to arthrititis, chronic back pain, chronic pain unrelieved by analgesics, unrelieved joint pain. Under Interventions it documented in part, Administer medications as ordered. The progress notes for R13 documented in part, - 01/27/2026 10:13 (AM) Note Text: At about 0600 (6:00 AM), the nurse was going to administer Methadone 10MG three tablets by mouth to the resident, but erroneously gave three tablets of Hydromorphone (Dilaudid) 8MG Tablets by mouth for pain. Resident was informed and advised to call immediately if feels any drowsiness, dizziness, or any thing. Resident is stable, alert and oriented X4 (to person, place, time and situation) at this moment, V/S (vital signs) obtained include BP (blood pressure): 146/79, P (pulse): 68, O2 SAT (oxygen saturation): 98%, T (temperature) 97.9, R (respiration): 18. Staff informed the incoming nurse and Unit Manager about the medication error. NP (nurse practitioner) [Name of NP] was notified via phone at about 0839 (8:39 AM) and ordered to put an hold on the Hydromorphone 8MG tablet for all the three scheduled doses. The daughter [Name of daughter] was also informed via phone at about 0844 (8:44 AM). Monitor is in progress as ordered. - 01/27/2026 12:30 (PM) SNF (skilled nursing facility) follow up [Name of NP] . seen today at the skilled nursing facility for accidental overdose. Per staff, patient was scheduled to receive 3 10mg tablets of methadone (30mg total). Patient instead received 3 8mg tablets of dilaudid (24mg total) at 6 a.m. Staff notified provider of incident at 8:30 a.m and reported patient remained alert and awake, overall stable. Vital signs remained stable. Narcan PRN (as needed) was ordered but not administered due to patient being stable. Afternoon dose of dilaudid was held. Methadone dose due at 12 p.m (30mg) was held, and one time dose of 20mg was ordered at 2 p.m. Orders were placed to reassess hourly and to assess for appropriate administration of dilaudid dose due at 4 p.m. Continue with frequent monitoring of status and vitals, with orders to monitor patient hourly for any change in condition and monitor vitals closely. Discussed incident with daughter [Name of daughter] over the phone . Plan: Naloxone 4 mg intranasal spray ordered PRN for opioid overdose; not administered as patient remained clinically stable. - Afternoon hydromorphone dose was held. - Scheduled methadone 30 mg dose due at 12 p.m. was held; ordered one-time reduced dose of methadone 20 mg at 2 p.m. - Ordered hourly monitoring of vital signs and clinical status. - Ordered reassessment before next hydromorphone dose due at 4 p.m. to determine appropriateness of administration. - Incident (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussed with daughter [Name of daughter] via telephone. - Continue close monitoring for delayed respiratory depression or change in mental status . Review of the medication error report dated 1/27/2026 documented in part, .At about 0600, the nurse was going to administer Methadone 10MG three tablets by mouth to the resident but erroneously gave three tablets of Hydromorphone (Dilaudid) 8MG Tablets by mouth for pain. Resident was informed and advised to call immediately if feels any drowsiness, dizziness, or any thing. Resident is stable, alert and oriented X4 at this moment, V/S obtained include BP :146/79, P :68, O2 SAT : 98%, T 97.9, R : 18.Staff informed the incoming nurse and Unit Manager about the medication error. NP [Name of NP] was notified via phone at about 0839 (8:39 AM) and ordered to put an hold on the Hydromorphone 8MG tablet for all the three scheduled doses. The daughter [Name of daughter] was also informed via phone at about 0844 (8:44 AM). Monitor is in progress as ordered. Resident Description: When asked, if feels anything, resident said, I am fine for now . No injuries observed at the time of incident . No injuries post incident . Attached to the medication error report was a telephone order dated 1/27/2026 at 9:11 AM to Monitor vital signs every 4 hours starting 1/27/2026 at 12:00 PM and ending 1/28/2026 at 12:00 AM, a vital sign summary which documented blood pressures on 1/27/2026 at 9:00 AM, 11:45 AM, 5:02 PM, and 8:33 PM, oxygen saturations on 1/27/2026 at 12:30 PM and 10:54 PM, pulses checked on 1/27/2026 at 9:00 AM, 11:45 AM, 5:02 PM, and 8:33 PM and respirations assessed on 1/27/2026 at 11:45 AM, 5:02 PM and 8:33 PM. On 7/22/2026 at 1:50 PM, an interview was conducted with LPN (licensed practical nurse) #2 who stated that the night shift nurse had reported to her when she arrived around 7:00 AM that he had administered three Dilaudid instead of three Methadone tablets to R13. She stated that she had immediately gone to assess R13, obtained vital signs, contacted the nurse practitioner and R13's daughter. She stated that R13 had told her that she was fine and the vital signs were stable, so she had made sure that they checked on her more often and monitored her more often. LPN #2 stated that the former assistant director of nursing had educated the nurse directly and observed him passing medications after the incident. She stated that if she had made the medication error she would immediately notify the resident, assess them, check the vital signs, ensure they had the call light in reach, check on them frequently, call the provider to get orders, and notify the family. LPN #2 stated that she would have expected the nurse to have called the provider prior to her arrival and had interventions in place prior to letting her know on her arrival to the facility because there was always a provider on call. On 7/22/2026 at 4:06 PM, an interview was conducted with the Director of Nursing (DON) who stated that she was aware that the medication error had occurred and that the staff had monitored R13, completed the incident report, and educated the nurse on the 5 rights of medication administration one to one. She stated that R13 did not have any adverse reaction and the NP had come in to see the resident. On 7/27/2026 at 10:15 AM, an interview was conducted with the Pharmacist who stated that Dilaudid was used to treat pain and a potential side effect of receiving too much was an opiod overdose and Narcan was always kept on hand. She stated that effects of opiod overdosing included low heart rate, respiratory suppression and sedation and required monitoring of blood pressure and breathing if there was a known overdose. She stated that the half-life of the medication was two to three hours and it was normally dosed every four to six hours and if a resident took the medication for an extended period they had probably built up some tolerance to the medication. The facility policy Medication Administration Policy documented in part, . The 5 Rights (right resident, right medication, right dose, right route, right time) must be confirmed at the following stages during medication administration: 1. Before removing the medication package/container from the cart/drawer . 2. Before removing the medication from the container . 3. After preparing the dose and before returning the medication to storage . On 7/27/2026 at 1:20 PM, (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Administrator and the Director of Nursing were made aware of the concern. No further information was provided prior to exit. Reference:(1) Hydromorphone is used to relieve severe pain. Hydromorphone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain . This information was obtained from the website: Hydromorphone: MedlinePlus Drug Information(2) Methadone is used to relieve severe pain. Methadone also is used to treat opioid addiction (physical and psychological reliance on a chemical found in prescription and street drugs). Methadone is in a class of medications called opiate (narcotic) analgesics. Methadone works to treat pain by changing the way the brain and nervous system respond to pain. It works to treat people who were addicted to opiate drugs by producing similar effects and preventing withdrawal symptoms . This information was obtained from the website: Methadone: MedlinePlus Drug Information(3) Although leg and back pain are common and usually go away without surgery, cauda equina syndrome, a rare disorder affecting the bundle of nerve roots (cauda equina) at the lumbar (lower) end of the spinal cord, is a surgical emergency. An extension of the brain, the spinal cord and lumbar nerve roots send and receive messages to and from the pelvic organs and lower limbs. Cauda equina syndrome occurs when the nerve roots in the lumbar spine are compressed (squeezed), cutting off sensation and movement. The nerve roots that control the function of the bladder and bowel are especially vulnerable to damage. Cauda equina syndrome is a surgical emergency. Without immediate treatment to relieve pressure, it can result in a range of problems, including: Permanent paralysis; Impaired bladder and/or bowel control; Loss of sexual sensation; Chronic pain. Even with immediate treatment, some patients may not recover complete function; earlier treatment does, however, offer the best outcomes for cauda equina syndrome . This information was obtained from the website: Cauda Equina Syndrome - OrthoInfo - AAOS(4) Pain might be acute or chronic. The type of pain is based on how long and how often you have pain. Acute pain starts suddenly and goes away when the cause is treated or healed. This pain lets you know that you may be injured or have a problem you need to take care of. Chronic pain lasts longer than three months or the time in which you should have healed. If you have chronic pain, it can occur most days or every day and may last for weeks, months, or even years. It can affect all aspects of daily life, including your mood and relationships. Treatment may not get rid of chronic pain, but it can help with your symptoms . This information was obtained from the website: Chronic Pain MedlinePlus		