STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495121	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherrydale Health & Rehabilitation Center	3710 Lee Highway Arlington, VA 22207

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on staff interview, clinical record review, and facility documentation review, the facility failed to notify the resident and the resident's legal representative of a medication change for one of twenty residents (Resident #112- R112). The findings included: On 6/24/25, during a clinical record review, it was noted that R112 was out of the facility on an extended leave of absence and was not available for interview during the survey. R112's clinical record included a power of attorney, which appointed his wife as his legal representative. According to R112's admission record/face sheet, it noted that R112's wife was his A/R [accounts receivable] guarantor, responsible party, and POA [power of attorney]- financial. The wife alleged that the facility started the resident on a muscle relaxer that she was not aware of. On 6/24/25-6/25/25, during a clinical record review it was noted that on admission, R112 was ordered cyclobenzaprine, which was a muscle relaxer, to be administered every eight hours as needed for muscle spasms. Then on 3/8/25, the order was changed to only be for fourteen days. There was no documentation within the clinical record to indicate that the initial order or the revised order dated 3/8/25, was reviewed and/or discussed with the resident or his legal representative. On 6/25/25 at 11:01 a.m., an interview was conducted with a registered nurse, who was the unit manager (RN #3). When asked to explain the process if they receive a new order from the medical provider, RN #3 explained that the nurse transcribes the order into the electronic health record. RN #3 went on to say, You can't assume the doctor told the patient, so you make sure to tell the resident the medication is starting, what it is for and contact the RP [responsible party] if the resident isn't their own RP. RN #3 further confirmed that R112's wife was his responsible party. RN #3 confirmed in the electronic health record of R112 that on 3/8/25, an order for cyclobenzaprine was received and there was no evidence that the resident or RP were made aware of the order. On 6/25/25 at 11:31 a.m., during an interview with the facility's Director of Nursing (DON), the above findings were discussed and reviewed. On 6/25/25 at 3:37 p.m., during a follow-up interview, the DON confirmed the above findings and that he had no supporting evidence that the resident and/or responsible party were made aware of the order for cyclobenzaprine. He stated that he would expect the nursing staff to review all orders and order changes with the resident and/or responsible party. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25, the facility policy titled, General Guidelines for Medication Administration was reviewed. This policy did not address physician orders other than indicating medications are administered in accordance with physician orders. On 6/25/25 at 4:30 p.m., during an end of day meeting, the facility administrator, director of nursing and corporate nurse consultant were made aware of the above findings. On 6/26/25, the facility staff were asked to provide the survey team with the facility policy regarding physician orders or changes in plan of care. The facility supplied a policy titled, Significant Change of Condition, which did not specifically address new orders other than in the event a resident has a status change. In which case the policy read, . 3. Responsible party will be notified of a change of condition . No additional information was provided.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on staff interview, clinical record review and facility documentation review, the facility staff failed to provide a resident with written notice and reason for a room change for one of twenty residents (Resident #112- R112). The findings included: On 6/24/25, during a clinical record review, it was noted that R112 was on leave of absence and was not scheduled to return prior to completion of the survey, therefore he was not able to be interviewed. On 6/24/25-6/25/25, during a clinical record review, according to the census tab, R112 was admitted to a room on the fifth floor. On 3/6/25, R112's room was changed to a different room on the fifth floor. On 5/22/25 R112 was moved from the fifth floor to a room on the fourth floor. Then on 6/13/25, R112 was again moved to another room on the fourth floor. According to the nursing progress notes there were no entries dated 3/6/25, to document the room change. There was a progress note dated 3/8/25, that read in part, . notified of room change on 03/08/2025 12:00 AM. [R112's wife's name redacted] notified on 03/08/2025. Reason for change: Medical management (i.e. isolation, acuity, treatments, symptoms mgmt, etc.). [R112's wife's name redacted] consented to room change. Nursing initiated room change. SW will continue to monitor as resident adjust to his new setting. According to a progress note dated 5/22/25 at 3 p.m., the note read, Resident was moved from 512A to 423A with skin intact and stable. Another note dated 6/13/25, read, Resident alert and verbally responsive. Resident is aware of the move. Resident was moved from 423A to 412B with skin intact and stable. NP notified and called place to wife but no answer. There were no details noted to indicate the reason for the room changes, nor that the room change was provided to the resident in writing. On 6/25/25, interviews were conducted with the nurse managers on the fourth and fifth floors and admissions director, none of which were able to explain why the room change from the fifth floor to the fourth floor was performed. On 6/25/25 at 3 p.m., an interview was conducted with the social worker, who explained that the room change was for bed management. The social worker stated that R112 was notified the day prior, but confirmed she had no evidence that he was provided information in writing of the room change. On 6/25/25 at 4:30 p.m., during an end of day meeting, the facility administrator, director of nursing and corporate nurse consultant were made aware of the above findings. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/25, the facility policy titled, Room to Room Transfer was reviewed. The policy read, The center will complete the transfer of a patient to a different room efficiently and without incident for the patient. Procedure: 1. Nursing will notify the Social Services Department of room change requests. 2. The Social Services Department will initiate appropriate documents, notify patient(s) and/or responsible parties, and obtain signatures as indicated. 3. The Interdisciplinary Team will work collaboratively to ensure all room transfers are handled efficiently. 4. Ensure all medical records are transferred appropriately. 5. Transfer all patient's belongings. 6. Orient patient to new room and location in the center. 7. Introduce patient to new roommate, if applicable. No additional information was provided.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, resident interview, staff interview, clinical record review and facility documentation the facility staff failed to ensure that one resident (Resident #102) out of a survey sample of 20 residents, was treated with respect and dignity by performing personal grooming without the resident's consent. The findings included: The facility staff shaved off Resident #102's full beard without first obtaining permission. On 6/24/25 at 11:30 a.m., during the initial tour of unit four of the facility an observation was made of Resident #102 standing at the nurse's station very upset about his beard being shaved off this morning. Resident #102 was observed with a redness and razor burn appearance to his face. Resident #102 had beard hair that was still on his neck area. He was very anxious and pacing on the unit. Resident #102 was saying that something needs to be done now for this hurting and burning on my face. On 6/24/25 at 11:35 a.m., an interview was conducted with Resident #102. Resident #102 said, I was anxious to be getting a shower and when in the shower room the girl just started shaving my mustache first then my beard. I was trying to stop her, but she just kept going and shaving my beard. I only have use of one arm and was unable to push her away, but I was going to try. Resident #102 was upset about his beard being shaved and said, I hope they will let it grow back. On 6/24/25 at 11:40 a.m., an interview was conducted with a certified nursing assistant, CNA#3. CNA#3 stated that Resident #102 was just shaved, and his face just became that red. She stated that she applied aftershave lotion after he was shaved. On 6/24/25 at 11:45 a.m., an interview was conducted with a licensed practical nurse, LPN#6. LPN#6 said, [Resident #102's name was redacted] family wanted his beard shaved off and hair trimmed. His sister had trimmed his beard and then requested it to be shaved off. On 6/25/25 at 1:45 p.m., an interview was conducted with Resident 102's sister. She was visiting with her brother today and agreed to answer some questions about his care. Resident 102's sister said, I never asked anyone to shave his beard. He has had that beard a very long time. I asked the staff here if they would make sure to clean his beard and so no food would be in his beard after he ate his meals. She stated Resident 102 was upset about the beard being shaved off because he has had it for a long time. On 6/25/25 at 2:30 p.m., a clinical record review was conducted. There was no documentation of consent or refusal noted for shaving Resident 102's beard, and his care plan was not updated to reflect the resident's grooming preferences. The nurse practitioner saw Resident 102 the day he was shaven. She ordered hydrocortisone cream to be applied to his razor burn on his face. On 6/25/25 at 3:00 p.m., a review of facility documentation was conducted. The facility document titled, Resident Rights Annual Review, read in part, .be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 4:30 p.m., an end of day meeting was held with the administrator and regional nurse consultant. They were informed 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 interviews, staff interview, clinical record review, and facility documentation review, the facility staff failed to administer medications to one of twenty residents (Resident #111- R111). The findings included: On 6/24/25 at 12:45 p.m., while in the dining room, R111 reported, I've never been in a facility that runs out of medications like this one, and runs out of pain medicine so often, why do they have such a problem getting meds to the patients? On 6/25/25, a clinical record review was conducted of R111's chart. According to the physician orders, R111 had orders that included, but were not limited to, Atorvastatin Calcium 40 mg tablet, that was to be given at bedtime daily and Apixaban 5 mg tablet that was to be administered every 12 hours. According to R111's medication administration record (MAR) on 6/19/25, the scheduled administration for 9 p.m., was blank with no indication that the medications were administered. R111's chart had no progress notes dated 6/19/25, that addressed why the medications were not administered. R111's chart contained no progress notes dated 6/19/25, to explain why medications were not administered. According to the census tab and progress notes, there was no indication that R111 was not at the facility at the time of scheduled administration. On 6/25/25 at 2:15 p.m., an interview was conducted with a registered nurse, who was the unit manager (RN #3). RN #3 explained that when medications are given, they are signed off on the MAR. RN #3 accessed R111's MAR and confirmed the above findings and stated that she can't say that R111 received the medications as ordered and the nurse that was assigned to R111 on the evening of 6/19/25, was an agency nurse that no longer works at the facility. RN #3 added, If it is not documented, it was not done. When asked what the importance of residents receiving their medications as ordered is, RN #3 said, Because they need it and you don't want them to have a heart attack or make them sicker. You don't want them to have adverse actions from not receiving medications for their condition. On 6/25/25 at 3:37 p.m., an interview was conducted with the facility's director of nursing (DON). The DON stated that he expects staff to sign off on medications following the administration. When asked what a blank on the MAR indicates, he stated that They didn't give or accidentally didn't sign off. If we see a blank hole we should call and address, it. The DON was informed of the above findings and reviewed R111's MAR and confirmed the above findings. He stated he had no evidence that R111 received the medications as ordered by the provider on the evening of 6/19/25. The facility policy titled, General Guidelines for Medication Administration with an effective date of 09/2018, was reviewed. The policy read in part, .IV. Documentation (including electronic). 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure that necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 4:30 p.m., during an end of day meeting, the facility administrator, DON and corporate nurse consultant were made aware of the above findings. No additional information was provided.

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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 resident interviews, staff interviews, clinical record review, and facility documentation review, the facility staff failed to ensure medications were available for administration to one of twenty residents (Resident #111- R111). The findings included: On 6/24/25 at 12:45 p.m., while in the dining room, R111 reported, I've never been in a facility that runs out of medications like this one, and runs out of pain medicine so often, why do they have such a problem getting meds to the patients? On 6/25/25, a clinical record review was conducted of R111's chart. According to the physician orders, R111 had orders that included, but were not limited to, Fluticasone Propionate Suspension to be administered with two sprays in each nostril in the morning. According to R111's medication administration record (MAR) on 6/21/25, the scheduled administration for 9 a.m., was noted with a 9, which according to the chart code legend indicated, Other/See progress notes. According to the progress note dated 6/21/25, it read, on order. On 6/25/25 at 2:15 p.m., an interview was conducted with a registered nurse, who was the unit manager (RN #3). RN #3 accessed R111's MAR and progress notes confirming that the resident did not receive the nasal spray as ordered due to it not being available. RN #3 explained the importance of residents receiving their medications as ordered is, RN #3 said, Because they need it and you don't want them to have a heart attack or make them sicker. You don't want them to have adverse actions from not receiving medications for their condition. RN #3 also explained that when a nurse notices the supply is low, should be ordering the medications to prevent them from running out and so they are available for administration as ordered. On 6/25/25 at 3:37 p.m., an interview was conducted with the facility's director of nursing (DON). The DON stated that he expects staff to follow the policy on when medications are not available and the resident and family should be informed that the medication was not available as well as the provider. The DON was informed of the above findings and reviewed R111's MAR and confirmed the above finding. The facility policy titled, Medication Unavailability with an effective date of 1/29/2024, was reviewed. The policy read, .A licensed nurse discovering a mediation on order that is unavailable will initiate appropriate steps to ensu8re medical treatment is provided as ordered. Procedure: 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. 3. A licensed nurse will documentation notification to the provider of the unavailability in the medical record. 4. A licensed nurse will notify the responsible party of any new orders and document notification in the medical record. On 6/25/25 at 4:30 p.m., during an end of day meeting, the facility administrator, DON and corporate nurse consultant were made aware of the above findings. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interview and facility documentation review, the facility staff failed to prepare and serve meals in accordance with the menu, affecting residents on four of four units. The findings included: For the lunch meal on 6/24/25, the facility staff failed to prepare the dessert on the menu. On 6/24/25 at 11:25 a.m., observations were conducted in the main kitchen. The facility dietary staff were observed preparing food to take to the steam table on each unit to distribute. On 6/24/25 at 12:31 p.m., the food arrived in the fifth-floor dining room accompanied by a dietary aide and the dietary manager. The entire meal service of residents on the fifth floor was observed and it was noted that each resident's meal ticket displayed that an apple crisp was the dessert being served. However, residents were served mixed fruit instead. The dietary manager was observed to compare each plate served in the dining room and permitted the plates to be served with no apple crisp served. On 6/24/25 at approximately 1 p.m., the dietary manager was asked about the apple crisp and showed a meal ticket, he said, I will have to check on that when I go back downstairs [referring to the kitchen]. At approximately 1:20 p.m., the dietary manager confirmed that the cook did not prepare the dessert apple crisp due to a call out and he ran out of time. According to the facility menu, the lunch meal was to include apple crisp. According to the facility policy titled, Menus with a revision date of October 2019, it read in part, . 6. Menus are served as written, unless changed in response to preference, unavailability of an item, or special meal. On 6/25/25, during an end of day meeting, the facility administrator and director of nursing were made aware of the above concerns. No additional information was provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, staff interview and facility documentation review, the facility staff failed to prepare and serve food at an appetizing/palatable temperature on one of four units. The findings included: On the fifth floor the facility staff failed to serve food at a palatable temperature. On 6/24/25 observations were conducted of the noon meal. On 6/24/25 at 11:25 a.m., observations in the main kitchen revealed the staff transferring pans of food to insulated transport boxes to be distributed to each unit. On 6/24/25 at 12 noon, observations on the fifth-floor dining room revealed tray racks that had food trays with plate/pellet bottoms on each tray. On 6/24/25 at 12:31 p.m., the food arrived in the fifth-floor dining room. The dietary aide removed the food from the insulated transport box and placed the pans of food into the steam table. The dietary manager obtained temperatures of the food items which were as follows (all temperatures recorded in Fahrenheit): green beans 197 degrees, macaroni/pasta 143.9 degrees, chicken 148 degrees, pureed chicken 119 degrees, pureed potatoes 146 degrees, pureed macaroni 145 degrees, mechanical soft chicken 150 degrees and pureed green beans 156 degrees. The temperature was not taken of garden salads covered in saran wrap that were sitting on an open to air tray, without any mechanism to maintain a chilled temperature. Staff distributed food to residents in the dining room and then began putting prepared plates onto the plate/pellet bottoms on the trays for distribution to resident rooms. On 6/24/25, during the lunch meal, interviews were conducted with Resident #111, Resident #123, and Resident #124, all expressed concerns that the food is not usually warm when received. On 6/24/25 at 1:10 p.m., the last resident meal tray was placed on a cart, which also included a test tray, which was being distributed to residents on the unit. On 6/24/25 at 1:21 p.m., the last resident was served their tray, at which time the dietary manager began taking temperatures of each food item on the test tray with the surveyor observing. The chicken measured 127.7 degrees, green beans 115 degrees, macaroni and cheese 120 degrees, milk 44 degrees, fruit cocktail 79.5 degrees and tea 74.1 degrees. The dietary manager and surveyor sampled each food item, and the dietary manager stated the chicken was lukewarm and dry, green beans were bland and should be hotter, the macaroni and cheese was bland and barely had any warmth. The fruit cocktail was described by the dietary manager as not cool. The tea was at room temperature and had no ice. The dietary manager confirmed that the food was not palatable. According to the facility policy titled, Meal Distribution with a revision date of October 2019, it read, . 2. The Dining Services Director will ensure that all food items are transported promptly for appropriate temperature maintenance (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/25 at 4:30 p.m., 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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 3. Resident #103's lunch was supposed to be grilled chicken salad and milk for his beverage and was not served according to his preferences on his meal ticket. On 6/24/25 at 12:45 p.m., an observation was conducted with residents' meal trays in the resident's room. Resident #103 was being served lunch in his room and had requested a grilled chicken salad for lunch. His meal ticket had grilled chicken salad, crackers, apple crisp, tea and milk, and there was no apple crisp, grilled chicken or milk on his lunch tray. On 6/24/25 at 1:00 p.m., an interview was conducted with Resident #103. He stated that it was many times that he did not receive what was on his meal tickets. Resident #103 said, When I request the salads most of the time the meat that is supposed to be on the salad isn't there, sometimes they bring it and sometimes not. He stated it was supposed to be apple crisp with lunch today and there was none. Resident #103 requested milk with his meals and stated milk was very seldom on his meal tray. On 6/24/25 at 1:15 p.m., an interview was conducted with the dietary aide (OS12). She stated that the meal ticket had what the residents liked and disliked and whatever is listed on the meal ticket was supposed to be served to the residents. OS12 stated that the aides in the dining room were to serve the beverages, should read the ticket, and was to serve everything on the ticket. On 6/25/25 at 2:30 p.m., a facility document was reviewed. The document was titled, Dining and Food Preferences, read in part, .the individual tray assembly ticket will identify allergies, food and beverage preferences or special request, and adaptive equipment as appropriate. On 6/25/25 at 4:30 p.m., an end of day meeting was held with the administrator and regional nurse consultant. They were informed of the above concerns. No additional information was provided prior to the exit conference. Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to serve meals in accordance with resident's meals preferences for five of twenty residents (Resident #111-R111, Resident #124- R124, Resident #125- R125, Resident #121- R121, and Resident #103-R103). The findings included: 1. For R111 R124, and R125, the facility staff failed to provide milk in accordance with the residents' preference. On 6/24/25 at 12:50 p.m., R111 was served her lunch meal in the dining room and her beverages consisted of one cup of tea. According to the resident's meal ticket, it read, 2. For five of eight residents eating lunch in the eating in the fifth-floor dining room, the facility failed to serve beverages in accordance with meal tickets to maintain proper hydration (Resident #111 (R111), Resident #123 (R123), Resident #124 (R124), Resident #125 (R125), and Resident #126 (R126). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherrydale Health & Rehabilitation Center	3710 Lee Highway Arlington, VA 22207

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/24/25 at 12:40 p.m., observations were conducted of the lunch meal service in the fifth-floor dining room. There were eight residents eating lunch in the dining room and four had milk listed on their meal ticket to be served. Neither of the three residents, Resident #111 (R111), Resident #124 (R124), or Resident #125 (R125), were provided with milk. On 6/24/25 at 12:45 p.m., an interview was conducted with R111. The resident reported that she can't drink tea, it makes me sick. I need milk, I'm supposed to have 8 ounces of whole milk once a day, it would be a miracle if I get it. I don't know what the problem is, why they have no juice, ice water, or anything other than tea with meals. According to resident #111's meal ticket it read, . NO ICED TEA. Listed as the items the resident was to receive was 2% milk- 8 oz, hot coffee or hot tea- 8 oz, neither of which were provided. On 6/24/25 at approximately 1 p.m., the dietary manager was approached and asked about the lack of milk provided to residents eating in the dining room and was shown Resident #111's meal ticket that said no iced tea and to serve milk and hot coffee or hot tea. He immediately began asking the certified nursing assistants who had provided the resident her tray and why she didn't receive the milk as per the meal ticket. After a few minutes and him stating he would take care of it moving forward, the surveyor had to ask if resident #111 could be given a cup of milk so that she had some form of beverage to consume with her meal. The dietary manager began telling the surveyor that he wanted to change the dining process so that the dietary staff handled all the food service to include the beverages so that they could ensure accuracy versus nursing providing the beverages. Following the surveyor having to ask, a certified nursing assistant then poured and provided resident #111 with a cup of milk. On 6/24/25, in the afternoon, an interview was conducted with the registered dietician (RD). The RD reported that she had been on-site since the prior survey and had conducted interviews with residents to obtain food/meal preferences and completed forms for each resident. The RD provided the surveyor with a binder containing the resident preference forms. Review of this revealed that R111 had no preference form on file, which the RD confirmed. The RD did provide the surveyor with a printout of the meal tracker form and said, I didn't find a preference form, but this has preferences listed. The meal tracker form for R111 read, NO FISH, NO ICED TEA. According to R124's meal ticket, he was to receive 2% milk- 8 oz, and eight ounces of iced tea. R124 only received tea with no ice. According to R124's Food Preferences Interview, which was not dated, the resident was to receive iced tea and milk with lunch daily. R125's meal ticket read in part, . Milk with every meal 2% milk- 8 oz, hot coffee or hot tea- 8 oz. R125 was served one cup of tea with her meal. During an interview with R125 when asked about the meals and beverages, the resident said, I don't get any milk or coffee, we get tea, that's it. You never get what's on the ticket, that's why I ask for a salad, I can't go wrong with a chef salad. R125's Food Preference Interview dated 6/18/25, indicated she was to receive milk at all meals. According to the meal tracker diet information it listed Milk with every meal. 2. For R121, whose preference was to receive oatmeal, the facility staff failed to provide it. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/25 at 10:05 a.m., an interview was conducted with R121. R121 was in bed and while conversing with the surveyor, a staff member entered the room and provided R121 with his breakfast tray. The certified nursing assistant delivering R121's tray reported that he liked to sleep late in the mornings, so she will heat his breakfast tray and provide it once he awakens. With R121's permission the surveyor reviewed the meal ticket and compared it to the tray contents. R121 received cheerios cereal, and the meal ticket indicated he was to have received oatmeal. When asked, R121 said, I would like to have oatmeal. On 6/25/25 at approximately 10:10 a.m., the surveyor asked the unit manager, who was a registered nurse (RN #1) to accompany her to R121's room. When asked about the cold cereal versus the oatmeal, RN #1 said, If oatmeal is on his ticket, he should have received oatmeal. The resident again confirmed he would like oatmeal. RN #1 returned to her office and called the kitchen via telephone but with no response. RN #1 then went downstairs to the kitchen. Upon her return, RN #1 stated, They do have oatmeal but was able to give no reason why R121 had not received the oatmeal in accordance with his meal ticket and preference. The facility policy titled, Dining and Food Preferences with a revision date of October 2019, was reviewed. The policy read in part, . 2. The Dining Services Director or designee will interview the resident or resident representative to complete a Food Preference Interview within 48 hours of admission. The purpose of identifying individual preferences for dining location, mealtimes, including times outside of the routine schedule, food, and beverage preferences. 3. The food preference interview will be entered into the medical record. 4. Food allergies, food intolerance, food dislikes, and food and fluid preferences will be entered into the resident profile in the menu management software system. 5. The Registered Dietitian/Nutritionist (RDN) or other clinically qualified nutrition professional will review, and after consultation with the resident, adjust the individual meal plan to insure adequate fluid volume and appropriate nutritional content for residents that do not consume certain foods or food groups . On 6/25/25, 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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observations, resident interview, staff interview, clinical record review and facility documentation review the facility staff failed to provide beverages to include, but not limited to milk, in accordance with meal tickets to maintain resident hydration for multiple residents on two units out of four units (Unit 4 and Unit 5). The findings included: 1. The facility staff failed to serve milk according to the planned menu for Resident #102, Resident #128, Resident #129 and Resident #130. On 6/24/25 at 12:40 p.m., an observation was made of the lunch meal being served in the dining room on Unit 4. There were approximately 15 residents in the dining room for lunch. The residents were served their meals and four of the residents, Resident #102, Resident #128, Resident #129 and Resident #130 were not served their milk according to their menu. There was a gallon of 2% milk available to be served to the residents in the dining room. On 6/24/25 at 1:00 p.m., Resident #129 said, I like my milk. He asked a staff member for milk and was never served the milk during the lunch meal. On 6/24/25 at 1:15 p.m., an interview was conducted with the dietary aide (OS12). She stated that the meal ticket had what the residents liked and disliked and whatever is listed on the meal ticket was supposed to be served to the residents. OS12 stated that the aides in the dining room were to serve the beverages, should read the ticket, and was to serve everything on the ticket. On 6/24/25 at 1:28 p.m., Resident 102 said, I like milk anytime, but I don't get my milk. I am in my 70's and I need that extra calcium. He was not served milk during the lunch meal. On 6/24/25 at 1:30 p.m., Resident #128 said, I like milk. Her ticket had Lactaid milk, and this milk was not available in the dining room for her to be served. On 6/24/25 at 1:35 p.m., Resident #130 said, I like milk with my coffee and my cereal in the mornings. He was not served any milk during the lunch meal. On 6/25/25 at 2:30 p.m., a facility document was reviewed. The document was titled, Dining and Food Preferences, read in part, .the individual tray assembly ticket will identify allergies, food and beverage preferences or special request, and adaptive equipment as appropriate. On 6/25/25 at 4:30 p.m., an end of day meeting was held with the administrator and regional nurse consultant. They were informed of the above concerns. No additional information was provided prior to the exit conference. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For five of eight residents eating lunch in the eating in the fifth-floor dining room, the facility failed to serve beverages in accordance with meal tickets to maintain proper hydration (Resident #111 (R111), Resident #123 (R123), Resident #124 (R124), Resident #125 (R125), and Resident #126 (R126). On 6/24/25 at 12:40 p.m., observations were conducted of the lunch meal service in the fifth-floor dining room. There were eight residents eating lunch in the dining room and four had milk listed on their meal ticket to be served. Neither of the three residents, Resident #111 (R111), Resident #124 (R124), or Resident #125 (R125), were provided with milk. On 6/24/25 at 12:45 p.m., an interview was conducted with R111. The resident reported that she can't drink tea, it makes me sick. I need milk, I'm supposed to have 8 ounces of whole milk once a day, it would be a miracle if I get it. I don't know what the problem is, why they have no juice, ice water, or anything other than tea with meals. According to resident #111's meal ticket it read, . NO ICED TEA. Listed as the items the resident was to receive was 2% milk- 8 oz, hot coffee or hot tea- 8 oz, neither of which were provided. According to R124's meal ticket, he was to receive 2% milk- 8 oz, and eight ounces of iced tea. R124 only received tea with no ice. R125's meal ticket read in part, . Milk with every meal 2% milk- 8 oz, hot coffee or hot tea- 8 oz. R125 was served one cup of tea with her meal. During an interview with R125 when asked about the meals and beverages, the resident said, I don't get any milk or coffee, we get tea, that's it. You never get what's on the ticket, that's why I ask for a salad, I can't go wrong with a chef salad. On 6/24/25 at approximately 1 p.m., the dietary manager was approached and asked about the lack of milk provided to residents eating in the dining room and was shown Resident #111's meal ticket that said no iced tea and to serve milk and hot coffee or hot tea. He immediately began asking the certified nursing assistants who had provided the resident her tray and why she didn't receive the milk as per the meal ticket. After a few minutes and him stating he would take care of it moving forward, the surveyor had to ask if resident #111 could be given a cup of milk so that she had some form of beverage to consume with her meal. The dietary manager began telling the surveyor that he wanted to change the dining process so that the dietary staff handled all of the food service to include the beverages so that they could ensure accuracy versus nursing providing the beverages. Following the surveyor having to ask, a certified nursing assistant then poured and provided resident #111 with a cup of milk. Resident #123's meal ticket indicated she was to have received eight ounces of hot coffee or hot tea and listed coffee a second time in the quantity of eight ounces. R123 only received a cup of tea with her meal. Resident #126 was supposed to receive 8 oz of milk and 8 oz of hot coffee or hot tea with her lunch meal. R126 was only provided with one small cup of milk. The facility policy titled, Dining and Food Preferences with a revision date of October 2019, was reviewed. The policy read in part, . 5. The Registered Dietitian/Nutritionist (RDN) or other clinically qualified nutrition professional will review, and after consultation with the resident, adjust the individual meal plan to insure adequate fluid volume and appropriate nutritional content for residents that do not consume certain foods or food groups . (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/25, 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility documentation review, the facility staff failed to store, prepare and distribute food in a sanitary manner in accordance with food service safety standards in the main kitchen. The findings included: In the main kitchen the facility staff failed to label food and store in a way to prevent contamination and to protect the integrity of the food. On 6/24/25 at 11:25 a.m., a tour of the main kitchen was conducted with the dietary manager in attendance. In the walk-in cooler there was a bag of green peas that had been opened and was not labeled with the open date or use by date. There was also a full case of green peas that the bag was open to air. The dietary manager was asked about the storage of opened items and stated, I had cases for each meal, they put that little bit back, I will have to ask why, we don't use partial cases because we have 200 residents. I would expect the bags to be tied up and the box closed. When asked about the date of open items, the dietary manager said, The date is important to know if they rotated it. Also in the walk-in freezer was a silver pan with saran wrap on top that was not covering the entire surface area, leaving the food exposed. The contents had ice build-up on the food. The dietary manager identified the food as turkey meatloaf and said, I will throw that out. There was a bag of bread dough that the dietary manager identified as Caribbean bread, which had a hole in the bag exposing the contents. There was a bag of four fish filets that were open to air, no label to identify the contents, when opened or to be used by and the dietary manager said was [NAME] and was opened two days ago when we served [NAME], it should have been wrapped up. There was a box of sausage patties that had a hole in the bag leaving the contents exposed. The case of bacon was open, the box was not closed, and the contents were easily seen and exposed and had no identification when it was opened or to be used by. In the stand-alone coolers there were three plates of garden salads that had no label to indicate when it was prepared or to be used by. There were three pitchers of a red liquid that had no dates or label to indicate the contents. The dietary manager stated it was juice that had been prepared for the meal. Review of the facility policy titled, Food Storage: Cold with a revision date of October 2019, was conducted. This policy read in part, . 5. The Dining Services Director/Cook(s) insures that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination. The CFR [Federal code] read, 3-305.11 Food Storage .D. A date marking system that meets the criteria . (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 2017 Food Code published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 3-302.15, page 64 stated: Package Integrity. Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants. On 6/25/25, during an end of day meeting the above findings were shared with the facility administrator and director of nursing. No additional information was provided. 2. The facility staff were stacking stainless steel pans and meal trays wet, which had the potential for bacteria growth. On 6/24/25 at 11:45 a.m., observations within the dish room were conducted which revealed a stack of stainless-steel sheet pans. The dietary manager removed several of the pans which were noted to have standing water and moisture. There were also stacks of meal trays and observation revealed they were also stacked wet and had significant food residue on them. When asked the dietary manager stated that stacking wet/wet nesting can cause bacteria to grow. According to the 2017 Food Code published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 4, section 4-901.11, titled Equipment and Utensils, Air-Drying Required pages 151-152 stated: After cleaning and sanitizing, equipment, and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food; and (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry. According to the facility policy with a revision date of October 2019, which was titled, Ware Washing, which read in part, 1. The Dining Services Director insures that the nutrition service staff is knowledgeable in proper technique for processing dirty dishware to clean through the dish machine and proper handling of sanitized dish ware . 4. The Dining Services Director ensures that all dishware is air dried and properly stored. On 6/25/25, during an end of day meeting the above findings were shared with the facility administrator and director of nursing. No additional information was provided.

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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 observations, staff interview, resident interview, clinical record review and facility document review the facility staff failed to ensure staff followed proper infection control practices to include hand hygiene and handling of table linens to prevent contamination during meal service on two of four units (Unit 4 and Unit 5) and failed to wear the proper personal protective equipment (PPE) for enhanced barrier precautions for Resident #108. The findings included: 1. The facility staff failed to change gloves between tasks and placed clean table linens on the floor before use in the dining room on Unit 4. On 6/24/25 at 12 noon, observations were conducted of the lunch meal service in the fifth-floor dining room. Facility staff were observed wearing gloves to prepare the beverages for resident's trays and while handling and distributing meals to residents in the dining room. The surveyor observed the dietary manager go to the handwashing sink but then leave the dining room. Because the surveyor was going to be observing food temperatures, the plating of food and partaking in a test tray, the surveyor also went to the hand washing sink in the dining room to wash her hands and noted that the soap dispenser was not working. When the dietary manager was asked about a handwashing location, he directed her to a staff area on the unit. Throughout the entire meal service of residents in the dining room, certified nursing assistants were wearing gloves, to distribute food and beverages, touching multiple surfaces and at no point performing any hand hygiene or changing of gloves. On 6/24/25 at 12:15 p.m., an observation was made in the dining room on Unit 4 during the lunch meal. During the entire meal service, the certified nursing assistants were wearing gloves to serve food and beverages, touching multiple surfaces without changing gloves or performing hand hygiene. One aide was observed placing a bag of clean table linens on the floor before placing them on the tables. On two tables she placed the table linens on the table after the tablecloth had touched the floor. On 6/24/25 an interview was conducted with a certified nursing assistant, CNA#3. When asked about wearing of the same gloves in the dining room during the lunch meal CNA#3 said, hand sanitizer not in the dining area yet and with the silver wear we should take gloves off to do that. It contaminates if you wear the same gloves and don't wash your hands. On 6/24/25 at 12:30 p.m., an interview was conducted with CNA#4 When asked about the clean table linen being placed on the floor in the dining room CNA#4 said, table clothes should not have been on floor or touched the floor causes cross contamination, I wear gloves to help with germs but not helping with germs when touching everything with same gloves. On 6/25/25 at 10:00 a.m., a review of facility document was conducted. The document titled, Standard Precautions, read in part, .change gloves between tasks and procedures. Perform hand hygiene upon removing gloves. Handle, transport and process used linen in a manner that prevents contamination of clothing and avoids transfer of microorganisms to other patients. On 6/25/25 at 4:30 p.m., an end of day meeting was held with the administrator and regional nurse consultant. They were informed of the above concerns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided prior to the exit conference. 2. For Resident #108 (R108), who was on enhanced barrier precautions, the facility staff failed to wear appropriate personal protective equipment (PPE) prior to providing direct care. On 6/24/25 at 12:18 p.m., during observations on the resident care unit, it was noted that R108's room had a sign outside the door that stated enhanced barrier precautions and staff were to wear an isolation gown and gloves during any high-contact activity. A staff member (other employee #7-OE#7) was observed in the room providing care/range of motion to the resident's legs/feet and then moved to his upper body, hands/arms and was noted to be only wearing gloves. On 6/24/25 at 12:30 p.m., the staff member OE #7 exited R108's room. OE #7 was interviewed by the surveyor and stated she was with the therapy department and was providing passive range of motion on his lower extremities and upper extremities, performed wrist and fingers range of motion, ankle pumps, and hip flexion. When asked why she wasn't wearing the proper PPE, OE #7 said, He has PPE precautions? I didn't see a sign. Usually, I have on all my stuff. When asked why it is important to wear PPE during care, OE #7 said, To keep any kind of infection from spreading and it has to stay in the room. OE #7 accompanied the surveyor back to R108's room and confirmed the signage for enhanced barrier precautions being present and a bin of PPE outside the room door. On 6/24/25-6/25/25, a clinical record review was conducted of R108's medical record. This review revealed that R108 had a physician order dated 6/24/25 that read, Enhanced barrier precaution r/t [related to] to enteral feeding and wounds. The facility policy titled, Enhanced Barrier Precautions (EBPs) with an effective date of 3/26/24, was reviewed. The policy read in part, Employees providing high-contact patient care activities will follow Enhanced Barrier Precautions (EBPs) for patients who meet the criteria . 3. EBPs require the use of gown and gloves by staff during high-contact patient care activities as defined below: a. Dressing, b. Bathing/showering, c. Transferring, d. Changing linens, e. Providing hygiene, f. Changing briefs or assisting with toileting, g. device care or use, h. wound care for chronic wounds. 4. Post Enhanced Barrier Precaution signage on wall outside the patient room. 5. Ensure PPE is available . On 6/25/25, 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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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, resident interview, staff interview, and facility documentation review, the facility failed to maintain an effective pest control program affecting four of four resident units. The findings included: On 6/24/25 at 12:10 p.m., while touring the facility and making observations, the surveyor entered a dually occupied resident room on the fourth floor. In the bathroom observations were made of multiple cockroaches crawling around on the floor. On 6/24/25 at 12:15 p.m., an interview was conducted with the maintenance assistant (Other Employee #5-OE#5). OE#5 was asked about pests within the facility and reported it is a problem. He reported a pest control contractor comes and has bait stations in the ceiling that chemicals are put in. OE #5 accompanied the surveyor to the resident room and confirmed the cockroaches crawling around the floor in the bathroom and stated they were coming from the corner and kicked the wall. When he kicked the wall approximately twenty cockroaches emerged from the wall and began crawling around. OED#5 stated he would caulk the baseboard. On 6/25/25 at 10:05 a.m., an interview was conducted with resident #121 (R121). R121 reported, Roaches are all over the place and mice too. The roaches are terrible, I would say this place is infested, ever since I came here a year ago, I see them, it is getting worse. They run across the floor quite often. On 6/25/25 at 10:10 a.m., an interview was conducted with resident #122 (R122) who resided in the room where the cockroaches were observed on 6/24/25. R122 reported that they have been having trouble with cockroaches, and he sees them crawling on the wall. On 6/25/25 at 1:32 p.m., an interview was conducted with the facility's maintenance director (Other Employee #1- OE#1). OE #1 reported to the survey team that he has certificates in pest control, but they have a company that comes in to provide pest control services weekly. OE #1 reported that prior to him starting at the facility they had a huge rodent problem. OE #1 went on to report that pest control is more of an issue in a building like this because it is extremely hard to treat a problem like that because we can't fumigate, the best we can do is schedule a time to bring residents out the room and he can spray the rooms. We have bait traps in the ceiling. To effectively treat a building like this you need to fumigate, and we don't have the empty space to move residents to do that. On 6/25/25 at 2:15 p.m., during an interview with resident #103 (R103), he reported seeing cockroaches all the time. On 6/25/25 at 2:30 p.m., an interview was conducted with a licensed practical nurse (LPN #4). When asked about pest issues within the facility LPN #4 failed to answer and reported they have books on each unit where they write down when they see pests. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495121	A. Building B. Wing	06/26/2025

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/25 a review of the pest control logs on each unit was reviewed as well as the pest control company's service reports. This review revealed that on the 200 unit, in the past three months four entries were made in the pest sighting/evidence log and all four noted roaches in resident rooms. The pest sighting log from the third floor noted nine entries in the past two months and all of which noted roaches. The fourth-floor unit logbook had six entries from 5/28/25-6/25/25, all of which noted roaches except for one, which did not indicate what type of pest was observed. The fifth-floor logbooks most recent three entries were all related to roaches. According to the pest control company's service reports the facility was on a cockroach/rodent program. During the technicians' visits he treated cockroaches and, in several reports, specifically 4/8/25 and 5/6/25, the report indicated he observed cockroaches in resident rooms. According to the facility policy titled, Pest Control with an effective date of 5/1/22, it read, the center environment will be inspected monthly and treated for pests by a corporate approved contractor. The policy referenced the pest sighting logbook, notification to the vendor of sightings, vendor provides services as per the corporate-approved agreement. On 6/25/25 at 4:30 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the concern that their pest control program was not effective. No additional information was provided.