STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martinsville Health and Rehab	1607 Spruce Street Martinsville, VA 24112

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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 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. Based on observations and staff interview, the facility staff failed to store and prepare food in a sanitary manner. The findings included:During an initial tour of the kitchen on 01/12/26 at 11:50 am, surveyor observed a box of ground meat with a handwritten note that read, Out to thaw 01/05/26, use by 01/11/26. Surveyor pointed this out to dietary manager. Dietary manager stated they would discard the meat. Surveyor observed the dishwasher to have a dried, crusty substance on the top corners. Dietary manager stated they clean this substance off every day, and it's back the next morning. Surveyor observed the oven in the kitchen to have dried food substance on the front outside of the oven doors. Surveyor asked the dietary manager how often the ovens are cleaned, and dietary manager stated, Weekly.On a follow-up visit to the kitchen on 01/12/26 at 1:05 pm, surveyor observed certified nurse's aide (CNA) #1 standing in the kitchen prep area. Surveyor observed that CNA #1 did not have a hair covering over her hair. Surveyor asked dietary manager if CNA #1 should be wearing a hair covering, and dietary manager stated that she should, and stated, I honestly didn't notice if she had a hair net on or not.Surveyor spoke with CNA #1 on 01/23/26 at 1:20 pm. Surveyor asked CNA #1 if they had put on a hair covering prior to entering the kitchen, and CNA #1 stated they had not.Dietary manager provided surveyor with an inservice form on 01/15/25 which read in part, Labeling and Dating Inservice. Items that are removed from a labeled case in the freezer and placed in the refrigerator for thawing should be labeled with the date of removal from the freezer and an appropriate ?use by' date as outlined in the Retention Guide attached (Example: A tube of ground beef). The Food Storage and Retention Guide attached to the inservice form read in part, Raw Meat/Poultry/Seafood: Fish, seafood, ground meat and all poultry (Once Thawed) 1-2 days.The concern of not storing and preparing food in a sanitary manner was discussed with the administrator, director of nursing, and regional director of clinical services on 01/15/26 at 2:00 pm.No further information was provided prior to exit.

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interview, clinical record review, and facility document review, facility staff failed to ensure the consultant pharmacist documented their findings in the clinical records after completing drug regimen reviews for (5) five of (5) five sampled residents reviewed for unnecessary medications, Resident #2, Resident #5, Resident #6, Resident #9, and Resident #55. The findings included: The consultant pharmacist failed to document their findings regarding drug regimen reviews in the resident's clinical records. During clinical record reviews the survey team were unable to determine if the consultant pharmacist had made recommendations during their monthly drug regimen reviews. The pharmacist had only documented, chart review completed by consultant pharmacist. There was no reference regarding a recommendation being made or not made. On 01/13/2026 at 4:30 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON) and Regional Nurse Consultant the issue with the incomplete records regarding drug regimen reviews was reviewed. The DON was able to provide the survey team with a list of residents that did not have recommendations after the pharmacist review(s). This list was not part of the resident's clinical record(s). On 01/15/26 the DON provided the survey team with a copy of their policy titled, Medication Monitoring Medication Regimen Review and Reporting. This policy read in part, .Resident-specific MRR [medication regimen review] recommendations and findings are documented.A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable format.within 48 hours of MRR completion. No further information regarding this issue was provided to the survey team prior to the exit conference.

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on resident interview, family interview, staff interview, ombudsman interview, clinical record review, and facility document review, the facility staff failed to treat residents with dignity and respect for (1) one of (28) twenty-eight sampled residents, Resident #55. The findings included:For Resident #55 the facility staff failed to treat the resident with dignity and respect as evidenced by discussing her personal information with her roommate's family member.Resident #55's clinical record listed diagnoses which included but not limited to morbid (severe) obesity due to excess calories.Resident #55's most recent minimum data set with an assessment reference date of 11/30/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.Resident #55's comprehensive care plan was reviewed and contained plans for Overweight/Obesity as related: Depression, Obese with BMI (body mass index) >30, (BMI 73.4) history of weight fluctuations with desire to lose weight. Resident desires to lose weight of 100 lb. and I am on a special diet-cause: morbid obesity. Resident expresses desire to lose weight.Surveyor spoke with Resident #55 on 01/13/26 at 11:40 am. Resident #55 stated, . (facility social worker [SW]) called her . (resident's roommate) mother and told her to stop bringing me food. She (SW) told her (roommate's mother) that I have gained 20 lbs, and if she doesn't stop bringing me stuff, they will move my roommate. It's none of her (resident's roommate) business. I felt like I was being stepped on, and I never got an apology. I was humiliated.Surveyor spoke with Resident #55's roommate's mother on 01/13/26 at 1:00 pm. Surveyor asked roommate's mother if the SW had called her to discuss Resident #55, and roommate's mother stated, She called me about bringing . (Resident #55) food and something about the floor and her (Resident #55) weight. I just thought that was . (Resident #55) personal stuff and she (SW) shouldn't be telling me about it. She (SW) said she (Resident #55) had gained a lot of weight. I only bring her iced tea, hot coffee, fresh fruits and salads. They had a meeting a couple of weeks later with the administrator, SW, doctor, and ombudsman. (Resident #55) asked me to come.Surveyor spoke with the SW on 01/13/26 at 1:20 pm regarding Resident #55. SW stated they did talk with Resident #55's roommate's mother but did not discuss resident's weight. SW stated, It was more along the lines of ?you need to talk to staff before you bring food to residents.'Surveyor spoke with the local long-term care ombudsman on 01/15/26 at 10:30 am regarding Resident #55. Ombudsman stated that Resident #55 called me, bawling her eyes out, and was very upset that the SW had called roommate's mother. Ombudsman stated they had a care plan meeting after this, and resident invited her roommate's mother to attend. Ombudsman stated that roommate's mother was upset that the SW said they would move her daughter to another room if she continued to bring Resident #55 food and felt as if was retaliation against her.Surveyor requested and was provided with a facility policy entitled Your Rights and Protections as a Nursing Home Resident which read in part, At a minimum, Federal specifies that nursing homes must protect and promote the following right of each resident. You have the right to Be Treated with Respect: You have the right to be treated with dignity and respect.The concern on not treating Resident #55 with dignity and respect was discussed with the administrator, director of nursing and regional director of clinical services on 01/15/26 at 2:00 pm.No further information was provided prior to exit.

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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. Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to accommodate the resident's needs and preferences to get out of bed for (1) one of (28) twenty-eight sampled residents, Resident #55. The findings included:For Resident #55 the facility staff failed to accommodate the resident's preference to get out of bed.Resident #55's clinical record listed diagnoses which included but not limited to morbid (severe) obesity due to excess calories and bed confinement status.Resident #55's most recent minimum data set with an assessment reference date of 11/30/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.Resident #55's comprehensive care plan was reviewed and contained plans for Overweight/Obesity as related: Depression, Obese with BMI (body mass index) >30, (BMI 73.4) history of weight fluctuations with desire to lose weight. Resident desires to lose weight of 100 lb., I am on a special diet-cause: morbid obesity. Resident expresses desire to lose weight, At risk for fall related to . (Resident #55) needs assistance of staff to transfer with a hoyer lift due to bilateral lower extremity weakness due to history of Guillain Barre Syndrome and Dx (diagnosis) of Morbid Obesity and Self-Care Deficit related to . (Resident #55) needs mostly extensive to total dependence assistance of staff to complete ADL's (activities of daily living). Interventions for these care plans include Transfer assistance (Transfer using the Hoyer Lift w(with)/staff assistance of at least 2), bed bath daily, encourage choices with care, Refer to therapy PRN (as needed) and Transfers: Transfer using the Hoyer Lift w/at least 2-staff persons assisting.Surveyor spoke with Resident #55 on 01/13/26 at 11:40 am. Resident #55 stated to surveyor, I have been in this bed for almost 3 years. This came from . (facility company name omitted) that I'm too wide to get in the Hoyer lift. I would like to get out of this bed. The lift will hold my weight. Last time they tried to get me up, the lift tipped, but that was because someone was behind and pulled on it. How would you like to lay in bed all the time? I would like to take therapy, but they have told the insurance company I have plateaued.During an end of day meeting on 01/13/26 at 4:30 pm, surveyor asked if staff ever attempt to assist Resident #55 to get out of bed and if they have a Hoyer lift that will accommodate her, and administrator stated, It's not a lift weight problem, but last time they tried to use the lift, it started shimmying and seemed unsafe to use with resident. The director of nursing (DON) stated the lift is rated for up to 600 lbs.Surveyor spoke with registered nurse (RN) #3 on 01/14/25 at 2:45 pm. Surveyor asked RN #3 if they ever attempt to get Resident #55 out of bed, and RN #3 stated, We've tried a few times and the lift almost flipped with her in it. Surveyor asked RN #3 if Resident #55 has a wheelchair, and RN #3 stated, She used to have one, but I haven't seen it in a couple of years. Surveyor asked RN #3 how Resident #55 is provided with ADL care, and RN #3 stated, She gets daily bed baths.During an end of day meeting on 01/14/26 at 5:05 pm, surveyor asked if the facility has a lift pad/sling that will accommodate Resident #55 and asked if resident has a wheelchair. Administrator stated they do have a lift pad and wheelchair for Resident #55. Surveyor asked how Resident #55 would be transferred in the event of an emergency, and DON stated, We would pull her with a sheet, if we had to.Surveyor spoke with the local long term care ombudsman on 01/15/26 at 10:30 am regarding Resident #55. Ombudsman stated the resident has expressed concerns about not getting out of bed, and that these concerns have been addressed at several care plan meetings. Ombudsman stated that resident's wheelchair was in her room until she got a roommate. Ombudsman stated, They really need to meet her needs, they are restricting her by not getting her up.Surveyor requested and was provided with a copy of the Hoyer lift user manual which read in part, DO NOT exceed maximum weight limitation of the patient lift. The weight limitation for the RPL 600-2 is 600 lbs. Surveyor observed a RPL 600-2 Hoyer lift in the facility on 01/15/26.Surveyor requested to see the lift pad/sling that is used for Resident #55, and DON provided this. The sling was observed to be rated for up to 1000 lbs.The concern of not accommodating Resident #55's desire to get out of bed was discussed with the administrator, DON (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and regional director of clinical services on 01/15/26 at 2:00 pm.No further information was provided prior to exit.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to honor resident's choices for (1) one of (28) twenty-eight sampled residents, resident #10. The findings included:For Resident #10 the facility staff failed to honor the resident's choice to have a shower in the morning instead of evening.Resident #10's clinical record listed diagnoses which included but not limited to Hemiplegia and Hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side.Resident #10's most recent minimum data set with an assessment reference date of 11/21/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section GG, functional abilities, coded the resident as needing partial/moderate assistance with bathing.Resident #10's comprehensive care plan was reviewed and contained a plan for Potential for Self-Care Deficit r/t (related to): Requires staff assistance with ADL's (activities of daily living) d/t (due to) physical functioning deficit, mobility, impairment, HX (history) of CVA (cerebrovascular accident) w(ith) Left Hemiplegia, Hx of Compression Fracture at the L2 Vertebral Body. Interventions for this care plan include Encourage choices with care.Surveyor spoke with Resident #10 on 01/13/26 at 8:45 am. Surveyor asked resident if she has any concerns with her care, and Resident #10 stated, The only problem I have is not getting my showers. I am supposed to get a shower on Mondays, Thursdays, and Saturdays, but I haven't had a shower in a week. The CNA (certified nurse's aide) came in yesterday and asked me if I wanted a shower and I told her yes. She told me someone else would come and take me. No one ever came. A CNA came in and washed me off this morning because I told her I was itching. Surveyor asked Resident #10 what time of day they take their shower, and Resident #10 stated, They give them in the evenings, but I would prefer to take mine in the morning. Surveyor asked Resident #10 if they have ever refused to take a shower and Resident #10 stated, Yeah, I have, when they come in here after I've gone to sleep.Resident #10's ADL's sheets were reviewed and read in part, Shower Monday/Thursday/Saturday night shift. Prefers to take shower between the hours of 4:30 am-6:30 am. Prefers shower over bed bath.Surveyor requested and was provided with a facility document entitled Resident Rights which read in part, The Resident has the right to choose activities schedules and health care consistent with his or her interests, assessment, and plans of care.The concern of not honoring Resident #10's choice to have a shower in the morning, and rather than a bed bath was discussed with the administrator, director of nursing and regional director of clinical services on 01/15/26 at 2:00 pm.No further information was provided prior to exit.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on staff interview and clinical record review, the facility staff failed to periodically review resident's advance directive information for (1) one of (28) twenty-eight sampled residents, Resident #50. The findings included:The facility staff failed to periodically review Resident #50's advance directive information with the resident and/or resident representative.Resident #50's diagnoses included chronic obstructive pulmonary disease, anxiety disorder, hypertension, and dementia.Section C of Resident #50's quarterly minimum data set (MDS) assessment with and assessment reference date (ARD) of 12/13/25 was coded 00. Per the MDS manual a score of 00=severe impairment in cognitive skills for daily decision making.During the clinical record review, the surveyor was unable to locate any information to indicate Resident #50's advance directive information had been reviewed since 01/17/24. On 01/14/2026 at 9:00 a.m., during an interview with the Social Worker (SW) this staff stated they had not reviewed advance directive information with this resident due to their cognitive status and the resident's family did not attend care plan meetings. On 01/14/2026 at 12:35 p.m., the SW provided the surveyor with evidence that they had reviewed the residents advance directive information with the residents' legal representative today (01/14/26) via phone. On 01/14/2026 at 5:05 p.m., during an end of the day meeting with the Administrator, Director of Nursing and Regional Nurse Consultant the issue with Resident #50's advance directive information not being reviewed was discussed. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and facility document review, the facility staff failed to provide Notice of Medicare Non-Coverage at least two days prior to the end of a Medicare covered Part A stay for (1) one of (3) three sampled residents, Resident #20. The findings included: For Resident #20, the facility staff failed to provide Notice of Medicare Non-Coverage at least two days prior to the end of the resident's Medicare covered Part A stay. Resident #20's diagnosis list indicated diagnoses, which included, but not limited to metabolic encephalopathy, muscle weakness, chronic kidney disease-stage 3, and atherosclerotic heart disease of native coronary artery. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of [DATE] assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. Resident #20's last covered day of Medicare Part A services was [DATE]. A Notice of Medicare Non-Coverage (NOMNC) was issued and signed by the resident's representative on [DATE]. On [DATE] at 8:49 AM, this surveyor spoke with the facility administrator and he informed surveyor that the NOMNC was not issued on time and by the time it was issued, they had not realized the resident's covered days had already expired. This concern was discussed on [DATE] at 4:30 PM at the end of day meeting with the administrator, director of nursing, and regional nurse consultant. Surveyor requested and received a facility policy titled Advance Beneficiary Notice-ABN with an effective date of 11/2020, which read in part, .The facility will give a completed copy of the ABN far enough in advance of an event about which a decision must be made by the beneficiary.so that the beneficiary can make a rational, informed consumer decision without undue pressure. Last minute notification can be coercive, and a coercive notice is a defective notice of skilled services. No further information regarding this concern was presented to the survey team prior to the exit conference on [DATE].

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, facility staff failed to provide required documentation to receiving entity at time of transfer/discharge for (3) three of (28) twenty-eight sampled residents, Resident #4, Resident #80, and Resident #91. The findings included:1. For resident #4, the facility staff failed to provide documentation that the required information was provided to the receiving healthcare institution for a transfer that occurred on 9/1/2025 and a transfer that occurred 11/26/25. Resident #4's diagnoses included but were not limited to, a history of stroke with hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness affecting one side of the body) as well as dysphagia (difficulty swallowing), type II diabetes, schizophrenia, bipolar disorder, anxiety disorder and epilepsy. The annual minimum data set (MDS) assessment with an assessment reference date of 12/16/25 assigned the resident a brief interview for mental status score of 10 out 15 indicating a moderate cognitive impairment. During an interview resident #4 would only smile and nod to surveyor and was not interviewable. The progress notes were reviewed. On 9/1/25 at 9:40 AM a change in condition note read, BP (blood pressure) 73/49 RR (respiratory rate) 30, T (temperature) 101.6 rhonchi bilateral lungs. Resident is diaphoretic. Only opens eyes when spoken to. Notified on call. Order given to send to ER (emergency room) for evaluation and treatment. There was no documentation to indicate what information the facility staff sent with the resident to the hospital. There was a note stating that a verbal report had been called in to the emergency room. A progress note dated 11/26/25 at 2:06 PM read in part, .received an order to send pt (patient) out to ER for eval/treatment There was no note to indicate what information if any was sent with the resident to the hospital. On 1/14/26 at 12:06 PM this surveyor asked the social worker to provide a copy of documents sent to the hospital with resident #4 on 9/1/25 and 11/26/25. The social worker returned with forms entitled, Notice of Involuntary Transfer or Discharge and Bed Hold Authorization for each hospitalization. On 1/14/2026 at 12:34 PM, the director of nursing informed the survey team that the facility staff was not sending required documentation with the residents upon transfer/discharge. The Director of Nursing (DON) provided documentation of education that had been done with the nursing staff on two separate occasions to show that it was an issue she had been addressing. On 1/15/26 at 10:50 AM this surveyor met with the DON and Regional [NAME] President of Operations. The DON explained that they had discovered a glitch in their software that was deleting the discharge packets from the system. My nurses have been doing them, but for some reason they are getting deleted and we don't know why. This surveyor asked for some sort of proof that resident #4's packets had been in the system at some point, but they were not able to produce any evidence. This surveyor requested and received a copy of the policy entitled, Transfer a Resident to the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospital which read in part, 4. Print the resident's face sheet, current medication list, pertinent labs/radiology reports, and any other clinical information pertaining to transfer reason. This concern was discussed at the pre-exit meeting on 1/15/26 at 1:57 PM with the administrator, director of nursing, regional vice president of operations, and regional nurse consultant. No further information was provided to the survey team prior to the exit conference. 2. For Resident #80, the facility staff failed to ensure the appropriate information was provided to the receiving healthcare institution for a transfer/discharge on [DATE]. Resident #80's diagnosis list indicated diagnoses that included, but were not limited to, volume depletion, atherosclerotic heart disease, schizoaffective disorder, kidney failure, and acute or chronic malnutrition. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/10/26, assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of the clinical record indicated Resident #20 was transferred to the hospital on [DATE]. No evidence that appropriate information was provided to the receiving healthcare institution for the transfer/discharge on [DATE] could be located. This surveyor requested evidence that appropriate information was provided to the receiving healthcare institution for the transfer/discharge on [DATE]. On 1/14/2026 at 12:34 PM, the director of nursing informed this surveyor that she agreed the facility staff is not sending required documentation with the residents upon transfer/discharge. This concern was discussed at the pre-exit meeting on 1/15/26 at 1:57 PM with the administrator, director of nursing, regional vice president of operations, and regional nurse consultant. Surveyor requested and received a facility policy titled, Transfer a Resident to a Hospital with an effective date of 3/2021, which read in part, .Emergency Transfer.3. Complete the Transfer Out (emergency) Assessment. 4. Print resident's face sheet, current medication list, pertinent labs/radiology reports, and any other clinical information pertaining to transfer reason. 5. Place printed content into transfer envelope.9. Send copy of.Involuntary Transfer form with the resident. No other information was provided to the survey team prior to exit on 1/15/26. 3. For Resident #91, the facility staff failed to provide documentation that the required information was provided to the receiving acute care hospital for a transfer that occurred on 12/30/25. Resident #91's diagnosis list indicated diagnoses, which included, but were not limited to adult failure to thrive, cerebral infarction, and polyneuropathy. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 12/11/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #91's clinical record included a nursing progress note dated 12/30/25 at 10:16 AM which revealed the resident had been complaining of shortness of breath, appeared to be in distress, and had an oxygen saturation level of 64% following increased oxygen administration. A provider order was received to send Resident #91 to the emergency department. A review of Resident #91's clinical record failed to reveal documentation of required resident information being provided to the acute care hospital. A facility policy titled, Transfer a Resident to a Hospital, dated 3/2021 indicated for an emergency transfer 4. Print resident's face sheet, current medication list, pertinent labs/radiology reports, and any other clinical information pertaining to transfer reason. 5. Place printed content into transfer envelope. This concern was discussed at a pre-exit meeting on 1/15/26 at 1:57 PM with the administrator, director of nursing, regional vice president of operations, and the regional nurse consultant. No further information regarding this concern was presented to the survey team prior to the exit conference on 1/15/26.

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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. Based on staff interview and clinical record review, facility staff failed to ensure an accurate minimum data set assessment for (1) one of (28) twenty-eight sampled residents, Resident #58. The findings included:The facility staff had coded Resident #58's annual MDS assessment to indicate the resident had been administered insulin. Resident #58 did not have a provider order for insulin and had not received insulin during the look back period of this MDS assessment.Resident #58's diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease, and hypertension.Section C (cognitive patterns) of Resident #58's annual MDS assessment with an assessment reference date (ARD) of 09/30/25 included a brief interview for mental status (BIMS) score of 9 out of 15 points. Per the MDS manual a 9=moderately impaired in cognitive skills for daily decision making. Section N (medications) had been coded to indicate this resident received insulin injections.During the clinical record review, the surveyor was unable to find a current or discontinued provider order for insulin.On 01/14/2026 at 9:12 a.m., Registered Nurse (RN) #1was interviewed regarding the coding of insulin on the MDS. On 01/14/2026 at 9:40 a.m., RN #1 confirmed the MDS had been coded incorrectly and stated a modification MDS had been completed. On 01/14/2026 at 5:05 p.m., during an end of the day meeting with the Administrator, Director of Nursing, and Regional Nurse Consultant the issue with the incorrect coding of the MDS was reviewed.No further information regarding this issue was provided to the survey team prior to the exit conference.

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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 Based on staff interview, clinical record review and facility document review, facility staff failed to complete (PASARR) for (1) one of (28) twenty-eight sampled residents, Resident #18. The findings included:Resident #18's diagnoses included but were not limited to chronic obstructive pulmonary disease, heart failure, dementia, psychosis, mood disorder, and major depressive disorder.Resident #18's quarterly minimum data set (MDS) assessment with an assessment reference date of 12/22/25 assigned the resident a brief interview for mental status score of 00 out of 15 indicating severe cognitive impairment.Resident #18's care plan included a focus that read in part, (resident name omitted) has a history of behaviors which include refusing showers or baths at times, refuses to allow staff to assist her. Physically striking others. Refuses room change; delusions-states we are being watched through the cameras. Refuses to see Dentist, Optometrist.This surveyor was unable to locate a Level I Preadmission Screening and Resident Review (PASRR) in the clinical record.On 1/13/26 at approximately 2:20 PM this surveyor asked the social worker if resident #18 had a PASRR. The social worker was unable to locate at PASARR in the clinical record and stated, She has an old UAI (Uniform Assessment Instrument) but there is no PASARR with it.On 1/13/26 at 4:46 PM the survey team met with the Administrator, Director of Nursing (DON) and the Regional Nurse Consultant. This concern was discussed at that time. The DON stated, She came before that was a requirement I thought. This surveyor stated that the resident was admitted to the facility in 2014.On 1/15/26 the social worker brought this surveyor a Level I PASARR with resident #18's name written on it and stated, She refused to do it. The form was blank except for the resident demographic information, and the social worker signature, date and facility address and phone number. A handwritten note at the bottom of the form read, RSD. (resident) refused to participate stating I'm doing that junk I've done it before.This surveyor requested and received a copy of the policy entitled Preadmission Screening and Resident Review (PASSR) Policy which read in part, It is the Facility's policy that a PASSR be obtained for every new admission to the Facility. This PASSR should be obtained prior to admission to the Facility.Prior to the admission to the Facility and as part of the referral review, the Facility Admissions Director (or designated admissions back-up) will verify that the PASSR has been completed, and the Facility has received a copy of the PASSR before the patient is admitted to the Facility. For long-term care residents already in the Facility without a Level I screening (admitted prior to July 1, 2019), a designated Facility staff member with medical knowledge of the resident and knowledge of the medical terminology in the Level I screening process will complete the screening.According to the dmas.virginia.gov website, All persons, regardless of payment status or reason for admission to a nursing facility, must be screened for mental illness (MI), intellectual disability (ID), and related conditions (RC). This screening is called a Level I Screening. If the nursing facility (NF) is processing admission of a non-Medicaid member, or anyone who does not have a Medicaid LTSS Screening, which includes the Level I Screening, the NF must complete or arrange for the completion of the Level I Screening. If a resident refuses or cannot participate, the facility must still complete the screening, and if a potential condition is identified, follow state procedures.This concern was reviewed with the administrative team during a meeting on 1/16/26. No further information was provided prior to the exit conference.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on staff interview, clinical record review, and facility document review, facility staff failed to develop a baseline care plan for (3) three of (38) thirty-eight sampled residents, Resident #4, Resident #64, and Resident #94. The findings included:1. For resident #4 the facility staff failed to complete a baseline care plan upon admission. Resident #4's diagnoses included but were not limited to, a history of stroke with hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness affecting one side of the body) as well as dysphagia (difficulty swallowing), type II diabetes, schizophrenia, bipolar disorder, anxiety disorder and epilepsy. The annual minimum data set (MDS) assessment with an assessment reference date of 12/16/25 assigned the resident a brief interview for mental status score of 10 out 15 indicating a moderate cognitive impairment. Resident #4 was initially admitted to the facility in April of 2024. The baseline care plan was initiated but only question #2 for primary language and question #4 for allergies had been answered. The rest of the form was blank including the section where the care plan was reviewed with the resident or family member. In December 2025 resident #4 returned from a lengthy hospital stay. A baseline care plan was generated but was incomplete and not reviewed with the resident or the family. On 01/14/26 the DON provided the survey team with a copy of their policy titled, Baseline Care Plan and Summary. This policy read in part, .Upon admission the admitting clinical team will develop an initial plan of care based on information upon admission.2. Communication with resident and family or responsible party A. Within 48 hours the resident and family or responsible party will be given a summary review of the baseline care plan. A member of the clinical team or IDT (interdisciplinary team) will review in person or via phone the summary of the baseline care plan. A copy will be provided to the resident, family and or responsible party. This concern was discussed at the pre-exit meeting on 1/15/26 at 1:57 PM with the administrator, director of nursing, regional vice president of operations, and regional nurse consultant. No further information was provided to the survey team prior to the exit conference. 2. For resident #64, the facility staff failed to complete the baseline care plan upon admission to the facility. Resident #64's diagnoses included but were not limited to: a history of stroke, peripheral vascular disease, muscle weakness, protein calorie malnutrition, major depressive disorder, and anxiety. The quarterly minimum data set (MDS) assessment with an assessment reference date of 1/6/26 assigned the resident a brief interview for mental status (BIMS) score of 14/15 indicating intact cognition. According to the MDS, resident #64 was dependent on staff for all activities of daily living such as bathing and dressing, as well as all mobility and was fed via tube with orders to have nothing by mouth (NPO). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/30/25 a baseline care plan was initiated for resident #64. The form was mostly blank including the section indicating who the baseline care plan was reviewed with. On 1/13/26 at 1:20 PM this surveyor interviewed resident #64's responsible party. When asked if they had received a baseline care plan shortly after admission to the facility they stated, No, I don't believe I did. On 01/14/26 the DON provided the survey team with a copy of their policy titled, Baseline Care Plan and Summary. This policy read in part, .Upon admission the admitting clinical team will develop an initial plan of care based on information upon admission.2. Communication with resident and family or responsible party A. Within 48 hours the resident and family or responsible party will be given a summary review of the baseline care plan. A member of the clinical team or IDT (interdisciplinary team) will review in person or via phone the summary of the baseline care plan. A copy will be provided to the resident, family and or responsible party. This concern was discussed at the pre-exit meeting on 1/15/26 at 1:57 PM with the administrator, director of nursing, regional vice president of operations, and regional nurse consultant. No further information was provided to the survey team prior to the exit conference. 3. For Resident #94, the facility staff failed to develop a baseline care plan. This was a closed record review. Resident #94's diagnoses included cerebral infarction, adult failure to thrive, diabetes, quadriplegia, and muscle weakness. Section C (cognitive patterns) of Resident #94's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 06/16/23 was coded 1/1/2 to indicate this resident had problems with long and short-term memory and was moderately impaired in cognitive skills for daily decision making. During the clinical record review, the surveyor was unable to find evidence that a baseline care plan had been developed. On 01/14/2026 at 11:30 a.m., during an interview with the Director of Nursing (DON) this staff stated they were unable to find a baseline care plan for this resident. On 01/14/2026 at 5:05 p.m., during an end of the day meeting with the Administrator, DON, and Regional Nurse Consultant the issue with the missing baseline care plan was reviewed. On 01/14/26 the DON provided the survey team with a copy of their policy titled, Baseline Care Plan and Summary. This policy read in part, .Upon admission the admitting clinical team will develop an initial plan of care based on information upon admission. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff interview, clinical record review, and facility document review, the facility staff failed to develop and/or implement a person-centered, comprehensive, activity care plan for (1) one of (28) twenty-eight sampled residents, Resident #80. The findings included:For Resident #80 the facility staff failed to develop and implement a comprehensive person-centered activity care plan to include measurable objectives and timeframes to meet the resident's mental and psychosocial needs and include the resident's goals, desired outcomes, and preferences for activities. Resident #80's diagnosis list indicated diagnoses that included, but were not limited to, volume depletion, atherosclerotic heart disease, schizoaffective disorder, depression, bipolar disorder, suicidal ideations, schizoaffective disorder, acute or chronic malnutrition, and personal history of mental and behavioral disorders. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/10/26, assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of Resident #80's clinical record and comprehensive care plan produced no evidence of a person-centered, activity care plan. On 1/14/2026 at 2:11 PM, this surveyor interviewed other staff #5 (OS#5) and reviewed Resident #80's care plan. OS#5 agreed that an activity care plan was not completed for the resident. This concern was discussed at the end of day meeting on 1/14/26 at 5:05 PM with the administrator, director of nursing, and regional nurse consultant. On 1/15/26, this surveyor reviewed Resident #80's person-centered comprehensive care plan with a focus which read in part, I have a short attention span exhibited by: Not being able to focus on anything for long.Date Initiated: 01/14/2026. A review of the goal and interventions read in part, .I will be able to Hold an object for 5 minutes at least three times a week by my next review.Date Initiated: 01/14/2026.I need encouragement to participate in activities at times, and like compliments for my attempts to participate.If I become less involved in group activities, please do 1:1 activities with me that I'll enjoy.Offer me shorter duration activities if I need them.Please give me help as I need it, giving easier instructions, cuing, and breaking the things I'm doing down into smaller steps. Surveyor requested and received a facility policy titled, Activity Care Plan with an effective date of 11/2020 which read in part, .It is the policy of this facility's activity department to develop and maintain individualized care plans as needed for each resident.an activity care plan will be developed which will reflect and meet the needs of a newly admitted resident.individualized activity care plans are integrated into the resident's total care plan. No further information regarding this concern was presented to the survey team prior to the exit conference on 1/15/26.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure the comprehensive person-centered care plan was reviewed and revised by the interdisciplinary team, for (1) one of (28) twenty-eight sampled residents, Resident #9. The findings included:For Resident #9, the facility staff failed to reassess the effectiveness of the interventions and review and revise the resident's comprehensive person-centered activity care plan to meet the resident's needs. Resident #9's diagnosis list indicated diagnoses that included, but were not limited to, cerebrovascular disease, spastic hemiplegia affecting right dominant side, schizophrenia, depressive disorder, and cognitive communication disorder. The most recent annual minimum data set (MDS) with an assessment reference date (ARD) of 12/20/25, was coded for the resident being rarely/never understood with short and long-term memory problems, and moderate impairment in decision-making. A review of the current comprehensive person-centered activity care plan disclosed an initiated date of 4/6/25 and the last revision date of 4/6/25 with no changes identified for the focus, goal or interventions. A review of the clinical record did not disclose any evidence of activity progress notes. Further review disclosed a Recreation Services Assessment for an annual review dated 12/30/24 and a Recreation Services Assessment dated 12/19/25 that was blank and noted as incomplete. A review of the completed MDS schedule revealed the following MDS assessments were completed on the following dates with no evidence of a completed activity assessment, activity care plan review, and/or activity progress notes:12/20/25-annual9/29/25-quarterly 6/29/25-quarterly On 1/14/26 at 11:22 AM, this surveyor interviewed other staff #5 (OS#5) and reviewed Resident #9's activity care plan, activity assessments, and activity progress notes. OS#5 informed this surveyor the care plan is supposed to be updated quarterly, annually, and with the MDS. OS#5 reviewed the annual activity assessment dated [DATE] with surveyor and agreed it was not completed and stated she must have gotten side-tracked and did not complete it and agreed she is supposed to complete a quarterly review/quarterly progress note for activities. OS#5 and this surveyor reviewed the interventions on Resident #9's activity care plan, and OS#5 agreed the resident had improved in group activity participation and was more social and agreed the activity plan of care should have been updated to reflect the resident's improvement and interests. OS#5 informed this surveyor that Resident #9's activity care plan would be updated. On 1/14/2026 at 12:04 PM, this surveyor was provided with an updated activity care plan for Resident #9. This concern was discussed at the end of day meeting on 1/14/26 at 5:05 PM with the administrator, director of nursing, and regional nurse consultant. Surveyor requested and received a facility policy titled, Activity Care Plan with an effective date of 11/2020 which read in part, .It is the policy of this facility's activity department to develop and maintain individualized care plans as needed for each resident.3. As a part of the care plan, activity plans are reviewed quarterly.4. A care plan is an ongoing process and should be updated as needed.5. Development/review/revision of the activity care plan is a result of the prior completed assessment. Surveyor requested and received a facility policy titled, Progress Notes with an effective date of 11/2020 which read in part, .It is the policy of this facility to complete a progress note in the following situations.2. No less than quarterly.4. Annually. No further information regarding this concern was presented to the survey team prior to the exit on 1/15/26.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, staff interview, resident interview, clinical record review, and facility document review, facility staff failed to provide activities of daily living care for (2) two of (28) twenty-eight dependent residents, Resident #10 and Resident #64. The findings included:1.For Resident #10 the facility staff failed to provide showers or daily bed baths. Resident #10's clinical record listed diagnoses which included but not limited to hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side and contracture, left hand. Resident #10's most recent minimum data set with an assessment reference date of 11/21/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section GG, functional abilities, coded the resident as needing partial/moderate assistance with showering/bathing. Resident #10's comprehensive care plan was reviewed and contained a plan for Potential for Self Care Deficit r/t (related to): Requires staff assistance with ADL's d/t (due to) physical functioning deficit, mobility impairment, Hx (history) of CVA (cerebrovascular accident) w/Left Hemiplegia, Hx of Compression Fracture at the L2 Vertebral Body. Interventions for this plan include Encourage choices with care and provide all needed assistance w/ADLs and mobility. Surveyor spoke with Resident #10 on 01/13/26 at 8:45 am. Resident #10 stated to surveyor the only concern they have with their care is not getting showers like they should. Resident #10 stated to surveyor that they are supposed to get a shower on Mondays, Thursdays and Saturdays, but they have not had a shower in a week. Resident #10 stated The CNA (certified nurse's aide) came in yesterday and asked me if I wanted a shower and I told her yes. She told me someone else would come and take me. No one ever came. They go tell the nurse I refuse, so they don't have to do their job. The CNA this morning came and washed me off because I told her I was itching. Surveyor asked Resident #10 what time of day they take their shower, and Resident #10 stated, They give them in the evenings, but I would prefer to take mine in the morning. Surveyor asked Resident #10 if they have ever refused to take a shower and Resident #10 stated, Yeah, I have, when they come in here after I've gone to sleep. Resident #10's ADL's sheets were reviewed and read in part, Shower Monday/Thursday/Saturday night shift. Prefers to take shower between the hours of 4:30 am-6:30 am. Prefers shower over bed bath. Resident #10's daily shower/bath sheets were reviewed and indicated that from 08/12/25 through 08/20/25 (8 days) resident received or was offered neither a shower nor a bed bath. Resident was neither offered nor received either a shower or bed bath between 08/26/25 and 08/31/25 (5 days). Surveyor requested and was provided with a facility policy entitled AM Care which read in part, Clinical services personnel will offer AM care each day to ensure resident's overall comfort, cleanliness, good grooming, and general well-being. Residents who are capable of performing their own personal care are encouraged to do so. Showers, baths, and shampoos are scheduled at least weekly and more often as needed. The concern of not providing ADL care for Resident #10 was discussed with the administrator, director of nursing, and regional director of clinical services on 01/15/26 at 2:00 pm. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit. 2. For resident #64 the facility staff failed to perform nail care for a dependent resident. Resident #64's diagnoses included but were not limited to: a history of stroke, peripheral vascular disease, muscle weakness, protein calorie malnutrition, major depressive disorder, and anxiety. The quarterly minimum data set (MDS) assessment with an assessment reference date of 1/6/26 assigned the resident a brief interview for mental status (BIMS) score of 14/15 indicating intact cognition. According to the MDS, resident #64 is dependent on staff for all activities of daily living such as bathing and dressing, as well as all mobility. On 1/12/26 at 3:40 PM During initial tour, this surveyor interviewed resident #64. During the conversation, this surveyor noted that the residents fingernails were long and jagged with brownish/black material caked under each one. This surveyor asked resident #64 if he liked his nails that long and he shook his head no. When asked if he would like for the staff to trim his nails he stated he shook his head yes. When asked when the last time someone had trimmed and cleaned his nails, he shrugged his shoulders. On 1/13/26 at 4:15 PM this surveyor entered resident #64's room. His nails were still long and dirty. When the resident saw this surveyor looking at his fingernails he stated, Mama will do it. This surveyor met with the Director of Nursing (DON) on 1/13/26 at 4:40 PM and asked what the policy for nail care is. The DON stated, It's done as needed. The DON was informed of this surveyors' observations of resident #64. On 1/14/26 at 11:45 AM this surveyor went to visit with resident. His nails were clean and had been trimmed. No further information was provided to the survey team prior to the exit conference.

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Martinsville Health and Rehab	1607 Spruce Street Martinsville, VA 24112

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide an ongoing, person-centered activity program to support resident choice, interests and physical, mental, and psychosocial well-being for (1) one of (28) twenty-eight sampled residents, Resident #80. The findings included:For Resident #80, the facility staff failed to provide an ongoing, person-centered, activity program to support resident choice, interests, and physical, mental, and psychosocial well-being. Resident #80's diagnosis list indicated diagnoses that included, but were not limited to, volume depletion, atherosclerotic heart disease, schizoaffective disorder, depression, bipolar disorder, suicidal ideations, schizoaffective disorder, acute or chronic malnutrition, and personal history of mental and behavioral disorders. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/10/26, assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. On 1/12/26 at 6:34 PM, this surveyor spoke with Resident #80's family member #1 (FM#1) via phone conversation and FM#1 informed surveyor facility staff wanted the resident to stay in bed related to health issues and was not sure if the facility staff were doing one-to-one activities with the resident. A review of the clinical record and comprehensive person-centered care plan produced no evidence of a person-centered activity care plan or any evidence of activity progress notes for Resident #80. A review of an Activity Participation Review dated 1/9/26 was blank and noted to be in progress. A review of a Recreation Services Assessment dated 1/13/26 was blank and noted to be incomplete. A review of Resident #80's admission MDS dated [DATE] Section F (Preferences for Customary Routine and Activities) was coded as being somewhat important to the resident to listen to music, be around animals such as pets, do things with groups of people, do favorite activities, go outside in nice weather, and participate in religious services or practices. This surveyor requested and received activity participation records for December 2025 and January 2026. A review of the hand-written activity participation records for December 2025 indicated Resident #80 was a passive participant for a sensory activity on the following dates:12/8/2512/13/2512/17/2512/22/2512/27/25 A review of the hand-written activity participation records for January 2026 indicated Resident #80 was a passive participant for a sensory activity on the following dates:1/4/261/7/261/9/26 A review of Resident #80's census listing disclosed the resident was transferred to the hospital on [DATE] and was re-admitted to the facility on [DATE]. On 1/14/26 at 2:11 PM, this surveyor interviewed other staff #5 (OS#5) and reviewed the hand-written activity participation records for 1/4/26 and 1/7/26. OS #5 confirmed the activities on those dates were completed with Resident #80. This surveyor informed OS#5 that Resident #80 was in the hospital during those dates, OS#5 then agreed the activities documented on 1/4/26 and 1/7/26 were marked in error and struck the entries out and hand-wrote error beside the 1/4/26, 1/7/26, and 1/9/26 entries on the activity participation record. OS#5 also agreed Resident #80 only received (5) five activities from 12/5/25 through 12/31/25. This surveyor and OS#5 reviewed the Activity Participation Review dated 1/9/26 and reviewed the Recreation Services Assessment dated 1/13/26. OS#5 agreed the assessments were not completed and agreed a comprehensive person-centered activity care plan was not completed for Resident #80. This concern was discussed on 1/14/26 at 5:05 PM at the end of day meeting with the administrator, director of nursing, and regional nurse consultant. Surveyor requested and received a facility policy titled, Activity Assessment with an effective date of 11/2020, which read in part, .It is the policy of this facility to utilize an activity interest assessment on each resident within 5 days of their admission.The assessment will reflect the resident's interests both current and past, and/or need for sensory or environmental stimulation.A progress note should be written after the initial assessment is completed to include resident status i.e.: cognition level; interest areas; potential areas of concern for activities to address; and areas (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other than activity interests that may better develop a plan and individualizes pertinent information of resident needs.The Resident's activity plan must be developed in conjunction with the comprehensive assessment. Surveyor requested and received a facility policy titled, Participation in Activities with an effective date of 11/2020, which read in part, .Residents have the right to attend and participate in activities of their choice . No further information was provided to the survey team prior to exit on 1/15/26.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, clinical record review, and facility document review, the facility staff failed to provided ordered treatment for pressure ulcers for (1) one of (28) twenty-eight sampled residents, Resident #4. The findings included:Resident #4's diagnoses included but were not limited to, a history of stroke with hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness affecting one side of the body) as well as dysphagia (difficulty swallowing), type II diabetes, schizophrenia, bipolar disorder, anxiety disorder and epilepsy. The annual minimum data set (MDS) assessment with an assessment reference date of 12/16/25 assigned the resident a brief interview for mental status score of 10 out 15 indicating a moderate cognitive impairment. On 1/3/26 at 11:25 AM a progress note read, Stage 2 pressure injury noted to sacrum. Area was cleansed with normal saline, barrier cream and foam dressing applied. Resident repositioned every 2 hours and prn (as needed). Incontinent care provided. No s/s of infection noted at present time. On call provider and (responsible party name omitted) made aware. Resident place on MD rounds. Will continue to monitor for healing. On 1/3/26 at 3:56 PM the Nurse Practitioner (NP) documented new orders in the progress notes, Cleanse the wound: Gently cleanse the wound with sterile saline or using Derma wound cleanser Apply Santyl: Apply the ointment directly to the wound surface at a thickness of about 2 mm (the thickness of a nickel), once daily Avoid certain products: Do not use Santyl with certain products, such as some detergents, acidic or basic cleaning solutions, or dressingscontaining silver or iodine, as they can reduce its effectiveness Moisturize (if needed): If the wound is dry, add moisture using a saline-moistened gauze, compatible wound gel Cover the wound: Cover the wound with foam dressing: Allevyn, Mepilex, etc.Change dressings daily, or as directed, to remove dead tissue and advance the healing process. The treatment administration record (TAR) for January 2026 was reviewed. A new order entered 1/3/26 at 3:35 PM read, Barrier cream to sacrum q (every) shift and prn (as needed) after incontinent episodes. There was no order for a dressing entered on the TAR 1/3/26 and the order for barrier cream did not include a cleansing step as in the NP's note. A nurse progress note dated 1/8/26 at 4:13 PM read, Dr. [NAME] in to see resident pressure injury found on left buttock informed resident and called RP (name omitted) no answer left message for her to return call. A document entitled Wound Evaluation and Management Summary was dated 1/8/26 and read in part, Stage 3 pressure wound to sacrum full thickness 1.4x1.2x0.2. Under the heading Dressing Treatment Plan the document read, Collagen sheet apply once daily and as needed if saturated, soiled or dislodged for 30 days. Under the heading Secondary Dressing the document read, gauze island with border apply once daily and as needed. Under the heading Peri Wound Treatment the document read, skin prep apply once daily and as needed. The TAR was reviewed on 1/13/26 and the above wound orders had not been entered. On 1/13/26 during the end of day team meeting with the Administrator, Director of Nursing (DON) and Regional Nurse Consultant, this surveyor informed the DON that I would like to observe wound care on 1/14/26 for resident #4. On 1/14/26 at 11:38 AM, this surveyor entered resident #4's room with the infection preventionist (IP) to observe wound care. This surveyor had noted that the wound care orders documented in the wound note on 1/8/26 had been put on the TAR with a date of 1/14/26. There was a dressing already on the wound dated 1/14/26. When the IP removed the dressing, this surveyor noted intact, red skin under the dressing. The IP checked to see if the area was blanchable, it was not but the wound was not open. On 1/14/26 at 11:50 AM the DON and the Regional Nurse Consultant were notified that the orders for wound care from 1/8/26 were not entered until 1/14/26 but the wound is healing and unopen. This surveyor requested a policy for wound care; the DON provided a policy for physician orders stating there was no policy for wound care. This concern was discussed at the pre-exit meeting on 1/15/26 at 1:57 PM with the administrator, director of nursing, regional vice president of operations, and regional nurse consultant.No further information was provided to the survey team prior to the exit conference.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, family interview, staff interview, clinical record review, and facility document review, facility staff failed to provide food that is prepared to conserve nutritive value, flavor, and appearance for (1) one of (28) twenty-eight sampled residents, Resident # 21. The findings included:For Resident #21 the facility staff failed to provide food that was palatable and attractive.Resident #21's clinical record listed diagnoses which included but not limited to dysphagia following cerebral infarction.Resident #21's most recent minimum data set with an assessment reference date of 11/16/25 assigned the resident a brief interview for mental status score of 9 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired.Resident #21's comprehensive care plan was reviewed and contained a plan for Potential for swallowing difficulty as related to: dysphagia. Interventions for this plan include diet as ordered.On 01/13/25 at 1 pm, surveyor spoke with Resident #21's mother. Resident #21's mother was visiting resident at this time. When surveyor began talking with Resident #21's mother, she stated, You're not here about her meal tray, I thought you were coming to talk about that. Surveyor asked Resident #21's mother what was wrong with the meal tray and resident's mother lifted the cover from the meal tray and stated, This is what she got. Surveyor observed a hamburger bun and what appeared to be breadcrumbs on the tray. Resident's mother reached into the tray and picked up the breadcrumbs and let them fall from her fingers, and stated, That is supposed to be a ground, breaded chicken patty. I don't know how she is supposed to eat that on a bun, if it was ever on the bun. It's dry as sawdust. Surveyor observed Resident #21's meal tray ticket and it read in part, Ground Breaded Chicken Patty for Bun, Hamburger Bun, Mayonnaise, Parmesan & Herb Roasted Cauliflower, chop, Oven Browned Potatoes, Sliced Peaches & Pears Resident #21's mother stated, Her ticket says she is supposed to have peaches, but they weren't on her tray. Surveyor did not observe any peaches/pears or a dish that would have contained them on the resident's tray.The concern of not providing food that is palatable and attractive was discussed with the administrator, director of nursing, and regional director of clinical services on 01/15/26 at 2:00 pm.No further information was provided prior to exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interviews, clinical record reviews, and facility document review, the facility staff failed to follow an established infection control program for (3) three of (28) twenty-eight sampled residents, Resident #4, Resident #32, and Resident #73. The findings included: 1. For resident #4, the facility staff failed to ensure the foley catheter drainage bag was not resting on the floor. Resident #4's diagnoses included but were not limited to, a history of stroke with hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness affecting one side of the body) as well as dysphagia (difficulty swallowing), type II diabetes, schizophrenia, bipolar disorder, anxiety disorder and epilepsy. The annual minimum data set (MDS) assessment with an assessment reference date of 12/16/25 assigned the resident a brief interview for mental status score of 10 out 15 indicating a moderate cognitive impairment. On 1/14/26 at 11:38 AM, this surveyor entered resident #4's room with the infection preventionist (IP) to observe wound care. This surveyor noted the foley catheter drainage bag was resting on the floor, the bed was in the low position. The IP began readying the resident for a dressing change. This surveyor asked the IP if the foley catheter drainage bag should be resting on the floor. They stated, No, it should not. The IP raised the bed enough to get the foley off the floor and hung it on the bed frame. On 1/14/26 at 11:50 AM the Director of Nursing (DON) was notified of this concern and asked for a policy on foley catheter care. The DON provided a policy entitled, Competencies with an effective date of 2/2017. The policy read in part, The nursing department will utilize the most current edition of Lippincott's Nursing Procedures and Lippincott's Manual of Nursing Practice for clinical standards of care in the facility. The DON pointed out a passage in the Nursing Procedures manual that read in part, Don't place the drainage bag on the floor, to reduce the risk of contamination and subsequent CAUTI (catheter associated urinary tract infection). This concern was discussed at the pre-exit meeting on 1/15/26 at 1:57 PM with the administrator, director of nursing, regional vice president of operations, and regional nurse consultant. No further information was provided to the survey team prior to the exit conference. 2. For Resident #32 the facility staff failed to ensure that gloves were not placed inappropriately on resident care equipment and on the floor. Resident #32's diagnosis list indicated diagnoses that included, but were not limited to, peripheral vascular disease, anxiety disorder, cognitive communication deficit, dementia, and dependence on supplemental oxygen. The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 12/22/25, assigned the resident a brief interview for mental status (BIMS) summary score of 7 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a tour of the facility on 1/12/26 at 12:50 PM, this surveyor observed (2) two gloves hanging on oxygen (O2) tubing near floor on right side of resident near O2 concentrator. On 1/13/26 at 9:07AM, this surveyor observed no gloves on O2 tubing. This surveyor observed 2 gloves near Resident #32's oxygen concentrator on the floor under the resident's bed. This concern was discussed at the end of day meeting on 1/14/26 at 5:05 PM with the administrator, director of nursing, and regional nurse consultant. On 1/15/26 at 1:57 PM, the director of nursing informed this surveyor, this issue had been corrected. Surveyor requested and received a facility policy titled, Guidelines for Disposable Resident Care Items with a revision date of 10/2020 which read in part, .Disposable items are discarded after the intended use for an individual resident.4. Single-use disposable items are discarded after each use. A. Examples of single-use items are gloves. No further information was provided to the survey team prior to exit on 1/15/26. 3. For Resident #73 the facility staff failed to follow established infection control procedures. Resident #73's clinical record listed diagnoses which included but not limited to acute cystitis without hematuria. Resident #73's most recent minimum data set with an assessment reference date of 12/05/25 assigned the resident a brief interview for mental status score of 4 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #73's comprehensive care plan was reviewed and contained a plan for I have a diagnosis of MRSA (methicillin resistant staphylococcus aureus) infection. Interventions for this care plan include Transmission based precautions per order. Resident #73's clinical record was reviewed and contained a physician's order summary which read in part, Transmission Based Precautions Contact Precautions every day and night shift for MRSA. On 01/13/25 at 8:15 am, surveyor observed certified nurse's aide (CNA) #1 in Resident #73's room. CNA #1 was not wearing any PPE (personal protective equipment) at this time. Surveyor returned to Resident #73's room at 8:20 am. Resident's door was closed; there was signage on the door that read STOP. Report to nurse before entering room and a cart containing PPE located outside door. Surveyor knocked on the door and heard someone say, Come in. Surveyor opened the door and observed CNA #1 seated on side of Resident #73's bed, assisting him with drinking fluids. CNA #1 was not wearing any PPE. Surveyor asked CNA #1 if they should be wearing PPE, and CNA #1 stated, I don't know, should I? Surveyor responded by saying, You should ask someone. Surveyor spoke with director of nursing (DON) on 01/15/26 at 8:40 am regarding CNA #1 not wearing PPE and sitting on resident's bed. DON stated that CNA should have been wearing PPE and should not have been sitting on resident's bed. Surveyor requested and was provided with a facility policy entitled, Transmission Based Precautions: Contact Precautions which read in part, Contact precautions are used to prevent the spread of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	microorganisms by direct or indirect contact with the patient or the patient's environment. Effective contact precautions require a single room, if possible, and the use of gloves and gowns by anyone having contact with the patient, the support equipment, or items that have come in contact with the patient or the patient's environment. The concern of not following established infection control procedures was discussed with the administrator, DON, and regional director of clinical services on 01/15/26 at 2:00 pm No further information was provided prior to exit.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on staff interview, clinical record review, and facility document review, the facility staff failed to offer a pneumococcal vaccine in accordance with nationally recognized standards for (1) one of (5) five sampled residents, Resident #14. The findings included:The facility staff failed to offer the resident a pneumococcal conjugate vaccine 15 (PCV15), 20 (PCV20), or 21 (PCV21) after their admission to the facility.The Centers for Disease Control and Prevention (CDC) website updated 10/07/25 recommends for individuals greater than 50 years or older that have only previously received only PPSV23: 1 dose of PCV15 or 1 dose PCV20 or 1 dose PCV21 at least 1 year after the last PPSV23 dose.Resident #14's age was greater than 50 and their diagnoses included diabetes and dementia.Section C (cognitive patterns) of Resident #14's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/12/25 included a brief interview for mental status (BIMS) score of 13 out of a possible 15 points. Indicating this resident was cognitively intact.On 01/13/26 the surveyor requested of the Infection Preventionist (IP) evidence of Resident #14's pneumococcal vaccines.On 01/13/2026 at 11:18 a.m., the surveyor and the IP reviewed Resident #14's vaccination status. On 04/05/23 Resident #14 had received the pneumovax 23 vaccine. The IP did not provide any further evidence to indicate this resident had received or had been offered any further pneumococcal vaccines.The facility policy titled, Pneumococcal Vaccinations with a revision date of 02/2022 read in part, The admitting nurse will research the medical record and resident history to determine if pneumococcal has ever been given. After determining vaccine status the admitting nurse determine what vaccine, if any, is recommended per current CDC guidance.Dosing Schedule.Adults with previous PPSV23 only may receive either PCV20 or PCV15 [greater than or equal to] 1 year after their last PPSV23 dose.On 01/14/2026 at 5:05 p.m., during an end of the day meeting with the Administrator, Director of Nursing, and Regional Nurse Consultant the issue with Resident #14's vaccine status was reviewed.On 01/15/26 at 12:15 p.m., during a phone interview with a staff from a local medical office this staff confirmed Resident #14 had been administered two pneumonia vaccines at their office. Vaccine #1 on 06/11/14 name of pneumococcal vaccine was unspecified. Vaccine #2 on 08/22/16 vaccine name was listed as pneumococcal polysaccharide PPV23. No further information regarding this issue was provided to the survey team prior to the exit conference.