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	11/13/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to protect the resident's right to be free from neglect for one resident (Resident #4- R4), in a survey sample of eight residents. The findings included:On 11/13/25, a clinical record review was conducted of R4's electronic health record. According to a minimum data set assessment with an assessment reference date of 8/25/25, the resident had a brief interview for mental status score of 15/15, which indicated they were cognitively intact. According to R4's care plan, there were no indications of any cognitive impairments or behavioral problems. On 11/13/25 at 10:30 AM, an interview was conducted with R4. R4 was asked about an incident that occurred on 4/9/25. R4 reported that initially she didn't recall the details of the incident and said, There's always something. When management is not here on weekends, it's pure hell. I don't get care; I lay in feces for hours. You think you are going to get care, and you don't. R4 reported they texted their child daily and gave details of the happenings. The resident requested the opportunity to reference text communication with their child on that day. R4's accessed text messages which stated that the resident had also texted the director of nursing. R4 reported that staff did not respond to the call light for assistance for incontinence care and felt threatened by the certified nursing assistant (later identified as CNA #1) and called the police. According to the text communication sent to the director of nursing (DON) [who was no longer employed by the facility at the time of survey], the resident reported that CNA #1 did not respond to the call bell and the resident was left to lay in feces. When the resident called the police, while the dispatcher was on the phone CNA #1 was asked to leave the room and did not adhere to the resident's request. The nurse then responded to the room with CNA #1, but the resident did not want CNA #1 to provide care and the nurse reported there was no one else to provide the care. CNA #1 later became argumentative with R4 and began displaying aggressive behavior. The details in the message to the DON were stated as, .When she finally realized I wasn't going to allow her to change me, she finally took her gloves off. As she was taking the gloves, she smacked her hands with the gloves, she rolled her hands into a fist with the gloves. I personally felt she was going to physically attack me. Her demeanor had gotten worse. The anger in her eyes & face had dramatically changed. Her erratic behavior was unsettling to me. The resident reported the police did arrive, she talked with them, the officer talked to the nurse and then returned to talk with R4 and the resident reported, . He [police officer] informed me that the CNA who I was working with had gone home. A new shift had just started & someone would be in shortly to take care of me . On 11/13/25, the facility administrator provided the surveyor with the incident summary and facility synopsis. According to the facility records, a nurse working the night of 4/9/25 provided a statement that she had to awaken CNA #1 to answer R4's call light. The nurse reported that CNA #4 was challenging to awaken. The nurse was not available at the time of survey for interview. The facility's conclusion in the incident synopsis read in part, Conclusion: Based on the investigation and interviews, we are substantiating an allegation of neglect. According to the facility synopsis, CNA #1 was noted prior to the incident to be at the nursing station and not responding to resident's requests for assistance/call lights. Review of CNA #1's personnel file, revealed termination of employment was effective 4/17/25. The facility policy titled, Administrative Reference Guide, with an effective date of 1/23/20, was reviewed. The policy read in part, . b. Neglect means a repeated or willful failure to provide timely and consistent services, treatment or care to a patient which are necessary to obtain or maintain a patient's health, safety or comfort; or a repeated or willful failure to provide timely and consistent goods and services necessary to avoid physical harm, mental anguish, or emotional distress, including but not limited to acts that cause, or could cause, pain or injury to a patient or death of a patient; acts that substantially disregard a Center's duties and obligations to a patient; acts that cause or could significantly or likely be expected to cause, mental or emotional damage to a patient. Examples include but are not limited to: . iii. Disregard of physical needs including, but not limited to, toileting and bathing, or continued omission in providing daily care and/or failure to address the omission. On 11/14/25 at 12:30 PM, the above findings were reviewed with the facility Administrator, Assistant Administrator, Director of nursing and Regional Director of Clinical Services. No additional information was provided.

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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 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. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to implement their abuse policy for one staff member, which affected one resident (Resident #4-R4) in a survey sample of eight residents. The findings included:For Resident #4, who was a victim of neglect, the facility staff failed to implement their abuse policy for a certified nursing assistant (CNA #1), who was the perpetrator. On 11/13/25, a clinical record review was conducted of R4's electronic health record. According to a minimum data set assessment with an assessment reference date of 8/25/25, the resident had a brief interview for mental status score of 15/15, which indicated they were cognitively intact. According to R4's care plan, there were no indications of any cognitive impairments or behavioral problems. On 11/13/25 at 10:30 AM, an interview was conducted with R4. R4 was asked about an incident that occurred on 4/9/25. R4 reported that initially she didn't recall the details of the incident and said, There's always something. When management is not here on weekends, it's pure hell. I don't get care; I lay in feces for hours. You think you are going to get care, and you don't. R4 reported they texted their child daily and gave details of the events of the day. The resident requested the opportunity to reference text communication with their child on that day. R4's accessed text messages which stated that the resident had also texted the director of nursing. R4 reported that staff did not respond to the call light for assistance for incontinence care and felt threatened by the certified nursing assistant (later identified as CNA #1) and called the police. According to the text communication sent to the director of nursing (DON) [who was no longer employed by the facility at the time of survey], the resident reported that CNA #1 neglected to respond to the resident's request/ call bell for incontinence care and then became aggressive. R4 reported to the DON, . When she [CNA #1] finally realized I wasn't going to allow her to change me, she finally took her gloves off. As she was taking the gloves, she smacked her hands with the gloves, she rolled her hands into a fist with the gloves. I personally felt she was going to physically attack me. Her demeanor had gotten worse. The anger in her eyes & face had dramatically changed. Her erratic behavior was unsettling to me. On 11/13/25, the facility administrator provided the surveyor with the incident summary and facility synopsis. According to the facility records, a nurse working the night of 4/9/25 provided a statement that she had to awaken CNA #1 to answer R4's call light. The nurse reported that CNA #4 was challenging to awaken. The nurse was not available at the time of survey for interview. The facility's conclusion in the incident synopsis read in part, Conclusion: Based on the investigation and interviews, we are substantiating an allegation of neglect. According to the facility synopsis, CNA #1 was noted prior to the incident to be at the nursing station and not responding to resident's requests for assistance/call lights. The charge nurses/supervisor for the shift was aware of CNA #1's actions, lack of attention to resident care, R4's concern which resulted in her calling the police, who responded but took no measures to remove CNA #1. On 11/13/25 a review of certified nursing assistant #1's (CNA #1) personnel file was conducted. This review revealed that the employee was hired on 3/31/25 and was terminated on 4/17/25. The facility staff failed to verify CNA #1 held an active and unencumbered certification to work as a certified nursing assistant until 4/8/25. The facility staff also failed to obtain a criminal background check on CNA #1 until 5/12/25, which was a month after the employee's termination. On 11/13/25 at 10:36 AM, an interview was conducted with the facility's human resources director (HRD). The HRD explained the hiring process and stated that prior to hire/employment the facility obtains a criminal background check and verifies their nursing license/certification. The HRD went on to state that this was important to make sure they have a license and to ensure they don't have any violent offenses or other offenses. During the above interview, the HRD was shown CNA #1's personnel file and confirmed that a criminal background check was not in the file and there was no evidence of a license verification in the personnel file. The HRD stated she would go look and see what she could find. On 11/13/25 at 12:20 PM, the HRD returned and reported that CNA #1 had previously worked for the facility from 9/5/23-11/1/24. With respect to the criminal background check, the HRD said, I'm not sure what happened here. With the license verification, the HRD stated that because she had worked at the facility previously and her license was still active, they did not pull it again. On 11/13/25 at 12:25 PM, the facility administrator confirmed that despite the fact that CNA #1 had previously worked for the facility and they had evidence at the time of her termination that her license remained active at the time of re-hire, they should have checked it again to ensure there were no adverse actions against the license and that it had not been suspended for any reason. According to the facility's policy titled, Prevention/Screening/Training, which read in part, 1. Criminal

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to take measures to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation was conducted for two residents (Resident #4- R4 and Resident #2-R2), in a survey sample of eight residents.The findings included:1. For R2 who reported an allegation of abuse, the facility staff did not remove the alleged perpetrator and permitted the employee to work the remainder of their shift, therefore having access to other residents. On 11/13/25, a review of facility documentation revealed that on 6/20/25 R2 reported to the facility administrator that a housekeeper (other staff #7- OS #7) said he would beat him [the resident] up. The facility administrator completed an incident summary which was sent to the state regulatory agency at 1:50 PM and noted that the employee had been suspended pending investigation. Review of the timecard for OS #7 revealed that on 6/20/25, the employee worked the remainder of his shift and did not clock out until 4:30 PM. Therefore, the facility failed to protect other residents from an alleged perpetrator while they investigated the allegation of abuse. 2. For R4, who reported an allegation of neglect and intimidation by a staff member, the facility staff failed to remove the alleged perpetrator and allowed the employee to work the following day for an entire shift providing direct resident care to other residents, therefore putting them at risk. On 11/13/25, a clinical record review was conducted of R4's electronic health record. According to a minimum data set assessment with an assessment reference date of 8/25/25, the resident had a brief interview for mental status score of 15/15, which indicated they were cognitively intact. According to R4's care plan, there were no indications of any cognitive impairments or behavioral problems. On 11/13/25 at 10:30 AM, an interview was conducted with R4. R4 was asked about an incident that occurred on 4/9/25. R4 reported that initially she didn't recall the details of the incident and said, There's always something. When management is not here on weekends, it's pure hell. I don't get care; I lay in feces for hours. You think you are going to get care, and you don't. R4 reported they texted their child daily and gave details of the happenings. The resident requested the opportunity to reference text communication with their child on that day. R4's accessed text messages which stated that the resident had also texted the director of nursing. R4 reported that staff did not respond to the call light for assistance for incontinence care and felt threatened by the certified nursing assistant (later identified as CNA #1) and called the police. According to the text communication sent to the director of nursing (DON) [who was no longer employed by the facility at the time of survey], the resident reported that CNA #1 neglected to respond to the resident's request/ call bell for incontinence care and then became aggressive. R4 reported to the DON, .When she [CNA #1] finally realized I wasn't going to allow her to change me, she finally took her gloves off. As she was taking the gloves, she smacked her hands with the gloves, she rolled her hands into a fist with the gloves. I personally felt she was going to physically attack me. Her demeanor had gotten worse. The anger in her eyes & face had dramatically changed. Her erratic behavior was unsettling to me. On 11/13/25, the facility administrator provided the surveyor with the incident summary and facility synopsis. According to the facility records, a nurse working the night of 4/9/25 provided a statement that she had to awaken CNA #1 to answer R4's call light. The nurse reported that CNA #4 was challenging to awaken. The nurse was not available at the time of survey for interview. The facility's conclusion in the incident synopsis read in part, Conclusion: Based on the investigation and interviews, we are substantiating an allegation of neglect. According to the facility synopsis, CNA #1 was noted prior to the incident to be at the nursing station and not responding to resident's requests for assistance/call lights. The charge nurses/supervisor for the shift was aware of CNA #1's actions, lack of attention to resident care, R4's concern which resulted in her calling the police, who responded but took no measures to remove CNA #1. Review of CNA #1's personnel file and timecard revealed that following the incident on 4/9/25, she was permitted to work a full shift on 4/10/25 from 7:05 AM until 3:34 PM, providing direct resident care. The facility policies titled, Prevention/Screening/Training, Reporting Requirements/Investigations, and Administrative Reference Guide, were reviewed. None of the policies addressed protection of residents from alleged perpetrators during an investigation regarding allegations of abuse or neglect. On 11/14/25 at 12:30 PM, the above findings were reviewed with the facility Administrator, Assistant Administrator, Director of nursing and Regional Director of Clinical Services. The administrator confirmed that OS #7 should have left the facility when the allegation was made and not permitted to work the remainder of the shift. On 11/14/25 at 1 PM, the facility administrator confirmed that nurses are the unit supervisors and responsible for the supervision of CNA's and should be taking measures

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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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to follow physician orders for three residents (Resident #1- R1, Resident #5-R5, and Resident #6-R6), in a survey sample of eight residents.The findings included:1. For R1, the facility staff failed to transcribe an order for antifungal medication, which resulted in the resident not receiving the physician ordered medication for two days. On 11/12/25, a closed record review was conducted of R1's chart. This review revealed that R1 was admitted to the facility on [DATE], following hospitalization. According to the hospital discharge summary, while hospitalized , R1 was diagnosed with candida UTI [urinary tract infection]. The hospital discharge summary read in part, . Given his complaint of worsening symptoms of abdominal pain and nausea, fluconazole was initiated . Discharge Medication List: Start taking these medications: fluconazole 200 mg Tabs, Start date: 8/2/25, Take 1 tab by mouth once a day. Indications: a fungal urinary tract infection. Dispense 13 tab. According to R1's physician orders, the order for fluconazole was not transcribed on admission to the nursing facility. The order for fluconazole was entered on 8/4/25, at which time the order read, Fluconazole Oral Tablet 200 mg. Give 200 mg by mouth one time a day for fungal urinary tract infection for 10 days. On 11/12/25 at 4:10 PM, an interview was conducted with licensed practical nurse #1 (LPN #1). LPN #1 explained the process when a resident is admitted and stated, The hospital will call report, we will get the orders, and the orders are put in by the unit manager. If the medication is not available in the Pyxis [automated medication dispensing system/emergency supply of medications], we will call the pharmacy, and they will deliver it before the time it is due/scheduled. LPN #2 reported that the pharmacy delivers to the facility multiple times a day, so getting mediations is not an issue. When asked if there is any reason it would take three-four days for a medication to start, LPN #2 said, Oh no, I don't know of any reason, we have most antibiotics and other medications in the Pyxis, but it doesn't take three days, no. On 11/12/25 at 4:25 PM, during an end of day meeting with the facility administrator, assistant administrator, and director of nursing (DON), the above concerns was discussed. The DON was asked to research why R1 was delayed in receiving the fluconazole medication. The facility staff were asked to provide any policies regarding the admission process and physician orders. On 11/13/25 at 10:42 AM, the DON was asked if she had any additional information regarding R1's fluconazole medication concerns shared the day prior. The DON said, Unfortunately we looked yesterday and there was nothing. It [the order] was put in on the fourth. I talked to the unit manager, and she said when she did her chart check she had identified they [the staff] had not put the order in. We looked under discontinued medications and it wasn't there. The DON confirmed that the medication should have been started on admission as ordered to start on 8/2/25. When asked what the risks are of R1 not receiving the medication as ordered, the DON said, Because it is a kind of antibiotic for fungal, the risk is that what's there [the bacteria] is multiplying and there is a greater risk of the infection going elsewhere. According to the facility policy titled, Physician's Orders, which had an effective date of 1/29/24, it read, 1. Upon every patient's admission or readmission or re-entry to the Center, a licensed nurse will notify the physician requesting and/or verifying physician's orders. The policy went on to read, 2. Upon receiving admission physician's orders from the physician, the nurse will record the order to include: a. Orders- medication and treatment orders must include: 1. Right name of patient. 2. Right name of medication. 3. Right dosage. 4. Right route. 5. Right time. 6. Include diagnosis/reason for use. On 11/13/25 at 12:30 PM, the above findings were again reviewed with the facility Administrator, Assistant Administrator, DON, and Regional Director of Clinical Services. No additional information was provided. 2. For R5 and R6, the facility staff failed to follow physician orders and implement the use of a anchor for the feeding tube. On 11/13/25 at 8:21 AM, licensed practical nurse #2 (LPN #2) accompanied the surveyor to the room of R6, so that observations of the peg tube (percutaneous endoscopic gastrostomy tube) (tube used for delivering nutrition to patient) could be made. Observations revealed that no anchor to secure the tube was in place. When LPN #2 was questioned about the use of an anchor, LPN #2 stated that the facility only uses anchors for foley/urinary catheters. On 11/13/25 at 8:40 AM, registered nurse #1 (RN #1) accompanied the surveyor to the room of R5. Observations of R5's peg tube revealed that no anchor/securing device was in place. No other concerns were noted. On 11/13/25, a clinical record review was conducted of R5 and R6's physician orders. R5 had an active order dated 11/3/25 that read, Anchor feeding tube every shift for tx [treatment]. R5 also had a prior physician order from 6/2/25-11/2/25, that read, Anchor feeding tube every shift for tx

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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. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure a resident was free from significant medication errors affecting one resident (Resident #1- R1) in a survey sample of eight residents. The findings included:For R1, the facility staff failed to transcribe a physician's order for an antifungal medication to be given for thirteen days, which delayed the initiation of treatment for three days. On 11/12/25, a closed record review was conducted of R1's chart. This review revealed that R1 was admitted to the facility on [DATE], following hospitalization. According to the hospital discharge summary, while hospitalized , R1 was diagnosed with candida UTI [urinary tract infection]. The hospital discharge summary read in part, . Given his complaint of worsening symptoms of abdominal pain and nausea, fluconazole was initiated . Discharge Medication List: Start taking these medications: fluconazole 200 mg Tabs, Start date: 8/2/25, Take 1 tab by mouth once a day. Indications: a fungal urinary tract infection. Dispense 13 tab. According to R1's physician orders, the order for fluconazole was not transcribed on admission to the nursing facility. The order for fluconazole was not initiated until 8/4/25, at which time the order read, Fluconazole Oral Tablet 200 mg. Give 200 mg by mouth one time a day for fungal urinary tract infection for 10 days. According to the medication administration record, R1 was administered the fluconazole from 8/4/25-8/13/25. On 11/12/25 at 4:10 PM, an interview was conducted with licensed practical nurse #1 (LPN #1). LPN #1 explained the process when a resident is admitted and stated, The hospital will call report, we will get the orders, and the orders are put in by the unit manager. If the medication is not available in the Pyxis [automated medication dispensing system/emergency supply of medications], we will call the pharmacy, and they will deliver it before the time it is due/scheduled. LPN #2 reported that the pharmacy delivers to the facility multiple times a day, so getting mediations is not an issue. When asked if there is any reason it would take three-four days for a medication to start, LPN #2 said, Oh no, I don't know of any reason, we have most antibiotics and other medications in the Pyxis, but it doesn't take three days, no. On 11/12/25 at 4:25 PM, during an end of day meeting with the facility administrator, assistant administrator, and director of nursing (DON), the above concerns was discussed. The DON was asked to research why R1 was delayed in receiving the fluconazole medication. The facility staff were asked to provide any policies regarding the admission process and physician orders. On 11/13/25 at 10:42 AM, the DON was asked if she had any additional information regarding R1's fluconazole medication concerns shared the day prior. The DON said, Unfortunately we looked yesterday and there was nothing. It [the order] was put in on the fourth. I talked to the unit manager, and she said when she did her chart check she had identified they [the staff] had not put the order in. We looked under discontinued medications and it wasn't there. The DON confirmed that the medication should have been started on admission as ordered to start on 8/2/25. When asked what the risks are of R1 not receiving the medication as ordered, the DON said, Because it is a kind of antibiotic for fungal, the risk is that what's there [the bacteria] is multiplying and there is a greater risk of the infection going elsewhere. The facility staff provided a policy titled, admission Assessment with an effective date of 1/29/24. The policy did not address admission orders. According to the facility policy titled, Physician's Orders, which had an effective date of 1/29/24, it read, 1. Upon every patient's admission or readmission or re-entry to the Center, a licensed nurse will notify the physician requesting and/or verifying physician's orders. The policy went on to read, 2. Upon receiving admission physician's orders from the physician, the nurse will record the order to include: a. Orders- medication and treatment orders must include: 1. Right name of patient. 2. Right name of medication. 3. Right dosage. 4. Right route. 5. Right time. 6. Include diagnosis/reason for use. On 11/13/25 at 12:30 PM, the above findings were again reviewed with the facility Administrator, Assistant Administrator, DON, and Regional Director of Clinical Services. No additional information was provided.

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	11/13/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for three residents (Resident #5- R5, Resident #6-R6, and Resident #8-R8) in a survey sample of eight residents.The findings included:1. For R5 and R6, the facility staff signed off on a peg tube anchor device was in place that was not being utilized. On 11/13/25 at 8:21 AM, licensed practical nurse #2 (LPN #2) accompanied the surveyor to the room of R6, so that observations of the peg tube (percutaneous endoscopic gastrostomy tube) (tube used for delivering nutrition to patient) could be made. Observations revealed that no anchor to secure the tube was in place. When LPN #2 was questioned about the use of an anchor, LPN #2 stated that the facility only uses anchors for foley/urinary catheters. On 11/13/25 at 8:40 AM, registered nurse #1 (RN #1) accompanied the surveyor to the room of R5. Observations of R5's peg tube revealed that no anchor/securing device was in place. On 11/13/25, a clinical record review was conducted of R5 and R6's physician orders. R5 had an active order dated 11/3/25 that read, Anchor feeding tube every shift for tx [treatment]. R5 also had a prior physician order from 6/2/25-11/2/25, that read, Anchor feeding tube every shift for tx. According to the treatment administration record (TAR), facility staff had signed off each shift three times daily from 11/7/25-11/12/25, that the anchor device was in place. According to R6's physician orders, an order was entered 10/30/25 and remained an active order at the time of review that read, Anchor feeding tube every shift for tx. According to R6's TAR, the anchor device was signed off three times daily, at each shift for the month of November, except for first shift on 11/6/25. The review revealed that on 11/11/25 and 11/12/25, LPN #2 had signed off as the anchor device having been in place. On 11/13/25 at 10:42 AM, an interview was conducted with the director of nursing (DON). When asked about the use of anchor devices for peg tubes, the DON said, we don't use an anchor, we clean it daily and use tape to secure the gauze [gauze dressing placed between the skin and tube bumper]. The surveyor notified the DON of R5 and R6 of having orders for anchor devices to be used and observations that morning revealed they were not in place, the DON stated she would have to get with central supply about an anchor device and if they could order them. The DON stated she was not aware of the physician's order, but if an order was present, they should be following the order. On 11/13/25 at 11:15 AM, a follow-up interview was conducted with LPN #2. LPN #2 was made aware of the physician order for the anchor device for the PEG tube and was asked about her signing off the two days prior that the device was in place. LPN #2 reported that she thought she was signing off that the yankauer [plastic suction tip used to suction a patient] was present in the drawer. On 11/13/25 at 12:30 PM, the facility Administrator, Assistant Administrator, DON and Regional Director of Clinical Services were made aware of the above findings. No additional information was provided. 2. For R8, who went to dialysis at an off-site location three days a week, the facility staff failed to document when the resident left and returned to the facility and failed to include Dialysis Communication Forms into the clinical record. On 11/13/25, R8 was identified as the only resident receiving dialysis services at the facility. According to R8's clinical record, there was no documentation of when the resident left the facility or returned from scheduled dialysis treatment sessions. According to R8's physician orders, the order read, Dialysis 3x weekly [name and address of dialysis site redacted]. There was no indication of when the resident's scheduled dialysis treatments were. On 11/13/25, a review of the facility's sign out book at the nursing station revealed no documentation with regards to R8's departures for dialysis. Review of R8's dialysis book used to communicate between the nursing facility and dialysis clinic was reviewed and didn't include any details of when the resident left or returned to the facility. On 11/13/25 at 12:30 PM, during a meeting with the facility's Administrator, Assistant Administrator, Director of Nursing, and Regional Director of Clinical Services, the above concerns was discussed. The Administrator confirmed that he would expect there to be documentation within R8's clinical record of when the resident left and returned. Review of the facility policy titled, Hemodialysis with an effective date of 1/29/24, was conducted. The policy read in part, . 1. The Dialysis Communication Form will be initiated prior to sending patient for dialysis. A dialysis center's designated form may be used in place of the center's Dialysis Communication Form. 2. Patient reports received from dialysis center will be uploaded to the medical record. A follow-up review of R8's clinical record revealed that no Dialysis Communication Forms had been uploaded into the clinical record for the month of November. No additional information was provided.

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	495121	A. Building B. Wing	11/13/2025

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to implement transmission-based precautions to prevent the spread of infections on two of four nursing units, fourth and fifth floors. The findings included:On 11/13/25 at 8:21 AM, licensed practical nurse #2 (LPN #2) was accompanying the surveyor to Resident #6's (R6) room for an observation. While LPN #2 were outside of the room donning necessary personal protective equipment, since the resident was on enhanced barrier precautions, it was observed that two staff members were in the room at the bedside assisting the resident and were only wearing procedure masks and gloves. When the surveyor questioned LPN #2 about the staff in the room, LPN #2 confirmed that they were to have an isolation gown on as well and she called the staff members to the doorway to discuss this. The two staff were identified as licensed practical nursing students. Interviews were conducted with the staff/students, and they reported they had been told last week if there was a yellow sign (pointing to the signage outside the room that was on yellow paper and noted enhanced barrier precautions), they only had to wear a mask. The surveyor asked if they read the sign because it indicated that a mask, gloves and isolation gown were to be worn, neither responded. On 11/13/25, during a clinical record review of R6's chart, it was noted that an active physician order read, Enhanced Barrier Precautions related to g-tube and tracheostomy tube. On 11/13/25 at 8:46 AM, observations were made of a certified nursing assistant #2 (CNA #2) in the room with Resident #9 (R9), the staff member was only wearing gloves and a procedure mask and was at the bedside adjusting the bedlinen. According to the signage outside of R9's room, it indicated the resident was on contact isolation and gloves, mask, and isolation gowns were required prior to entering the room. Observations of the supply bin outside of R9's room revealed an adequate supply of isolation gowns were available. When CNA #2 was exiting the room, they were noted to be carrying two bags, one that had soiled linen and the other with trash. CNA #2 was interviewed and reported he had pulled R9 up in the bed. When asked about the lack of an isolation gown, CNA #2 stated he had not seen the sign. CNA #2 proceeded to exit the room, had not removed the isolation gown or gloves and went to a soiled utility room to discard the bags. On 11/13/25, during a clinical record review of R9's chart, it was noted that the resident had an active physician order that read, Contact precaution r/t [related to] ESBL [extended spectrum beta-lactamase] [a bacteria] in urine. On 11/13/25 at 8:50 AM, while observations were being conducted of medication administration on the fifth floor, two nurses were noted to be working on a medication cart. Licensed practical nurse #3 (LPN #3) was observed removing medications from their package, putting them into the palm of her hand and then placing them into a medication cup. An interview was conducted with LPN #3 and she confirmed she should not be touching medications with her bare hands. On 11/13/25 at 9 AM, a staff member was observed to exit Resident #10's room, wearing a procedure mask, gloves, and isolation gown. The staff member started going through items in the cart with her gloved hands and removing various items from a supply cart in the hallway, while wearing the personal protective equipment (PPE). The employee then re-entered the resident's room. Prior to exiting the room, the employee doffed the PPE and performed handwashing. Upon the employee's exit from the room, an interview was conducted. The employee identified themself as a respiratory therapist (RT). When asked about wearing the PPE into the hall and accessing the supply cart with her gloved hands and then returning to the room, the RT explained that she had gone into the room to retrieve supplies and returned to get them and I didn't touch anything. I work in a hospital and understand infection control. On 11/13/25 at 9:15 AM, during walk-through observations were made on the fourth-floor resident care unit. A nurse was observed in the hallway at a medication cart, the nurse donned gloves and administered eye drops to a resident in the hallway. The nurse then removed her gloves, performed no hand hygiene and began using the computer and then handled medication cards that were on top of the medication cart and returned the medication cards to a drawer within the cart. Upon closing the drawer, the nurse then used hand sanitizer. On 11/13/25 an interview was conducted with LPN #3. LPN #3 explained that PPE is important to protect yourself and also protect the patient whose immune system has been compromised, and we don't want to spread infection around. On 11/13/25 at 10:42 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked to explain the use of PPE with enhance barrier precautions and contact isolation. The DON said, on contact-based precautions you have to put on gloves, mask, and gown up before entering the room. She explained with enhanced barrier precautions, If you provide care you have to wear a gown. When asked if changing bed linen would require use of an isolation gown, the DON said, yes