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	04/24/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40902 Based on observation, interview, and policy review, the facility failed to ensure a resident's rights (R90) were honored during dining and that staff provided a homelike dining experience during meals affecting many residents on 1 of 4 units. Findings include: Observations on 04/22/25, at 12:45 PM, revealed 15 residents were seated in the dining room during lunch and on 04/21/25 at 5:43 PM there were 19 residents seated in the dining room for dinner. All residents were served on trays. Staff did not remove resident's plates, silverware or cups and place them on the dining table. Observation on 4/22/25 at 12:46 PM, R90 was seated at a dining room table. Certified Nurse Aide (CNA)7 placed the resident's tray down and while still standing next to the resident stated, She's a feeder. During an interview on 04/21/25 04:58 PM, CNA 4 said that they serve meals on the trays because it has always been done that way. She said they always leave the trays on the table with the resident's food on the tray because it was probably cleaner than the table. During an interview on 04/22/25 at 12:50 PM, CNA7 said they have always left the trays on the table when they serve meals, and they have never been told to take the plates, cups, and silverware off of the tray. She also said that saying feeder was an inappropriate term and she should not have called the resident that right in front of her. During an interview on 04/24/25 at 7:53 AM, the Director of Nursing (DON) said staff should place the food on the tray, take the tray to the table, remove everything from tray and place the plates, cups and silverware in front of the resident. The DON said that staff should allow the residents to eat a meal in a way they don't feel like they were in a cafeteria and that it was a homelike environment. He also stated that staff should never use the word feeder because that word was inappropriate, and all staff know that. When questioned about the use of the term feeder, the DON said that staff should say . the resident required assistance with feeding. Review of the facility's policy titled Meal Delivery dated 01/29/24 revealed that meal items will be removed from trays in group dining areas, to the extent possible. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided prior to survey exit.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 28106 Based on record review and staff interview, the facility staff failed to ensure the resident was afforded the right to participate in the treatment plan for one of 46 residents. Resident #27 was not afforded the opportunity to participate in care planning and treatment. The findings include: Review of R27's clinical record did not evidence R27 had been given the opportunity to be involved in ongoing treatment/care planning. Diagnoses for R27 were documented to include: Dementia with behavioral disturbance, diabetes, depression, anxiety, and chronic kidney disease. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 02/23/2025, in which R27 was assessed with a cognitive score of 15 out of 15, indicating cognitively intact. On 4/23/25 at 9:00 a.m. the social worker (other staff, OS #2) was interviewed and asked to present evidence to show that R27 was invited to participate in care. OS #2 verbalized the information is usually kept in the clinical record and would review the record to find the information. On 4/23/25 at 11:27 a.m. the director of social services (OS #1) was interviewed regarding R27's participation for care and treatment. OS #1 said that usually residents are invited to care plan meetings to participate in their care and should be done on admission, quarterly, annually, and upon a significant change in status. OS #1 verbalized that she was unable to find the needed documentation. R27 was not interviewed during the time of the survey due to being on leave with family. On 4/23/25 at 4:47 p.m. the above finding was presented to the administrator and director of nursing. No other information was presented prior to exit conference on 4/24/25.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview, and clinical record review, the facility staff failed to honor a preference for twice weekly showers for one of thirty-nine residents in the survey sample (Resident #187). The findings include: According to the clinical record, Resident #187 (R187) was admitted to the facility with diagnoses that included femur fracture, osteoarthritis, chronic kidney disease, irritable bowel syndrome, gastroesophageal reflux disease, osteoporosis, anxiety and depression. The minimum data set (MDS) dated [DATE] assessed R187 as cognitively intact. On 4/21/25 at 5:08 p.m., R187 was interviewed about quality of life/care in the facility. R187 stated most weeks, she was getting only one shower per week. R187 stated that she wanted showers twice a week and was aware there was a state requirement for residents to get at least two showers per week. R187's clinical record documented the resident was scheduled for weekly showers on Tuesday and Friday. R187's record documented a shower was given on 4/8/25 and the next shower was not given until 4/18/25. Showers scheduled for 4/11/25 and 4/15/25 were not given. On 4/23/25 at 2:55 p.m., the certified nurses' aide (CNA #6) caring for R187 was interviewed about the resident's showers. CNA #6 stated that she did not know why the resident missed showers on 4/11/25 and 4/15/25. On 4/23/25 at 3:01 p.m., the registered nurse unit manager (RN #3) was interviewed about R187's missed showers. RN #3 reviewed the shower sheets and found no documentation of showers on 4/11/15 and 4/15/25. RN #3 stated residents were supposed to get showers twice per week unless they preferred only bed baths. RN #3 stated she was not sure why the showers were not provided as scheduled. R187's plan of care (revised 4/21/25) documented that the resident required assistance with activities of daily living due to recent fracture and weakness following hospitalization . This finding was reviewed with the administrator, director of nursing, and regional nurse consultants during a meeting on 4/23/25 at 4:45 p.m., with no further information provided prior to the end of the survey.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52322 Based on facility policy review, record review, and interview, the facility failed to obtain food preferences upon admission for one of one residents (R175) in the sample of 46 residents, causing R175 not to have his preferences provided and honored. Failure to provide resident's food preference has the potential to result in weight loss. Findings include: Review of the facility's policy titled Dining and Food Preferences dated October 2019 revealed, .The Dining Service 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 . Review of the Face Sheet found in the electronic medical record (EMR) revealed R175 was admitted to the facility on [DATE] with a diagnosis of Guillian-Barre Syndrome. Review of the Physician Orders found under the order tab in the EMR dated 02/12/25 revealed .Regular diet, Regular texture, Thin Liquids consistency Large Portions . Review of the Care Plan found under the care plan tab dated 02/12/25 revealed .the resident is at risk for weight loss or malnutrition and dehydration related to chronic disease, receiving therapeutic diet to promote wt. [weight] maintenance . Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/14/25, revealed R175 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating no cognitive impairment. Further review revealed R175 required partial to moderate assistance during meals. During an interview on 04/21/25 at 4:35 PM, R175 stated he thought he had lost some weight because the food was not to his liking, and he could not eat it. During an interview on 04/23/25 at 11:50 AM, the Registered Dietician (RD) stated, He (R175) does not have any preferences in place. Usually nursing reaches out to me. I haven't heard anything from them. No additional information was provided prior to survey exit.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 28106 Based on resident interview, staff interview, clinical record review, and facility document review, the facility failed to ensure reasonable care for the protection of personal property for one of forty-six residents, Resident #137 (R137). R137 did not have a personal property invoice completed upon admission. The Findings Include: Clinical record review revealed that diagnoses for R137 included acute respiratory failure, diabetes, urine retention, chronic pain, and obstructive uropathy. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/2/2025, which assessed R137 with a cognitive score of 12 out of 15, indicating cognitively intact. On 4/21/25 at 4:39 PM, an interview with R137 was conducted. R137 verbalized that he had been missing a pair of ear pods and felt that they had been taken by staff about 6 months prior. R137 explained that he did report the concern but could not remember who he reported it to. When asked if the facility staff had filled out an inventory list upon admission, R137 verbalized no one had ever filled out a inventory list. Review of R137's clinical record did not evidence an inventory form had been filled out. On 4/23/25 at 10:00 a.m., license practical nurse (LPN #5) was interviewed regarding resident's inventory list. LPN #5 explained when a resident is admitted an inventory form is filled out and and placed into a log book, which is kept at the nurses station so that the list can be added to if needed. The inventory log book was then reviewed with LPN #5 and the inventory list for R137 could not be found. LPN #5 verbalized it could have been misplaced, but should be kept in the log book. On 4/23/25 at 1:21 p.m., the director of clinical services (administrative staff, AS #4) was interviewed regarding care and protection of personal belongings. AS #4 verbalized a belongings list is created upon admission. Also present was a nurse consultant, who reviewed the medical record and the personal belonging logs, but was unable to locate a personal belonging list for R137. The facilities policy titled Personal belongings read, in part, 3. Compete a Resident Property List after advising the patient to send his/her valuables and money home . On 4/23/25 at 4:47 p.m., during an end of day staff meeting, the director of nursing (DON) and administrator were made aware of the above finding. No other information was provided prior to exit conference on 4/24/25.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 25232 Based on interview, document review and review of facility policy, the facility failed to implement their abuse policy in notifying the Department of Health Professions (DHP) after receiving an allegation of sexual abuse against Registered Nurse (RN) 2, involving one resident (Resident (R)50) reviewed for abuse, out of a sample of 46 residents. Findings include: Review of the facility's policy titled, Abuse/Neglect/Misappropriation/Crime dated 02/05/23 indicated, Procedure .b. Notify within 24 hours the DHP for incidences involving nurse aides, RNs, Licensed Practical Nurses (LPN's), Physicians, or other licensed or certified by DHP Review of the facility's event synopsis indicated, R50 reported that, on or about Saturday, 12/14/24, the wound nurse [RN2] came to her room to assess her wound on her peri-area and provide treatment. R50 states while he [RN2] was applying wound cream, he [RN2] began rubbing her vagina to a point where she stated it was excessive and told him [RN2] to stop several times prior to blocking him [RN2] with her hands and stopping him [RN2]. R50 denies penetration. Skin assessment is in progress. Psych and Social Services referral initiated, [name of the county police redacted] police department notified. Physician notified. Interview on 04/24/25 at 11:00 AM, the [NAME] Present (VP) of Operations confirmed that the allegation against RN2 was not reported to the DHP and should have been per facility policy. No additional information was provided prior to survey exit.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on record review, interviews, and facility policy review, the facility failed to provide evidence that actual and potential allegations of abuse/neglect were thoroughly investigated for two residents (Resident 50, Resident 128), of 46 sampled residents. Findings include: 1. For Resident 50 (R50), facility failed to ensure an allegation of sexual abuse was thoroughly investigated. Review of facility's policy titled, Abuse/Neglect/Misappropriation/Crime dated 02/05/23 indicated, .The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations. Review of Admission Record located under the Profile tab in the Electronic Medical Record (EMR) indicated R50 was admitted to the facility on [DATE]. Review of R50's quarterly Minimum Data Set (MDS) with Assessment Referent Date (ARD) of 02/22/25 indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact, was able to make herself understood, and understood others. During an interview on 04/21/25 at 5:05 PM, R50 said that the wound nurse (Registered Nurse (RN2) was starting to massage cream on her inner thighs with his hands and once he reached her vagina, the pressure increased. R50 said that his massaging had started to evoke sexual stimulation to the area, and she found herself aroused. R50 said that she asked him a few times to stop, but he ignored the requests until R50 put her hands in front of her vagina. R50 stated this happened on 12/14/24 and that it was not until sometime in February 2025 that she told the facility's Director of Nursing (DON). When asked why she waited to report the incident, R50 stated that she had been embarrassed. Review of the facility's synopsis indicated, R50 reported that on or about Saturday, 12/14/24, the wound nurse [RN2] came to her room to assess her wound on her peri-area and provide treatment. R50 states while he was applying wound cream, he began rubbing her vagina to a point where she stated it was excessive and told him to stop several times prior to blocking him with her hands and stopping him. R50 denies penetration. Skin assessment is in progress. Psych and Social Services referral initiated, [name of the county polic redacted] police department notified. Physician notified. Review of the facility's Final Report, dated 2/25/25, revealed, On 02/18/25 [name of the police officer redacted] interviewed R50. The previous Wound Nurse [RN2]'s contact information was requested and provided to the officer. A skin assessment was completed with no new injuries or bruising noted on the resident . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This report indicated that RN2's last day worked was 01/14/25. This report also indicated that all alert and oriented residents who received care from the wound nurse who were still at the facility were interviewed for abuse including inappropriate touching, with all residents having denied abuse. There was no documented evidence that the facility interviewed with staff, including the alleged perpetrator (RN2). During an interview on 04/24/25 at 9:24 AM, the DON confirmed, after reviewing the investigative file, there were no staff interviews and there was no evidence of an attempt to contact/interview the alleged perpetrator (RN2). During an interview on 04/24/25 at 10:20 AM, the [NAME] President (VP) of Operations, who was communicating with the Administrator via text, confirmed that there was no interview with RN2. The VP indicated that the Administrator said that he completed an interview with Nurse Practitioner/Other Staff but did not document those interviews. No additional information was provided prior to survey exit. 47067 2. For Resident 128 (R128), the facility failed to conduct a thorough fall investigation to rule out abuse/neglect. Review of R128's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included hemiplegia & hemiparalysis, muscle weakness, and cognitive communication deficit. Review of R128's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/28/25 and located in the resident's EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. Further review revealed that his primary language was Spanish. Review of R128's Care Plan dated 03/01/24 and located in the EMR under the Care Plan tab revealed R128 was at risk for complications related to impairment of communication and potential for poor health literacy secondary to primary language in not English, resident is Spanish speaking. Interventions in place were to assist in using translate apps as available or requested to communicate needs and involve resident's representative to translate. The care pan also identified R128 was at risk for falls and included the fall intervention of bed in low position. Review of R128's Nurse's Note dated 04/29/24 and located in the EMR under the "Notes" tab written by Licensed Practical Nurse (LPN) 2 revealed, resident rolled over and fell during personal care by assigned Certified Nurse Aide (CNA) 5, resident assessed with abrasion noted to left second toe. Further review revealed risk factor that contributed to fall was noncompliance, and new intervention placed was education for noncompliance. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R128's the facility synopsis dated 04/28/24, which was completed by LPN2 revealed, assigned CNA called resident to room at 10:30 AM and resident found sitting on the floor, denies pain, CNA stated resident rolled out of bed while supporting him with care. Further review revealed statement by CNA5, which read I was supporting resident with personal care, and he rolled over the bed. As CNA5 no longer worked at the facility, surveyor attempts at contact resulted in no response. During an interview on 04/23/25 at 9:09 AM, LPN2 stated that R128 was a high fall risk, was able to understand English and respond appropriately. LPN2 stated he was unaware of R128's fall intervention for a low bed. LPN2 stated that on 04/29/24 a CNA (unsure who) reported that R128 fell out of the bed during care, but he was unsure of what specifically happened. He said he thought R128 was not listening, but he was unsure if there was an interpreter present, or if there was any issue with R128 not understanding the instructions given by the CNA during care. LPN2 stated that he did not witness the incident. During an interview on 04/23/25 at 4:21 PM, R128 was observed seated in the wheelchair beside his bed and the bed was in a low position. R128 said, They did this [indicating the low bed position] today but before it was and raised his hand up high by his head level. During an interview on 04/24/25 at 7:57 AM, the Director of Nursing (DON) said if an intervention was care planned that he expected staff to follow those interventions every time. The Director of Nursing (DON) stated he expected staff to try and identify root cause of falls especially during care with staff. The DON stated after reading the incident report he did not feel there was sufficient documentation to explain what happened. He stated staff should have asked a lot more questions to figure out what occurred. The DON stated that he also expected that appropriate interventions be put in place after a fall and that staff would provide an interpreter for residents who have language barriers. Review of the facility's policy titled Falls Management Program dated 01/29/24 revealed that Complete the Post-Fall investigation to determine, to the extent possible, the cause of patient fall. Using the post-fall investigation, a licensed nurse will: investigate the fall, and record findings surrounding the fall. A licensed nurse will review, revise, and implement interventions to the care plan based on: Post Fall investigation findings, Review of Device Assessment, and Review of Fall Risk Scoring Tool. No additional information was provided prior to survey exit.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview and review of the Resident Assessment Instrument (RAI), the facility failed to ensure that a comprehensive MDS assessment was completed accurately for one resident (R41) in the sample of 46 residents. Findings include: Review of R41's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed re-admission to the facility on [DATE]. Review of R41's admission Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 02/19/25, revealed the Brief Interview for Mental Status (BIMS) revealed a score of 14 out of 15, which indicated no cognitive impairment. Further review revealed that the nutrition section of this MDS did not indicate any weight loss. Review of R41's Progress Note, dated 01/09/25, written by the registered dietician (RD), revealed weight loss of -5.0% change over 30 days, -7.5% change over 90 days, and -10.0% change over 180 days, which constituted a significant weight loss. Review of R41's Progress Note, dated 02/11/25, written by the RD revealed weight loss of -5.0% change over 30 days, -7.5% change over 90 days, and -10.0% change over 180 days, which also constituted a significant weight loss. During an interview on 04/24/25 at 7:57 AM, the Minimum Data Set (MDS) coordinator stated that they get weight change information through morning meetings which were also their weekly risk meetings. The MDS coordinator stated that she also reads the 24-hour report daily and physician orders. When presented with the above findings, MDS coordinator stated that R41 had had a significant weight loss, that she had been unaware of the significant weight loss, and that it should have been indicated on the MDS assessment with the ARD of 02/19/25. During an interview on 04/24/25 at 8:18 AM the Director of Nursing (DON) said he expected staff to be knowledgeable of the MDS process and would expect staff to complete assessments correctly. Review of the RAI Manual dated 10/01/19 indicated, . It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set [MDS] items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment No additional information was provided prior to survey exit.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review and staff interview, the facility failed to ensure that an accurate Preadmission Screening and Resident Review (PASARR) Level I assessment was completed after admission for one (Resident (R)40) out of 46 sampled residents. Findings include: Review of R40's Admission Record located in the Resident Information tab of the electronic medical record (EMR), revealed R40 was readmitted to the facility on [DATE] with diagnoses including bipolar and major depressive disorder. Review of R40's EMR and hard chart revealed no PASARR level I. During an interview on 04/23/25 at 12:47 PM the Director of Social Services (SSD) revealed she had not identified that R40 never had a PASARR Level 1 completed on admission but should have. During an interview on 04/23/25 at 1:05 PM the Administrator stated that R40 did not have a PASARR Level 1 completed at time of admission to the facility. During an interview on 04/24/25 at 8:20 AM the Director of Nursing (DON) stated when a resident was admitted he expected that the admissions director to have identified when a resident did not have a PASARR completed. If they did not have the PASARR Level 1, staff should have notified the management team one should have been completed. No additional information was provided prior to survey exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 52322 Based on observation, record review and interviews, the facility failed to develop and implement a care plan for two of two residents (Resident (R) 128 and R175), in the sample of 46 residents. Findings include: 1. For R175, the facility failed to develop and implement a person-centered comprehensive care plan that included his food preferences. Review of the Face Sheet found in the electronic medical record (EMR) revealed R175 was admitted to the facility on [DATE] with a diagnosis of Guillian-Barre Syndrome. Review of R175's Physician Orders found under the order tab in the EMR dated 02/12/25 revealed, .Regular diet, Regular texture, Thin Liquids consistency Large Portions . Review of R175's Care Plan found under the care plan tab dated 02/12/25 revealed, .the resident is at risk for weight loss or malnutrition and dehydration related to chronic disease, receiving therapeutic diet to promote wt. [weight] maintenance . The care plan did not address food preferences. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 03/14/25 revealed R175 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating no cognitive impairment. During an interview on 04/21/25 at 4:35 PM, R175 stated he thought he had lost some weight because the food was not to his liking, and he could not eat it. During an interview on 04/23/25 at 11:10 AM, the Registered Dietician (RD) confirmed that dietary did not implement the goal of reviewing dietary preferences with R175 as needed. The RD confirmed that R175's Care Plan had not been developed to include resident's food preferences. 2. For R128, the facility failed to implement the intervention care planned to reduce fall risks. Review of R128's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included hemiplegia & hemiparalysis, muscle weakness, and cognitive communication deficit. Review of R128's quarterly MDS with an ARD of 02/28/25 and located in the EMR under the MDS tab revealed a BIMS score of three out of 15, which indicated the resident was severely cognitively impaired. Review of R128's Care Plan dated 11/05/24 and located in the EMR under the Care Plan revealed the resident was at risk for falls and intervention in place was bed in low position. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/21/25 at 3:36 PM and 04/22/25 at 2:20 PM, revealed R128 was sitting in bed, however, the bed was not in a low position. During an interview on 04/23/25 at 9:09 AM, LPN 2 stated R128's bed was not in a low position, which he had been asked to observe. LPN2 stated that R128 was a high fall risk, was able to understand English and respond appropriately. LPN2 stated he was unaware of R128's fall intervention for a low bed. During an interview on 04/23/25 at 4:21 PM, R128 was observed seated in the wheelchair beside his bed and the bed was in a low position. R128 said, They did this today but before it was and raised his hand up high by his head level. During an interview on 04/24/25 at 7:57 AM, the Director of Nursing (DON) said if an intervention was care planned that he expected staff to follow those interventions every time. No additional information was provided prior to survey exit.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52322 Based on facility policy review, record review, and interview, the facility failed to completely fill out a Durable Do Not Resuscitate form for one of one resident (R)185) in the sample of 46 residents which could cause the R185 to receive unnecessary treatment. Findings include: Review of the facility's policy titled, Do Not Resuscitate (DNR) dated [DATE] revealed .If the DNR is not intact or has been altered, or has not been filled out completely, it is not considered valid for withholding CPR [cardiopulmonary resuscitation] . Review of the Face Sheet found in the electronic medical record (EMR) under the Profile tab revealed R185 was admitted to the facility on [DATE] with a diagnosis of Spinal Stenosis. Review of the Durable Do Not Resuscitate Order found under the miscellaneous tab dated [DATE] revealed R185 signed the form, and the physician signed the form, but the form was not marked that the resident was capable of carrying out the decision. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated [DATE] revealed R185 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated no cognitive impairment. Review of the Care Plan found in the care plan tab in the EMR dated [DATE] revealed .The resident has an advance directive of Do Not Resuscitate Order The resident will be informed of the advance directive choices available thru review period. The residents will have their advanced directive wishes honored through the review period. Honor Residents Advance Directive Choices. Referral to physician as needed for advanced directive changes . During an interview on [DATE] at 1:04 PM, Director of Nursing (DON) confirmed the form was not fully filled out. The DON stated, .an individual would be treated as a full code since the form is not filled out properly.

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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. 21875 Based on observation, staff interview and clinical record review, the facility staff failed to follow physician orders for one of thirty-nine residents in the survey sample (Resident #103). The findings include: A nurse administered a 50 mg (milligram) dose of the medication Lyrica to Resident #103 when the physician ordered a 25 mg dose. On 4/22/25 at 8:04 a.m., a medication pass observation was conducted with licensed practical nurse (LPN #5), who was administering medications to Resident #103 (R103). Included in medications administered to R103 was one capsule of Lyrica 50 mg (milligrams). R103's clinical record documented a physician's order dated 4/18/25 for Lyrica 25 mg, with instructions to give one capsule per day for 30 days for treatment of myalgia. The clinical record included no current order for Lyrica 50 mg. On 4/22/25 at 9:01 a.m., LPN #5 was interviewed about the administered dose of Lyrica 50 mg, when the order required a 25 mg dose. LPN #5 reviewed the clinical record and stated that R103's Lyrica order was changed on 4/18/25 from a 50 mg per day to 25 mg per day dose. LPN #5 reviewed the pharmacy supply cards for R103, which revealed R103's medication supply included a card for the Lyrica 50 mg and another card with recently prescribed Lyrica 25 mg capsules. LPN #5 stated, I pulled the wrong card. LPN #5 stated that she should have given the 25 mg dose but instead used the 50 mg supply card from the previous order. This finding was reviewed with the administrator, director of nursing and regional nurse consultants, during a meeting on 4/23/25 at 4:45 p.m., with no further information provided prior to the end of the survey.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on observations, interview, record review, and facility documentation, the facility failed to ensure the environment was free of accident hazards, failed to implement fall intervention as care planned, and failed to conduct thorough investigation to identify post-fall causal factors for one resident (Resident 128 -R128) in the sample of 46 residents. Findings include: Review of R128's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included hemiplegia & hemiparalysis, muscle weakness, and cognitive communication deficit. Review of R128's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/28/25 and located in the resident's EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. Further review revealed that his primary language was Spanish. Review of R128's Care Plan dated 03/01/24 and located in the EMR under the Care Plan tab revealed R128 was at risk for complications related to impairment of communication and potential for poor health literacy secondary to primary language in not English, resident is Spanish speaking. Interventions in place were to assist in using translate apps as available or requested to communicate needs and involve resident's representative to translate. The care pan also identified R128 was at risk for falls and included the fall intervention of bed in low position. Review of R128's Nurse's Note dated 04/29/24 and located in the EMR under the "Notes" tab written by Licensed Practical Nurse (LPN) 2 revealed, resident rolled over and fell during personal care by assigned Certified Nurse Aide (CNA) 5, resident assessed with abrasion noted to left second toe. Further review revealed risk factor that contributed to fall was noncompliance, and new intervention placed was education for noncompliance. Review of R128's the facility synopsis dated 04/28/24, which was completed by LPN2 revealed, assigned CNA called resident to room at 10:30 AM and resident found sitting on the floor, denies pain, CNA stated resident rolled out of bed while supporting him with care. Further review revealed statement by CNA5, which read I was supporting resident with personal care, and he rolled over the bed. As CNA5 no longer worked at the facility, attempts at contact resulted in no response. Observation on 04/21/25 at 3:36 PM and 04/22/25 at 2:20 PM, revealed R128 was sitting in bed, however, the bed was not in a low position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/25 at 9:09 AM, LPN 2 stated R128's bed was not in a low position, which he had been asked to observe. LPN2 stated that R128 was a high fall risk, was able to understand English and respond appropriately. LPN2 stated he was unaware of R128's fall intervention for a low bed. LPN2 stated that on 04/29/24 a CNA (unsure who) reported that R128 fell out of the bed during care, but he was unsure of what specifically happened. He said he thought R128 was not listening, but he was unsure if there was an interpreter present, or if there was any issue with R128 not understanding the instructions given by the CNA during care. He stated that he did not witness the incident. During an interview on 04/23/25 at 4:21 PM, R128 was observed seated in the wheelchair beside his bed and the bed was in a low position. R128 said, They did this [indicating the low bed position] today but before it was and raised his hand up high by his head level. During an interview on 04/24/25 at 7:57 AM, the Director of Nursing (DON) said if an intervention was care planned that he expected staff to follow those interventions every time. The Director of Nursing (DON) stated he expected staff to try and identify root cause of falls especially during care with staff. The DON stated after reading the incident report he did not feel there was sufficient documentation to explain what happened. He stated staff should have asked a lot more questions to figure out what occurred. The DON stated that he also expected that appropriate interventions be put in place after a fall and that staff would provide an interpreter for residents who have language barriers. Review of the facility's policy titled Falls Management Program dated 01/29/24 revealed that Complete the Post-Fall investigation to determine, to the extent possible, the cause of patient fall. Using the post-fall investigation, a licensed nurse will: investigate the fall, and record findings surrounding the fall. A licensed nurse will review, revise, and implement interventions to the care plan based on: Post Fall investigation findings, Review of Device Assessment, and Review of Fall Risk Scoring Tool. No additional information was provided prior to survey exit.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 20413 Based on observation, interviews, and policy review, the facility failed to provide a qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional with appropriate competencies and skills ensures palatable, therapeutic meals are provided to meet the residents' needs and preferences and carries out the functions of the food and nutrition service for all residents at the facility. Findings include: 1. During observation of food preparation on 04/22/25 at 10:24AM, there was no qualified dietitian or other clinically qualified nutrition professional present. Interview with the Head [NAME] on 04/22/25 at 10:25AM, she stated that the qualified nutrition professional quit about three weeks ago. The Registered Dietitian (RD) from the sister facility has been helping a couple times a week. During the interview 04/22/2025 at 11:20AM, the RD from sister facility stated there was no clinically qualified nutrition professional at this facility. It's been about three weeks since the last one was here. During the interview 04/23/2025 at 11:00AM, the Corporate Registered Dietitian (OS4) stated the facility did not have a clinically qualified nutrition professional. OS4 stated, It's been about three weeks since the last one was here. The RD from another facility started coming to this facility two times per week to help out. 2. The facility failed to ensure food was palatable for residents who attended the resident council meetings and complained that the food was not served at palatable temperatures because the food was cold. (Refer to F804) 3. The facility failed to ensure the facility maintained and practiced food service by offering each resident drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. (Refer to F807) 4. The facility failed to date, label, and/or cover bread products stored in the kitchen, which had the potential to create an environment for food-borne illnesses. (Refer to F812)

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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. 20413 Based on observation and interview, the facility failed to ensure food was served at proper and appetizing temperatures for seven (Resident (R) 32, R35, R49, R66, R86, R89 and R154) out of 46 sampled residents, increasing the risk for altered nutritional status. Findings include: During the resident council meeting on 04/23/25 at 1:30PM, R32, R35, R49, R66, R86, R89 and R154 complained that the food they receive at their meals was served cold. On 04/21/25 at 3:35PM, a policy for food palatability was requested from the Registered Dietician (RD), who was from the sister facility. The RD stated that there was no policy regarding palatability. The RD explained that there were some issues from different residents about the food not being served hot. When questioned, the RD stated that she had not done a test tray at this facility to determine whether the food that was served to the residents was served hot. When questioned further, the RD stated that she had not implemented any interventions to address the complaints about the food being cold. On 04/23/25 from 12:30 PM to 12:35 PM, food temperatures were taken of food on the steam tablet in the presence of two Corporate Registered Dietitians,0S4 and OS5. Test trays were taken from second floor satellite kitchen, and temperatures were recorded as follows: Regular turkey meatloaf - 150 degrees Fahrenheit (F) Mashed Potatoes - 145 degrees F [NAME] Gravy - 146 degrees F Corn - 158 degrees F On 04/23/25 at. 2:05 PM, the test tray arrived at the unit and when it was the last tray remaining, temperatures were taken by OS4 and recorded as follows: Regular turkey meatloaf - 104 degrees F Mashed Potatoes - 104 degrees F [NAME] Gravy - 104 degrees F Corn - 103 degrees F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	From the test tray, the meatloaf, mashed potatoes with gravy and corn with butter were tasted and found to be cold. Both OS4 and OS5 agreed that the meatloaf, mashed potatoes with gravy and corn with butter tasted cold. OS4 stated that it was too long of a period of time between when food was being served to the residents. Neither the OS4 or the OS5 offered any explanation as to why the food had taken so long to arrive on the unit. No additional information was provided prior to survey exit.

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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. 20413 Based on observations, interviews, and facility documentation, the facility failed to provide drinks at meals that were consistent with the residents' preferences and meal slips for 12 of 46 residents. Findings include: On 04/22/25 at 12:35PM, the lunch meal was observed in the main dining room on Unit 2. It was observed that twelve residents did not receive their milk with their lunch. Review of all 12 residents' meal slips showed that milk should have been included with their meals. A review of the lunch menu noted that milk was to be served for all diets. Upon interview on 04/22/25 at 12:40PM, Resident (R) 89, R66, and R86, all stated that milk had not been provided or offered to them. R89, R66 and R86 stated that meals had been served in the past that did not include milk. Review of the meal slips for R89, R66 and R86 showed that six ounces of milk should have been provided. During the lunch observation on Unit 2 on 04/23/25 about 12:30PM, it was again observed that there were 12 residents who were served their lunch meal without milk, which was confirmed by a corporate registered dietician (OS4), who also was present. OS4 directed the Head Cook, who was serving food, to make sure that the 12 residents received their milk, as noted on their meal slips. OS4 also directed that the residents who were eating in their rooms be served milk with their lunch meal. During an interview on O4/23/2025 at 1:30PM, OS4 stated that she did not realize that 12 residents on Unit 2 were not receiving milk with their meals, along with residents who were served their meals in their rooms. OS4 stated that there was no reason the residents were not served their milk, as it was available, and listed on both the lunch menu and the residents' meal slips. No additional information was provided prior to survey exit. 28106 Based on observation, resident interview, and staff interview, the facility staff failed to provide drink preferences for one of 46 residents. Resident # 80 (R80) was not provided milk as indicated on the meal ticket. The findings include: According to the clinical record, diagnoses for R80 included difficulty walking, dialysis, diabetes, chronic kidney failure, and peripheral vascular disease. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/29/2025, which assessed R80 with a cognitive score of 15 out of 15, indicating cognitively intact. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on 4/21/25 at 3:53 p.m., R80 verbalized concerns regarding food preferences, that what shows on the meal ticket is not always what is on the tray, and some things are missing. On 4/21/25 at 5:45 p.m., R80's meal tray was observed and was compared with the meal ticket. The meal ticket indicated 2% milk to be an item on the meal tray but was missing from the meal. When asked about the milk, R80 verbalized he didn't drink milk all the time, but would like to have the option, as it is listed on the meal ticket. The meal serving line was observed at this time and evidenced milk was available for distribution. On 4/22/25 at 1:16 p.m., the lunch meal for R80 was observed and again did not have 2% milk on the tray, as listed on the meal ticket. At this time, license practical nurse (LPN #4) was asked to verify R80's meal with the meal ticket. LPN reviewed the ticket and verbalized that R80 should have received milk on the tray. LPN #4 then went to the dining room and retrieved a milk for R80. On 4/23/25 at 4:47 p.m., the above findings were presented to the administrator and director of nursing. No other information was presented prior to exit conference on 4/24/25.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 20413 Based on observation, interview, and facility policy review, the facility failed to date, label, and/or store food products safely to decrease the risk of food borne illness, potentially affecting 185 of 189 residents who consume food prepared from the facility's kitchen. Findings include: Review of the facility's policy titled, Storage Areas dated [DATE] indicated, It is the intent of this center to store food in a manner that maintains quality and safety. First in first out should be followed with Refrigerator Food codes and internal tools may be used as a reference for proper dating. Observation on [DATE] from 02:30 PM to 03:15 PM, during the initial kitchen inspection with the Registered Dietitian (RD), from a sister facility, revealed dinner rolls and crescent rolls being stored in the main refrigerator. The kitchen's bread storage racks revealed dinner rolls in an open plastic bag inside a cardboard box, exposed to air, unlabeled, and undated. The crescent rolls were wrapped in plastic wrap but were undated and unlabeled. In the kitchen's dry goods storage room, it was observed that Perfect rice was in a large open bag with no date; Arborio rice was in a large, open paper bag with no date, and extra-long rice was in a large, open paper bag with no date. During an interview on [DATE] at 4:15 PM, the RD confirmed the concerns and stated that bread products should be in closed packaging and dated by staff when taken out of the main refrigerator. The RD confirmed that the rice products should be stored in closed containers and dated by staff after it was opened. The RD also stated that there was no schedule for food being checked for dates or expired food. No additional information was provided prior to survey exit.

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observations, interviews, record review and policy review, the facility failed to ensure that staff followed the Infection Control and Prevention Program standards, policies, and procedures affecting five residents (Resident (R) 346, R56, R3, R145, and R178) of 46 sampled residents. Immediate Jeopardy (IJ) was determined related to the failure to disinfect multi-use glucometers with a manufacturer approved disinfectant when performing fingerstick blood glucose testing between residents, with the IJ start date identified as 4/22/25 at 8:14 AM. Following the facility's provision of an acceptable Immediate Jeopardy Removal Plan, the survey team verified full implementation of the removal plan, and the Immediate Jeopardy was subsequently removed on 04/23/25 at 11:20 AM. After the removal of the Immediate Jeopardy, the remaining noncompliance was determined to be at the scope and severity of Level Two - Pattern, with potential for more than minimal harm. Findings include: 1. For Resident (R) 346, R56, R3, and R145, the facility failed to ensure that multi-use glucometers were properly disinfected with an approved environmental protection agency (EPA) disinfectant when performing fingerstick blood glucose testing between residents. During medication administration on 04/22/25 at 8:14 AM, Registered Nurse (RN) 1 obtained R346's blood sugar (BS) and did not disinfect the glucometer prior to placing it back into the caddy. At 8:17 AM, RN1 obtained R56's BS with the same glucometer without it being disinfected prior to use. At 8:28 AM, RN1 finished and cleaned the glucometer with a germicidal wipe; however, RN1 did not allow it to dry before placing it back into the caddy. Review of R346's Admission Record under the tab Profile located in the Electronic Medical Record (EMR) indicated R346 was admitted to the facility on [DATE] with a diagnosis of type two diabetes mellitus. Review of R346's Order Summary under the tab Orders located in the EMR, dated 04/12/25 indicated, Fingerstick BS every six hours. Review of R56's Admission Record under the tab Profile located in the EMR indicated R56 was readmitted to the facility on [DATE] with a diagnosis of type two diabetes mellitus. Review of R56's Order Summary under the tab Orders located in the EMR dated 09/15/24 indicated, AccuCheck's before meals and at bedtime. Interview on 04/22/25 at 1:00 PM, RN1 confirmed that she did not disinfect the glucometer between residents and indicated that she should have. RN1 verbalized that the glucometer can be disinfected with either the germicidal wipes or with alcohol wipes if the germicidal wipes are not available. During another medication observation on 04/22/25 at 11:00 AM, LPN2 wiped the glucometer with alcohol wipes before and after use to obtain the BS results for R3. LPN2 verbalized that this was the process that the facility uses to clean the glucometer. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a third medication observation on 04/22/25 at 12:15 PM, Licensed Practical Nurse (LPN) 1 verbalized that the glucometers are cleaned with alcohol pads. LPN1 was observed completing R145's BS check and then afterwards, LPN1 cleaned the glucometer with alcohol pads and allowed the glucometer to dry. Review of R145's Admission Record under the tab Profile located in the EMR indicated, R145 was readmitted to the facility on [DATE] with a diagnosis of type two diabetes mellitus. During an interview on 04/22/25 at 2:20 PM, the DON stated that the glucometers should be sanitized with a germicidal wipe, left wet to dry one to five minutes, then put up, and this was to be done between residents. He stated that it depended on the type of wipes they get from the manufacturer. The DON explained that white bottom container of wipes with red top are five minutes and the white bottom container of wipes with purple top is one minute. The DON confirmed that alcohol wipes should not be used. Review of facility's policy titled, Patient Care Equipment dated 04/06/23 indicated, It is the center's policy to maintain an environment that reduces the risk of transmitting and acquiring infections, therefore all clinical equipment shall be handled in such a manner as to eliminate, reduce or minimize the spread of disease. Procedure .13. Glucometers: a. Clean the outside of the meter using a lint-free cloth. Clean in accordance with the manufacturer's recommendation. Review of the facility provided User's Guide for the Meter Memory glucometers, which were used to obtain the blood sugars, revealed that the glucometers should be cleaned and disinfected between each patient and requires a germicidal wipe disinfectant, which alcohol is not. The survey team discussed the potential for this facility's failure to disinfect multi-glucometers with an appropriate disinfectant increases the likelihood of transmission of bloodborne pathogens among all residents requiring this point-of-care testing. It was determined that immediate action was needed to prevent the likelihood of transmission of bloodborne pathogens between residents. Following consultation with the SA to confirm that immediate Jeopardy (IJ) exists, the facility's Administrator, Administrator in Training (AIT), Director of Nursing (DON), Regional Director of Clinical Services, and [NAME] President of Operations were informed on 04/22/25 at 3:44 PM that the facility was in IJ. The facility provided the following Immediate Jeopardy Removal Plan, that was accepted on 04/22/25 at 5:22 PM. Plan Corrective Action for those residents found to be affected by the deficient practice: A. R346, R56, and R145 had no negative outcomes related to the deficient practice. Corrective Actions taken for residents with potential to be affected by deficient practice: A. Residents who require blood sugar monitoring will have their glucometers cleaned after each use with the appropriate disinfectant that will kill bloodborne pathogens and kept out until the dry time has completed. Two glucometers will be placed in each nurses cart to allow for time in-between use to allow for proper disinfection. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Systemic Changes put into place to ensure the deficient practice does not recur: A. The Interdisciplinary Team (Administrator, Director of Nursing, Assistant Director of Nursing, Director of Social Work, Activities Director, Dietary Manager, Business Office Manager, Director of Maintenance, Director of Housekeeping and Laundry, Human Resources, and Unit Managers) will be educated by the Regional Director of Clinical Services on the facility policy for using glucometers to maintain infection control standards. This education will cover how to disinfect the glucometer after use on each patient and the required dry time to prevent the spread of bloodborne infections. All licensed nursing staff will be educated by the DON or designee on the glucometer cleaning policy per manufacturer guidelines to include the steps to take to use and disinfect after each patient. This education will be provided to agency nurses prior to starting with the facility. Any nurse who hasn't completed will be educated before the start of their next shift. The Administrator to conduct an ADHOC Quality Assurance Performance Improvement Meeting on 4/22/25 including the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Director of Social Work, Activities Director, Dietary Manager, Business Office Manager, Director of Housekeeping and Laundry, and Unit Managers to review the policy for the use of glucometers. Monitoring of corrective action to ensure the deficient practice does not recur. A. DON or designee will monitor the procedure for disinfecting the glucometer between residents by random observations of glucometer usage/use five times per week for four weeks and weekly for four weeks. Completion of removal plan 4/22/25 at 9:00pm. The Administrator made the Medical Director aware of the Immediate Jeopardy via telephone on 4/22/25 at 4:14pm The survey team reviewed the in-service training documentation/signature sheets for nursing staff and verified procedures were in place to educate the remaining staff prior to the start of their next shift. All staff educated had a competency checklist completed, that included indications of return demonstration of proper disinfecting procedure. No concerns were noted. The survey team reviewed education of interdisciplinary team regarding disinfection procedure of glucometers, reviewed documentation of ad hoc QAPI meeting held by administrator on 4/22/25 regarding F880 IJ, interviewed all nurses providing direct care and medication administration on units 2, 3, 4, and 5, with all able to describe/verbalize steps for proper disinfection of glucometers using germicidal wipes. The survey team also verified that two glucometers and supply of germicidal wipes were available on all medication carts in use in the facility. No concerns were noted. The survey team reviewed the form that had been developed for monitoring the disinfecting procedure for glucometers in coming weeks, as listed in removal plan. No concerns were noted. After consulting with the SA, the survey team determined that the removal plan was fully implemented and that the likelihood of serious injury, serious harm, serious impairment, or death no longer existed, the facility was notified that the Immediate Jeopardy had been removed on 04/23/25 at 11:20 AM. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. For R178, who was on Enhanced Barrier Precautions (EBP), facility staff failed to wear personal protective equipment (PPE) during catheter care. Review of facility policy titled, EBP dated 03/26/24 indicated, Employees providing high-contact patient care activities will follow EBP for patients who meet the criteria. Procedure: 1. May be indicated for patients .with indwelling medical devices (.urinary catheter) .3. EBP require the use of gown and gloves by staff during high contact patient care activities as defined below .g. device care or use (.urinary catheter) Review of facility policy titled, Personal Protective Equipment, dated 05/27/21, indicated, PPE is provided to employees at no cost to them. Procedure .2. Gloves .Disposable gloves are to be replaced if contaminated, if torn or punctured, or if the gloves' ability to function as a barrier is compromised. Review of R178's Admission Record under the tab Profile located in the EMR indicated R178 was admitted to the facility on [DATE] with a diagnosis of obstructive and reflux uropathy. Review of R178's Order Summary under the tab Orders located in the EMR dated 03/27/25 indicated, EBP related to Foley and trach, every shift for precaution. 3. For R178, facility staff failed to ensure that soap was used during catheter care, and failed to ensure that gloves were changed before going from a dirty area to a clean area, along with appropriate hand hygiene. During catheter care observation on 04/23/25 at 11:07 AM, Certified Nursing Assistant (CNA) 2 was observed gathering two washcloths, and one towel which he brought into R178's room without putting on any PPE prior to entering room. After putting on gloves, one washcloth dropped on the floor. CNA2 picked the washcloth up off the floor with a gloved hand and placed it on the overbed table. With the same gloves, CNA2 went through R178's dresser drawers and found a gray wash basin. CNA2 added a small amount of water in the basin without soap and placed the basin on the overbed table. At this time, CNA2 removed his gloves and emptied R178's Foley catheter. CNA2 applied gloves again, wiped the catheter tubing with the wet washcloth, in a downward motion, changed the direction of the washcloth, and dried the tubing while wearing the same gloves. CNA2 refastened the incontinent brief on R178. During an interview on 04/23/25 at 11:15 AM, CNA2 stated that PPE (gown, gloves, and mask) should have been worn because he is on EBP related to catheter care. He confirmed that he did not wear the appropriate PPE. CNA2 stated that gloves should be changed when going from a dirty area to a clean area. CNA2 said that he did not change his gloves when going from a dirty area to a clean area. CNA2 explained that he did not put soap into the water because he thought it was just a demonstration, so he .just left it out. During an interview on 04/23/25 at 2:00 PM, RN3 indicated that PPE (gown, gloves, mask) should have been worn due to R178 being on EBP. RN3 indicated that CNA2 should have used soap in the water and should have changed gloves when going from dirty area to clean area. During an interview on 04/23/25 at 3:00 PM, the DON stated that he expected that CNA2 to wear appropriate PPE (gown, gloves, mask) due to R178 being on EBP. The DON stated that he expected CNA2 to add soap to the water and change his gloves when going from a dirty area to a clean area. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	No additional information was provided prior to survey exit. 21875 4. For Resident #56, staff failed to follow infection control practices for proper positioning of a urinary catheter bag. R56's clinical record documented that Resident #56 (R56) was admitted to the facility with diagnoses that included cerebral infarction with hemiplegia, diabetes, hypertension, anemia, obstructive uropathy, and cognitive communication deficit. The minimum data set (MDS) dated [DATE] assessed R56 with moderately impaired cognitive skills. The record also included a physician's order dated 9/17/24 for a Foley urinary catheter for management of urinary retention due to obstructive uropathy. On 4/21/25 at 2:53 p.m., R56 was observed in bed. The urine collection bag for R56's catheter was positioned with the bottom part of the bag resting on the floor. The bag was strapped to the bed frame but was not positioned or strapped to ensure the bag was off the floor. On 4/22/25 at 7:51 a.m., R56 was observed in bed. The urinary catheter bag was observed positioned with the bottom part of the bag resting on the floor. On 4/23/25 at 8:52 a.m., the registered nurse (RN #1) caring for R56 was interviewed about the catheter bag seen resting on the floor. RN #1 stated the catheter bag was not supposed to be on the floor but was supposed to be attached to the bed frame so that the bag remained off the floor. On 4/23/25 at 9:02 a.m., the unit manager (RN #3) was interviewed about R56's catheter bag observed on the floor. RN #3 stated catheter bags should be positioned below the bladder and without contact with the floor for infection prevention. The facility's policy titled Urinary Catheterizations (effective 1/29/24) documented under procedures for management of urinary catheters, .Maintain drainage bags below the level of the bladder .Ensure drainage bags are not touching the floor . This finding was reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 4/23/25 at 4:45 p.m., with no further information provided prior to the end of the survey.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52322 Based on facility policy review, record review, and interviews, the facility failed to provide the required documentation and/or refusals related to administration of vaccinations for influenza, pneumococcal, and COVID-19 for four of five Residents (R)(13, 57, 56, 157) which increased the risk of acquiring, transmitting, and/or experiencing complications of respiratory infections. Findings include: Review of the facility's policy titled, COVID-19 Vaccinations dated 03/11/24 revealed .Prior to administering any COVID-19 Vaccine (and for each dose) complete the following for patients: Screen for eligibility (contradictions, precautions, previous doses, etc.) If contraindicated or refused, document in patient's medical record . Review of the facility's policy titled, Influenza Vaccination dated 05/01/23 revealed .Influenza vaccine should be offered annually. During flu season refer to the CDC influenza website for additional information. The optimal time to administer influenza vaccine is in late September or early October of each year. The flu shot can be given after the flu season ends . Review of the facility's policy titled, Pneumococcal Vaccinations dated 08/04/2023 revealed .Prior to administering a pneumococcal vaccination to patients, complete the following: 1. Screen for eligibility (contradictions, previous doses, etc.) 2. Allow the resident and/or RP (responsible party) to accept or refuse vaccine . 1. Review of the Face Sheet found under the profile tab in the electronic medical record (EMR) revealed R13 was admitted to the facility on [DATE] with a diagnosis of type two diabetes. Review of R13'sImmunization record revealed no documentation of administration of influenza and pneumococcal vaccines or refusals from the resident or responsible party. 2. Review of the Face Sheet found under the profile tab in the EMR revealed R57 was admitted to the facility on [DATE] with a diagnosis of type two diabetes. Review of R57's Immunization record revealed no documentation of administration of influenza and pneumococcal vaccines or refusals from the resident or responsible party. 3. Review of the Face Sheet found under the profile tab in the EMR revealed R56 was admitted to the facility on [DATE] with a diagnosis of type two diabetes. Review of R56's Immunization record revealed no documentation of administration of influenza, COVID-19, and pneumococcal vaccines or refusals from the resident or responsible party. 4. Review of the Face Sheet found under the profile tab in the EMR revealed R157 was admitted to the facility on [DATE] with a diagnosis of type two diabetes. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R157's Immunization record revealed no documentation of administration of COVID-19 and pneumococcal vaccines or refusals from the resident or responsible party. During an interview on 04/23/25 at 5:27 PM, the Infection Preventionist (IP) stated, We do not have any documented refusals or administrations for these resident. The IP stated that it was her process to look up the Virginia Data for vaccination history. No other information was provided prior to survey exit.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on observation, resident interview, and staff interview, the facility staff failed to maintain safe and functioning equipment. Resident #80's (R80) hand assist bar in the bathroom was not securely anchored to the wall. The findings include: Clinical record documented that diagnoses for R80 included difficulty walking, dialysis, diabetes, chronic kidney failure, and peripheral vascular disease. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/29/2025, which assessed R80 with a cognitive score of 15 out of 15, indicating cognitively intact. During an interview conducted on 4/21/25 at 3:53 p.m., R80 verbalized concerns regarding the hand assist bar in the bathroom. R80 reported that it is not secured to the wall and is worried about it being pulled off the wall when trying to get off the toilet. R80 said the concern has been reported but no one has repaired it. At this time, the hand rail was observed loosely anchored to the wall and when pulled on, the bar would move approximately 2 inches, scraping the wall. 04/23/25 at 11:59 AM, the maintenance director (other staff, OS #9) was interviewed. OS #9 said that the facility has a leadership team that are assigned to rooms, who are supposed to look at rooms each day, Monday through Friday, and report or log a work order if there is a repair is needed. OS #9 then reviewed the work orders for R80's room (room [ROOM NUMBER]), verbalized that there were no work orders pending, and indicated the last repair in the room was to change out a light. At this time, the OS #9 and the administrator (along with the surveyor) observed R80's bathroom. After observing the poorly secured grab bar, OS #9 verbalized that there should have been a work order placed and indicated that the bar was not safe to be used. On 4/23/25 at 4:47 p.m., the above findings were presented to the administrator and director of nursing. No other information was presented prior to exit conference on 4/24/25.