STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495144	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Petersburg Healthcare Center	287 East South Boulevard Petersburg, VA 23805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to protect the resident's right to be free from abuse and neglect for four residents in a survey sample of 53 residents (Resident #61- R61, Resident #74-R74, Resident #76-R76, and Resident #77-R77). This non-compliance resulted in R61 sustaining a fracture, R74 having a bloody nose, R76 having scratches, all which required medical interventions, which constituted harm for those three of the four residents. This noncompliance resulted in the identification of immediate jeopardy (IJ) and substandard quality of care which began on 10/29/24 and required immediate facility intervention to protect residents from abuse and neglect. The facility had self-identified the deficient practice and achieved past non-compliance. Following the removal of IJ on 10/28/25 by implementation of a plan of correction, the scope and severity was lowered to a level three, isolated.The findings included:1. For R61 the facility neglected to provide the appropriate assistance during a mechanical lift transfer, which resulted in the resident being found with bruises and pain to her right leg and later diagosed with a tibia/fibula fracture, which constituted harm. R61 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to schizophrenia, chronic atrial fibrillation, generalized anxiety disorder, acute pulmonary edema, dysphasia, neuropathy, peripheral, vascular disease, recurrent depressive, mood disorder, and hypokalemia. The most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/11/25 coded Resident # 61 as having a Brief Interview for Mental Status (BIMS) score of 0 out of a possible 15 indicating severe cognitive impairment. R61 was coded as requiring assistance from staff with all aspects of ADL care. A review of the clinical record revealed that on 9/1/25 resident # 61 had increasing complaints of pain in her right leg and bruising to her right leg. The facility staff notified the nurse practitioner who ordered x-rays of both lower legs, and it was found that the resident had a right tibia/fibula fracture. The clinical record revealed that the doctor was notified who then sent the resident out to the emergency room for further evaluation and treatment. R61 returned to the facility on 9/4/25 with a splint in place A review of the incident investigation revealed that the facility interviewed staff as well as other residents and it was found that CNA #7 (certified nursing assistant) was observed by another resident transferring resident # 61 with a mechanical lift, alone without another staff member being present. CNA #7 was placed on suspension during the investigation however she resigned from her position prior to the conclusion of the investigation. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the clinical record revealed the following care plan entry Focus: [resident name redacted] has an ADL Self Care Performance deficit, requires assistance with ADL r/t [related to] cognitive deficit, intellectual disability, Functional Deficit, impaired mobility, neuropathy, schizophrenia Date Initiated: 09/04/2025 Revision on: 09/04/2025. The Goal: [resident name redacted] will maintain/improve current level of function through review date. Date Initiated: 06/23/2023 Revision on: 10/27/2025 Target Date: 03/01/2026. Interventions: Resident requires the use of mechanical lift with 2 person support Date Initiated: 06/23/2023 On the afternoon of 3/11/26 an interivew was conducted with CNA #4 who stated that all transfers requiring a mechanical lift must use two people. On the morning of 3/12/26 an interview was conducted with the DON [director of nursing] who stated that it is facility policy that anyone transferring with a mechanical lift must have two staff members. The DON further stated that the CNA #7 resigned but other staff as well as residents had reported she would transfer residents alone with the mechanical lift. On 3/12/26 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #74 (R74), the facility staff failed to provide adequate supervision to protect the resident from physical assault by another resident resulting in a bloody nose thus constituting harm. On 3/12/26, during a clinical record review of R74's chart, it was noted that on 9/7/24, a nursing note entry read, Resident to resident altercation. This resident was struck by another resident in the nose and cheek. Nose did have some bleeding although has subsided. Tylenol (Acetaminophen) given. Instructed to apply ice. Also, on 9/7/24, a change in condition note was entered into R74's clinical record, it read in part, .nose injury from altercation no bleeding no edema from nose right cheek slightly edematous. The doctor ordered PRN [as needed] pain medication and ice if needed. According to the medication administration record for R74, the resident was given Acetaminophen on 9/7/24 for an associated pain score of 7. On 9/8/24, R74 was again given Acetaminophen for a pain score of 5. On 3/12/26-3/13/26, review of the documentation provided by the facility was reviewed. According to an incident synopsis and incident summary, the facility gave the following details regarding the incident. On the evening of 9/7/2024, [Resident #118's- R118 name redacted] and [Resident #74's name redacted] were observed by other residents, in a verbal altercation while outside in the facility courtyard playing cards. The verbal escalated, in which [R118's name redacted] was observed throwing cards at [R74's name redacted] and then stood up and struck him in his face resulting in a bloody nose. At this time, it was witnessed [Resident #75's name redacted] stood up to stop the altercation which ended in [R118 and R74's names redacted] on the ground. On 3/13/26 at 9:11 AM, an interview was conducted with Resident #74 and Resident #75, who were roommates. R74 was asked about the incident that occurred on 9/7/24. R74 reported he recalled the incident and said, I really wanted to beat his a$$. R74 recalled that no staff were present when the incident occurred. R74 denied feeling any different following the incident and reported it didn't affect (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	him or his daily routine. R75, the roommate didn't add to the conversation and didn't acknowledge that he recalled the incident. 3. On 10/29/24 Resident #77 (R77) was a victim of verbal abuse by a certified nursing assistant (CNA #5), which was witnessed by another staff member (CNA #6). The resident suffered psychosocial harm as a result as documented by a mental health provider, licensed professional counselor. On 03/12/26, during a clinical record review of R77's chart a Licensed Professional Counselor (LPC) note entry dated 10/30/24 was noted. The note read in part, . The staff accused was heard by another staff and they were removed. [R77's name redacted] had more isolation this day, staying in her room for a longer period of time. Although she could not recall what happened due to her memory, she did have increased delusions and hallucinations. She had higher anxiety and was possibly experiencing acute stress. Staff is supporting and monitoring her mood. On 3/12/26, a review of the facility's documentation regarding the incident was reviewed. There was a typed paragraph/letter format of the facility investigation summary, an incident synopsis/alleging the initial allegation of abuse with minimal details, and only two staff witness statements. There was no evidence of any additional staff working having been interviewed, no resident interviews to include Resident #77 or the roommate. According to the statement from CNA #6, it indicated CNA #6 stated she heard CNA #5 state 'What the f*** is your problem? We need to get ready,' to Resident #77. According to the facility's investigation summary it noted that the allegation of abuse was unsubstantiated. On 03/12/2026 at approximately 11:40AM an interview was conducted with the Administrator. She was shown the investigation file, and the Administrator confirmed the investigation was incomplete. The administrator was shown the statement from CNA #6 who alleged to have witnessed the incident of verbal abuse and was asked based on the investigation only containing the two statements from the CNAs, how the allegation was unsubstantiated. The administrator confirmed based on the investigation information she was unable to determine why that conclusion had been made and indicated she did not agree with the prior administrator's conclusion. 4. For Resident #76 (R76), who was displaying behaviors, the facility staff left R76 unattended in the presence of another resident who assaulted R76, resulting in scratches that required physician orders for treatment. On 3/12/26-3/13/26, a review of R76's clinical record was conducted. This review revealed that according to R76's care plan he had a communication barrier and used an interpreter, because English was not the resident's dominate language. According to a progress note dated 10/22/25, it read, Resident had a physical altercation with a staff and another resident while seated in the wheelchair on the corridor located by his room Resident was observed going into the wound nurse's office and assaulting her and spitting on another resident. Staff was able to intervene to separate the residents; [R76's name redacted] was relocated to his room; head to toe complete, revealed minor scratches to back, abdomen, bil. [bilateral/both] arms/legs; skin otherwise intact, no complaints of pain or discomfort voiced via interpreter line.resident placed on 1:1 for safety, local law enforcement notified. According to the facility investigation documents it alleged that R76 went into the wound care nurse's (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	office, hit her and pushed her. The nurse exited the office to call for assistance. During that time another resident, (Resident #16-R16) told R76 to sit down. R76 then spit on R16 causing [R16's name redacted] to physical assault him [R76] (sic). On 3/11/26, an interview was conducted with the wound care nurse. The wound care nurse (WCN) recalled the events involving R76. The WCN recalled that she had helped R76 in the hallway then went into her office. While at the filing cabinet with her back to the door, she was startled to turn around and see R76 walking toward her. She said he kept approaching her. When asked if the resident made physical contact, she couldn't recall. She said she was scared, maneuvered past him and left the office to get assistance. The WCN was asked if she was aware that R76's dominant language was not English which may have been a factor in the resident not responding to her asking him to leave. The WCN acknowledged that she should have ensured R76 was safe prior to leaving the resident in the presence of another resident. On 3/11/26 at 10:48 AM, an interview was conducted with R76 using the facility's interpreter line via telephone, as R76's primary language was Spanish. R76 reported no concerns. On 3/12/26 at 8:30 AM, an interview was conducted with the facility administrator. A conversation was held regarding the incident involving R76, the wound care nurse and then R76 being assaulted by R16. The administrator stated that her expectation is for staff to make sure a resident is safe before leaving them. When asked if the wound care nurse ensured R76 was safe, the administrator said, I cannot prove he [R76] was safe before she left, if it isn't documented it didn't happen. On 3/12/26 in the afternoon, an interview was conducted with Resident #16. R16 was asked about the incident and reported that he recalled the wound care nurse left the room. R16 asked R76 to sit down and then R76 spit on him. R16 went on to explain that where he came from spitting on someone is the most disrespectful thing you can do and it just set him off causing him to hit and curse the resident. 5. For R76 the facility staff failed to protect the resident from an incident of physical and verbal abuse by a staff member. A clinical record review of R76's chart revealed no documentation regarding the incident of abuse that occurred on 7/29/25. On 3/11/26 at 10:48 AM, an interview was conducted with R76 using the facility's interpreter line via telephone, as R76's primary language was Spanish. R76 reported no concerns. On 3/12/26, a review of the facility's investigation file was conducted. The file included an incident synopsis and investigation summary on 7/29/25, R76 was hit with a towel twice and cursed by certified nursing assistant #4 (CNA #4) which was witnessed by LPN (licensed practical nurse) #8. On 3/12/26 at 9:55 AM, an interview was conducted with LPN #8. LPN #8 recalled, So it was about five something in the morning, I was on wing 2, as I was charting, I heard some yelling on wing 2, I thought someone had fallen or needed help. [Resident #76's name redacted]'s door was open and [Certified nursing assistant #4's name redacted] was yelling. I asked her what was going on, she was washing him up, said he spit on her and she had to hit him. I told her to leave the room; he has the right to refuse care. She [CNA #4] refused to stop washing him. He did spit on her, I told her to go, as we were leaving, she turned around and whipped him with the towel. His nurse came in and another (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	CNA came in and helped remove [CNA #4's name redacted] after that. LPN #8 was asked how R76 responded. LPN #8 said, He seemed afraid and was fighting. LPN #8 went on to report R76 was combative prior to the incident but said, you have to tell him what you are going to do, he doesn't really understand English. Within the facility's investigation documents was a statement from another staff member who reported that CNA #4, . she took the wet towel and slapped him across the face and called him a bth. The facility administrator's investigation summary substantiated the incident of abuse and CNA #4 was terminated as a result. Other staff who wrote witness statements and witnessed the incident were no longer working at the facility and/or were unable to be reached during the survey. According to the facility's abuse policy titled, Abuse, Neglect and Exploitation Policy – Virginia, it read in part, .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property. On 3/12/26 at 4:37 PM, the survey team met with the facility administrator, director of nursing and regional director of operations. They were notified that the survey team had identified Immediate Jeopardy (IJ) in the area of freedom from abuse, neglect and exploitation. The above findings were discussed and the IJ template was read and a copy provided to the administrator via email. On 3/12/26, following the identification of IJ, the facility's administrator and regional director of operations provided credible evidence that they had self-identified the non-compliance and implemented a plan of correction. They provided the survey team with a performance improvement plan that involved the previous administrator, who was the administrator at the time of several of the incidents. The administrator was then terminated on 1/2/25 for performance concerns that included their role as the abuse coordinator for the facility. The facility again on 10/22/25, self-identified concerns regarding abuse following the incident on 10/22/25 involving R76. The facility took measures to protect the residents by removing them from each other, assessed for injuries, and psychosocial outcomes. The facility then conducted interviews with all interviewable residents regarding abuse and conducted skin assessments of residents who were not interviewable. All staff were educated on abuse, neglect and misappropriation of property. The facility conducted an audit to ensure 100% of staff had received education. The facility implemented ambassador rounds to include interviews with residents daily to identify concerns regarding abuse and/or neglect. On 10/28/25, the quality assurance and performance improvement committee met to review the facility's actions and implemented monitoring that would continue for three months. The facility provided credible evidence of all actions taken and achieved past noncompliance as of 10/28/25, at which time the scope and severity was lowered to a level three, isolated. On 3/13/26, following review of the facility's submitted credible evidence the regional director of operations was made aware that past noncompliance had been confirmed by the survey team. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	No further information was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure residents receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 resident (#29) in a survey sample of 53 residents.For resident #29 (R29) the facility staff failed to ensure adequate hygiene and grooming assistance for a resident who is dependent on staff for ADL careR29 was admitted to the facility on [DATE] with diagnosis and that included but not limited to atrial fibrillation, alcohol, abuse, history of right hemispheric CVA with left upper extremity weakness, low back pain, and alcohol induced dementia. R29's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/1/25 coded R29 as having a brief interview of mental status score of three out of a possible 15 indicating severe cognitive impairment. R29 was coded as requiring moderate assist from staff for all aspects of ADL (activities of daily living) [bathing, dressing, personal hygiene, etc.] care.On 3/10/26 at 11:00 am R29 was observed in the hallway, his hair appeared extremely oily and unkempt. R29 was noted to have food in his beard and stains on his shirt. He had a strong odor of urine and body odor. On 3/11/26 at 3 PM, R29 was in the wheelchair and in the hallway, the food stains on his shirt, hair oily and uncombed, and his beard had food debris in it. R29 still was noted with a strong body odor and smells of urine.A review of the clinical record revealed that R29 was scheduled to have two showers per week. Resident # 29 did not receive 4 of his 12 showers for the month of February and had only received 2 bed baths in March, none of the entries were coded as refusals. On 3/11/26 an interview was held with CNA #3 who stated that R29 did not usually refuse showers and that R29 was unable to complete his own personal hygiene and bathing and shampooing his hair. On 3/11/26 at approximately 3:30 pm an interview was attempted with R29 was unsuccessful as R29 was unable to follow the conversation.A review of the clinical record revealed the following entry for ADL care: [Resident name redacted] has an ADL Self Care Performance deficit r/t metabolic encephalopathy, impaired cognition, alcohol induced dementia Date Initiated: 10/01/2025 Revision on: 12/18/2025Goal: [Resident name redacted] will improve current level of function Date Initiated: 10/01/2025Interventions: Shower /Bathe Self: Supervision/Touching Assist-Helper cues and/or touches/steadies resident Date Initiated: 01/12/2026On 3/12/26 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure the residents right to a dignified existance for 2 residents (resident #10 and resident #94) in a survey sample of 53 Residents.The findings included:1.For R10 the facility staff failed to ensure the resident was fully dressed before exiting her room, thus allowing her to exit the room and propel herself approximately 40 ft down the hall to the nurses station wearing nothing but an incontinence brief, in full view of other residents, staff and visitors.R10 was admitted to the facility on [DATE] with diagnoses that included but were not limited to bipolar disorder, major depressive disorder, schizophrenia, chronic kidney disease, heart failure, and history of falls. Resident #10's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/21/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 13 out of 15 indicating moderate cognitive impairment. R10 was coded as needing moderate to fully dependent on staff for all aspects of ADL and personal care apart from eating. R10 was able to self-propel her wheelchair for ambulation in the facility. The MDS section E0200 Behavioral Symptoms coded R10 as follows: Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) (E0200A) 1-3 days. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) (E0200B) 1-3 days Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) (E0200C) 1-3 days. E0900. Wandering - Presence & Frequency Has the resident wandered? (E0900) 1-3 days.On 3/10/26 at approximately 3 pm licensed practical nurses #6 and #7 (LPN's # 6 and 7), (the off-going day shift LPN and on-coming evening LPN) were observed making walking rounds and giving report on each resident as they briefly stopped at each door. LPN's 6 & 7 were observed briefly stopping at Resident #10's room)before moving on down the hall. Within one minute, Resident #10 was then observed by surveyors exiting her room dressed only in an incontinence brief and propelling self approximately 40 feet to the nurse's station in full view of staff visitors and other residents. Once at the nurse's station LPN #5 (Unit Manager) came from behind the nurse's station and said redirected the resident back to her room. On 3/10/26 at approximately 3:15 pm an interview was conducted with the Unit Manager and LPN's 6 and 7. The Unit Manager stated that resident #10 had not come out of her room without clothes on before. She stated this is the first time she had witnessed this behavior. LPN 6 and 7 both stated that R10 has not come out of her room without a top on.A review of the clinical record revealed the following care plan entry: FOCUS: [R10 name redacted] has a behavior problem related to bipolar, takes off brief and urinating on the floor in her room and in the hallway of the facility. Yelling, smoking cigarettes in her room, disrobes in her room and wheels out of her room in the hallway, reusing to wear briefs, refuses incontinence care Date Initiated: 09/12/2025 Revision on: 03/10/2026.GOAL: [R10 name redacted] will have fewer episodes of behaviors through review date. Date Initiated: 09/12/2025 Revision on: 02/24/2026 Target Date: 02/24/2026INTERVENTIONS: Administer medications as ordered. Observe and document s /sx of effectiveness and side effects. Educate resident / resident representative to medication effectiveness and side effects Date Initiated: 09/12/2025Approach, speak in calm manner. Date Initiated: 09/12/2025Behavioral health consults as needed; 1:1 supervision until evaluation is complete. Date Initiated: 03/10/2026 Revision on: 03/10/2026Communicate with resident / resident representative regarding behaviors, and treatment Date Initiated: 11/04/2025Consult with: Pastoral care, Psych services, and/or support groups Date Initiated: 11/04/2025.On 3/10/26 at 4:00 pm, attempts were made to interview R10, but were unsuccessful as the resident did not wish to speak to the surveyor and began yelling and using (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	profanity.On 3/13/26 the Administrator was made aware of the findings, and no further information was provided. 2. For R94 the facility staff failed to ensure the resident was dressed appropriately to maintain dignity.R94 was admitted to the facility with diagnosis that included, but we're not limited to hypertension, hyper lipidemia, seizure, disorder, malnutrition, anxiety, disorder, depression, bipolar disorder, and schizophrenia.Resident #94 most recent brief interview for mental status (BIMS) score was a zero out of a possible 15 indicating severe cognitive impairment. Resident number 94 was coded as being able to eat independently resident was dependent on staff for toileting, hygiene, dependent on staff for bathing and showering dependent on staff for upper body and lower body dressing dependent on staff for taking off and putting on footwear dependent on staff for personal hygiene section GG of the MDS states that R94 Is dependent on staff for turning repositioning lying to sitting on the bed, not attempted due to medical condition or safety. Sit to stand, not attempted due to medical condition or safety transfer bed to chair, not attempted due to medical condition or safety. R94 was dependent on staff for all aspects of ADL care. Once transferred to the wheelchair was able to propel herself by moving her feet.On 3/11/26 at approximately 3:30 pm, R94 was found in her room with curtain closed around bed, all linens off of the bed on the floor, visible from the hall, Resident had a dirty stained t shirt pulled up over her head completely covering her face and head, he breasts were exposed. The Resident did not respond when spoken to. Surveyor stepped out into the hallway and alerted RN #1 who was walking by. RN #1 was asked if this was an acceptable condition for this resident, RN #1 replied No but she is Geri- psych and resistant to care and she pulls the sheets off her bed. This statement was made in the resident's room in front of the resident.On 3/11/26 at 4:15 pm an interview was conducted with CNA 3 who stated that they should not refer to residents by their diagnosis.On 3/12/26 at 12:00 pm an interview was conducted with LPN 6 who stated that residents should be addressed as Mr. or Miss and their last name. She said residents should never be referred to as a diagnosis or condition. On 3/12/26 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to implement their abuse policy for 1 resident (Resident #113), and 1 employee (Employee #6) in a survey sample of 53 Residents, and the facility as a whole. The findings included; For Resident #113, the facility staff failed to notify the state agency timely after a serious injury and further failed to file an accurate 5-day follow-up report to the state agency of the results of their internal investigation. Resident #113 was most recently admitted to the facility on [DATE]. Diagnoses included: Parkinson's disease, bipolar disorder, anemia, and depression. At the time of survey, the Resident had expired due to the incident and so could not be interviewed. The closest Minimum Data Set (MDS) assessment to the survey time period associated with the event that injured Resident #113, was an unplanned discharge assessment with an assessment reference date (ARD) of 1-20-25. Prior to the incident Resident #113 was coded with a Brief Interview of Mental Status score of 13 indicating mild cognitive impairment. The Resident was independent for most activities of daily living and was her own decision maker and responsible party. Nursing and physician progress notes were reviewed and revealed a note on 1-20-25 at 1:00 A.M., that described finding the Resident with bruising and bleeding noted to head and face. [NAME] and throat appear discolored-purple, eyes darkened, lower lip purple, mouth bloodied, groggy and delayed verbal responses, due to the severity of the injuries to head will be transferred to the ER (emergency room) for evaluation. On 2-26-26 during the survey all facility investigation records were requested from the Administrator and the Regional Director of Operations (RDO). Among them were statements collected from staff including the Licensed Practical Nurse (LPN) who responded to the Resident after a CNA (Certified Nursing Assistant), found the Resident on the floor and reported it. In those records the LPN documented on 1-20-25 head felt lumpy, .when asked what happened Resident's words were gibberish. Resident to ER for further evaluation. On 1-20-25 an evaluation document was completed at 1:26 A.m. by a staff nurse in the facility. That evaluation described the Resident as found laying on her front side (face down) on the floor with legs stretched out straight and arms on her side. The staff member also included that a floor mat was present. Floor mats are placed beside beds in the resident's rooms for those with histories of falls to provide a cushioned area should the residents fall to mitigate injuries. Those mats are cushioned and run the entire length of the sides of the bed. An initial facility reported incident (FRI) was received in the Virginia Department of Health, Office of Licensure and Certification (VDH/OLC) on 1-20-25 at 10:07 A.M. (9 hours after the event) documenting that the Resident had an unwitnessed fall, injuries none, and that the hospital called the facility to inform them that the Resident arrived with suspicious bruises. The description went on to state that Law enforcement then followed up at the facility. A second Addendum report was received at VDH/OLC on 1-20-25 at 1:34 P.M (12.5 hours after the event). The addendum documented injuries, none, injury of unknown origin, and added that the (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receiving hospital had communicated to the nursing facility that they were making an allegation of sexual and physical abuse, No staff named at this time. The facility is fully cooperating with law enforcement and has launched their own investigation. The Resident was initially sent to the closest hospital on 1-20-25 at 2:00 A.M. (an hour after the incident). The first hospital then transferred the Resident to a second hospital according to facility documents and an APS (Adult Protective Services) report, after assessment and stabilization. The transfer was due to severe injuries requiring neurosurgery and care beyond their scope. The Resident arrived at the second hospital on 1-20-25 at 4:30 A.M., and was unconscious, unresponsive, and was already intubated at the time of arrival. The documentation goes on to say that discussions with the nursing facility alleged that the extensive injuries were from the Resident falling out of a seated position in a wheelchair and the Resident was found on the floor by a Certified Nursing Assistant (CNA). The hospital and APS description of injuries included old and new bruising on the body covering most of their arms, their legs, and over much of their body, the front of their neck, face, the top of their head, the back of their head, the back of their neck, their back, their abdomen, swelling and bleeding of the brain, and vaginal tearing and bleeding. At the second hospital, after assessment the Resident was stated to have significant bruising and injuries, and is not likely to survive their injuries, (location name) police department has been contacted. The Resident was transferred to the Intensive Care Unit (ICU) and expired on 1-24-25. On 1-20-25 at 9:32 A.M. a local Police Department Detective arrived at the facility to begin a forensic investigation and was in possession of a search warrant and secured the scene with other officers. Virginia Social Services/Adult Protective Services (APS) became involved as the hospital contacted them and reported the event for further investigation of physical and sexual abuse. On 2-25-26 the Administrator was interviewed and revealed that the only male working the night of the incident with Resident #113 was CNA (#3). As the investigation continued, it was learned that Resident #113 had reported an allegation of abuse on 12-30-24 involving her roommate (who was non-verbal) and CNA (#3). The full facility investigation completed for that incident was reviewed and deemed unfounded by the facility. CNA (#3) returned to work on 12-31-24. Time clock punch records for staff were requested and reviewed. The documents revealed that on 1-19-25 CNA (#3) was on duty overnight, and in the area, of Resident #113, and assigned to the next-door neighbor of Resident #113. Those same records indicated that he did not work after that. Interview with the RDO reveled that CNA (#3) was terminated on 8-19-25, late however did not return to work after the incident on 1-20-25. The Human Resources Director at the time had not removed his name from the roster in error which was a clerical error. Time clock records revealed this to be accurate. On 1-20-25 10:07 AM., the first report (FRI) of the incident, which was identified as an injury of unknown origin, and injuries none, was sent to the VDH/OLC, Late, (9 hours after the incident) and with incorrect information as found on floor post unwitnessed fall. The Facility staff were aware of the incident and serious injury within 2 hours of the incident as the facility sent the Resident to the hospital with serious injury and had communication with the hospital. Federal regulation requires a 2-hour report time, after the serious injury is known. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second Addendum report was received at VDH/OLC on 1-20-25 at 1:34 P.M (12.5 hours after the event). The addendum documented injuries, none, injury of unknown origin, and added that the receiving hospital had communicated to the nursing facility that they were making an allegation of sexual and physical abuse, No staff named at this time. The facility is fully cooperating with law enforcement and has launched their own investigation. This second report was also 7.5 hours late as the Abuse allegations were known at approximately 6:00 A.M. on 1-20-25 when the police detective made them aware of the criminal investigation upon their arrival. The facility Abuse policy was received as requested and revealed the following. The facility policy described under the heading Screening . a state criminal background check will be performed. During the course of the survey, it was identified by a second surveyor that screening of a state criminal background check had never been completed for Employee (#6). The policy goes on to instruct that under the heading Reporting.injuries of unknown source will be reported immediately, but not later than 2 hours after the allegation is made, if the events of the allegation involves abuse or results in serious bodily injury. Accurate and timely reporting of this incident to the state agency (VDH/OLC) did not happen. On 1-24-25 the 5-day follow-up Fri Investigation Final Report was completed by the Interim Administrator at the time of the incident who no longer worked for the facility. The timeline in the document described their conclusions (which by this time were known by the facility to be inaccurate). The document stated the following. The cause of the injury is unable to be substantiated., (and it is still being classified by them as) Allegation of abuse/mistreatment, injury of unknown origin, .and unwitnessed fall. The report continued documenting On the morning of 1-20-25, staff found (Resident #113 name) in (sic) the floor after an unwitnessed fall. Resident had bruising on her face and neck from the fall and had signs of head trauma from the fall. (these fall assumptions had not been proven, and the severe extent of the injuries were not disclosed) .911 was called and Resident transported to (name of hospital). At approximately 6:00 A.M., law enforcement arrived at the facility to inform they were investigating suspicious bruising. The report goes on to say, Law enforcement returned at 12 noon on 1-20-25 with a subpoena for medical records and to retrieve items from the patient's room. The subpoena indicated there was vaginal tearing and bleeding. Facility amended their initial report to include allegation of abuse/mistreatment. The 5-day follow-up document goes on to describe the facility investigation and facility response to the allegation. Finally, the document stated that the facility investigation thus far does not indicate that any abuse/mistreatment occurred. However, due to the fact that this is an ongoing police investigation, facility is unable to substantiate or unsubstantiate the allegations until the police conclude their investigation. Facility will continue to cooperate with law enforcement and will update this FRI if the police department is able to substantiate abuse occurred, or provides additional information related to this case. No update to this FRI was ever made by the facility. The police subpoena was reviewed and indicated it was issued at 9:30 A.M. and the facility was served at that time. Further the facility staff failed to make an initial report to the state agency timely, within 2 hours according to federal regulation for the known serious injury and failed to provide an accurate follow up report that was misleading when the details of the incident were known to them. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-20-25 A Quality Assessment and Process Improvement (QAPI) meeting was held with department directors, the RDO, the Administrator, and the DON. The meeting-initiated responses of the facility to the investigation, statements from staff, training on abuse, and statements from all residents who were queried as to abuse observations of others or self. The documents revealed signatures of those attending and those involved in the ongoing investigations and corrections. The RDO also supplied a chronology of events timeline which described the actions of those involved in the facility after the event regarding the incident. On 2-25-26 the Employee record for CNA (#3) was reviewed and revealed one sworn statement document provided by CNA (#3) that described in 1992 the CNA had been found guilty of misdemeanor larceny and the attestation was signed by him on 11-11-24. No other convictions nor pending criminal charges were revealed by the staff member. A review of state court records revealed that CNA (#3) had also been charged on 6-11-24 of a obtaining money by false pretenses felony and was found guilty on 10-27-25 after plea bargain to False statement on a criminal background history, misdemeanor with a sentence for 12 months in jail, however, all jail time was suspended after the conviction of that charge. That criminal act was evidenced to have happened again as the sworn statement provided to the facility dated 11-11-24 and signed by the prospective employee (5 months after pending criminal charges) revealed he made a materially false sworn statement again. Charges were pending for the 6-11-24 arrest and not revealed on the sworn statement document by CNA (#3), when he was hired at the facility on 11-25-24, as was described and mandated on the document . A criminal background check was completed by the facility on 11-11-24, and received by them revealing the 1992 larceny conviction, however, the pending charges of obtaining money by false pretenses was not yet a conviction, and so did not show up on that criminal records check and were not revealed by CNA (#3) as required. In summation, the facility staff failed to implement their abuse policies in regard to timely reporting and accurate reporting of an abuse allegation. They further failed to screen a new employee (Employee #6) for a criminal background check found during the survey which was unrelated to this incident. On 2-26-26 at 4:00 p.m., the facility Administrator, RDO, and DON were made aware of findings, at the end of day debriefing meeting. The facility stated they had no further information to provide. This allegation is Substantiated with a related Federal deficiency at F-607. 2. The findings included: [DATE] 25 random employee records were reviewed for compliance with the facilities per-employment screening and background check. Of the 25 records, Employee #6 did not have a sworn statement on file nor was the facility able to find an electronic copy of the sworn statement. Upon further investigation employee #6 did not have a Virginia State Police background check on file nor was an electronic copy able to be found. [DATE] at 8:20 AM interview with Other staff #1, Regional Human Resources representative from the corporate office was interviewed. Other #1 was informed that Employee #6 had no sworn statement (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nor background check performed by the Virginia State Police (VSP) documented to be on file. The facility was unable to locate the file on paper nor electronic copy of records. [DATE] at 1:38 PM a teleconference interview was conducted with Other #3 VSP background check personnel. Other #3 stated that there was no background check performed on Employee #6. The employee records showed that Employee #6 was hire on [DATE] and had access to all residents until termination on [DATE]. The facility P&P #: NS 1019-01-VA page 9 of 23 states Following the personal interview and upon recommendation of the interviewer, a background check will be performed. Additional information received appeared to be old court and criminal information on Employee #6 b ut not a VSP background check. [DATE] at 1030 AM these finding were reviewed with the facility Administration and DON.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to report incidents of abuse in accordance with regulatory requirements for three residents (Resident #52, Resident #74 and Resident #76) in a survey sample of 53 residents.The findings included:1. For Resident #52 (R52), who struck another resident with a rock, resulting in a cut to the other resident's forehead, the facility staff failed to report the incident to regulatory authorities as required. According to facility documentation and an incident summary, on 8/31/24, R52 allegedly striking [other resident's name redacted] on his forehead with a small rock. [Other resident's name redacted] was attempting to place a flower in [R52's name redacted] hair and [R52's name redacted] became irritate. The residents were separated for the courtyard. police notified [sic]. The facility failed to have credible evidence that the incident of abuse was reported to adult protective services or the state survey agency within 24 hours of the incident. The facility only had credible evidence of the investigation findings having been reported to adult protective services on 9/6/24. 2. For Resident #74 (R74), who was assaulted by another resident, the facility staff failed to have credible evidence that the incident was reported in a timely manner. On 3/12/26, during a clinical record review of R74's chart, it was noted that on 9/7/24, a change in condition note was entered. According to that note, it read in part, .nose injury from altercation no bleeding no edema from nose right cheek slightly edematous. The doctor ordered PRN [as needed] pain medication and ice if needed. On 9/7/24, a nursing note entry read, Resident to resident altercation. This resident was struck by another resident in the nose and cheek. Nose did have some bleeding although has subsided. Tylenol given. Instructed to apply ice. According to the medication administration record for R74, the resident was given Acetaminophen on 9/7/24 for an associated pain score of 7. On 9/8/24, R74 was again given Acetaminophen for a pain score of 5. On 3/12/26-3/13/26, review of the documentation provided by the facility was reviewed. According to an incident synopsis and incident summary, the facility gave the following details regarding the incident. On the evening of 9/7/2024, [Resident #118's- R118 name redacted] and [Resident #74's name redacted] were observed by other residents, in a verbal altercation while outside in the facility courtyard playing cards. The verbal escalated, in which [R118's name redacted] was observed throwing cards at [R74's name redacted] and then stood up and truck him in his face resulting in a bloody nose. At this time, it was witnessed [Resident #75's name redacted] stood up to stop the altercation which ended in [R118 and R74's names redacted] on the ground. On 3/13/26 at 9:11 AM, an interview was conducted with Resident #74 and Resident #75, who were roommates. R74 was asked about the incident that occurred on 9/7/24. R74 reported he recalled the incident and said, I really wanted to beat his a$$. R74 recalled that no staff were present when the incident occurred. R75, the roommate didn't add to the conversation and didn't acknowledge that he recalled the incident. There was no evidence of the incident being reported to adult protective services or the state survey agency until the investigations summary was sent via fax on 9/13/24. 3. For Resident #76 (R76), who was assaulted by another resident, the facility staff failed to report the incident of abuse to the regulatory agencies. On 3/12/26-3/13/26, a review of R76's clinical record was conducted. This review revealed that according to R76's care plan he had a communication barrier and used an interpreter. According to a progress note dated 10/22/25, it read, Resident had a physical altercation with a staff and another resident while seated in the wheelchair on the corridor located by his room Resident was observed going into the wound nurse's office and assaulting her and spitting on another resident. Staff was able to intervene to separate the residents; [R76's name redacted] was relocated to his room; head to toe complete, revealed minor scratches to back, abdomen, bil. [bilateral/both] arms/legs; skin otherwise intact, no complaints of pain or discomfort voiced via interpreter line.resident placed on 1:1 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for safety, local law enforcement notified. According to the facility investigation documents it alleged that R76 went into the wound care nurse's office, hit her and pushed her. The nurse exited the office to call for assistance. During that time another resident, (Resident #16-R16) told R76 to sit down. R76 then spit on R16 causing [R16's name redacted] to physical assault him [R76] (sic). The facility failed to have any credible evidence that this incident was reported to the state survey agency or that the investigation summary was reported to any of the regulatory agencies. On 3/12/26 at 11:13 AM, an interview was conducted with the facility administrator. The administrator was asked to explain the process when the facility receives an allegation of abuse, or an incident of abuse occurs. The administrator said, when get allegation of abuse, do initial FRI [facility reported incident], get witness statements from staff, after that we notify the appropriate parties, who are the ombudsman, APS [adult protective services], law enforcement, DON [director of nursing], MD [medical doctor], RDO [regional director of operations] and myself [administrator] and any other party that is necessary. Regarding the timing of reporting, the administrator said, anything with abuse we do reporting within 2 hours and anything other than that, I have a 24-hour time frame to get it reported. On 3/13/26 at 8:56 AM, an interview was conducted with the facility's director of nursing (DON). When asked to explain the reporting process for allegations of abuse, the DON said, We do an initial report to the OLC [state survey agency], ombudsman and APS (adult protective services) . Once we gather all of the information we talk about it and put everything together and form a conclusion and it gets sent to the OLC, ombudsman, and APS. The DON was asked, why reporting is important, the DON said, so they can be aware of what id going on in the facility between residents, to see if there is anything we need to put in place or prompt their investigation. When asked about timing of reporting, the DON said, initially within 2 hours and the final within 5 days. The facility's policy titled, Abuse, Neglect and Exploitation Policy-Virginia which was undated, was reviewed. The policy on age [AGE] read in part, . V. Reporting of Incidents and Facility Response: 1. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury a. If the events that cause the allegations do not result in serious bodily injury, reporting to the administrator (Executive Director) and to other reporting regulatory bodies must occur within twenty-four (24) hours. 2. Alleged violations are reported immediately to the Executive Director of the facility. a. The ED/designee will report appropriate incidents to the Adult Protective Services and the Division of Licensing and Regulation as required by state law. 3. The results of the facility's investigation must be reported to the survey agency, the ED/Designee and other officials in accordance with state law, within five working days of the incident. No additional information was provided prior to the conclusion of the survey.

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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. Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to have credible evidence of a thorough investigation of an allegation of abuse for one resident (Resident #77) in a survey sample of 53 residents. The findings included: On 03/12/26 at 01:35 PM, an attempt was made to interview Resident #77, but the resident was not available. On 03/12/26, a clinical record review of Resident #77's chart was performed. A Licensed Professional Counselor (LPC) note entry dated 10/30/24 read, The staff accused was heard by another staff and they were removed. [Resident #77] had more isolation this day, staying in her room for a longer period of time. Although she could not recall what happened due to her memory, she did have increased delusions and hallucinations. She had higher anxiety and was possibly experiencing acute stress. Staff is supporting and monitoring her mood. Within the investigation file was a typed paragraph/letter format of the facility investigation summary, an incident synopsis/alleging the initial allegation of abuse with minimal details, and only two staff witness statements. There was no evidence of any additional staff working having been interviewed, no resident interviews to include Resident #77 or the roommate. According to the statement from CNA #6, it indicated CNA #6 stated she heard CNA #5 state ?What the f*** is your problem? We need to get ready,' to Resident #77. According to the facility's investigation summary it noted that the allegation of abuse was unsubstantiated. On 03/12/2026 at approximately 11:40AM an interview was conducted with the Administrator. She was shown the investigation file, and the Administrator confirmed the investigation was incomplete. The administrator was shown the statement from CNA #6 who alleged to have witnessed the incident of verbal abuse and was asked based on the investigation only containing the two statements from the CNAs, how the allegation was unsubstantiated. The administrator confirmed based on the investigation information she was unable to determine why that conclusion had been made. On 03/12/26, the above findings were reviewed with the Administrator, RDO (Regional Director of Operations), DON (Director of Nursing), and RDCS (Regional Director of Clinical Services). No additional information was provided.

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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. 3. For Resident #76 (R76), the facility staff failed to remove the one-on-one supervision on the care plan, when it was discontinued. On 3/10/26, R76 was observed in his room lying in bed with no one else present in the room. R76 did not respond when spoken to. On 3/11/26 at 10:48 AM, an interview was conducted with R76 using the facility's interpreter line via telephone, as R76's primary language was Spanish. R76 reported no concerns. On 3/11/26, during a clinical record review, it was noted that R76's care plan had an intervention dated 10/22/25 that read, 1:1 supervision related to resident to resident altercation. On 3/11/26 at 2:03 PM, an interview was conducted with registered nurse #2 (RN #2), who was the care plan coordinator. RN #2 explained that care plans are updated during daily clinical meetings, when there is a change in condition, or when they have order changes. RN #2 went on to state that the care plan is important so the plan of care is followed, everyone knows what is going on and the goals. When asked to explain the importance of the care plan being up to date, RN #2 said, So as their condition changes everyone knows what is going on with the resident. The information is a tool so that certified nursing assistants (CNAs) know how to care for the resident. During the above interview with RN #2 she was asked about R76 being on one-to-one observation. RN #2 confirmed the resident was not on one-to-one and she would review the care plan. On 3/11/26 at 3:46 PM, RN #2 returned to the surveyor and reported that R76's one-to-one had been for less than 24 hours and said, It should have been resolved before now. According to the facility policy titled, Plan of Care Overview Revision 7.0 printed on 3/11/26, it read in part, . 2. Nurses are expected to participate in the resident plan of care for reviewing and revising the care plan of resident they provide care for as the resident's condition warrants. III. Care Plan documents. b. Care plan documents are resident specific/resident focused and reflect resident/representative opportunities for participation and preferences. On 3/11/26, during an end of day meeting, the above findings were reviewed with the facility administrator and director of nursing. No additional information was provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical recrord review, and facility documentation the facility staff failed to ensure residentsrecei ve treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan for 1 Resident (#10) in survey sample of 53 Residents.For Resident #10 (R10) the facility staff failed to ensure the resident received her medication in accordance with professional standards of practice and physician orders. R10 was admitted to the facility on [DATE] with diagnoses that included but were not limited to bipolar disorder, major depressive disorder, schizophrenia, chronic kidney disease, heart failure, and history of falls. R10's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/21/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 13 out of 15 indicating moderate cognitive impairment. R10 was coded as needing moderate to fully dependent on staff for all aspects of ADL and personal care apart from eating. R10 was able to self-propel her wheelchair for ambulation in the facility. The MDS section E0200 Behavioral Symptoms coded R10 as follows: Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) (E0200A) 1-3 days. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) (E0200B) 1-3 days Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) (E0200C) 1-3 days. E0900. Wandering - Presence & Frequency Has the resident wandered? (E0900) 1-3 days.On 3/11/26 a review of the clinical record revealed that R10 had gone out to the hospital on [DATE] and returned on 12/29/25. R10 had orders for Invega Sustena (an anti-psychotic) administered one a month for management of the symptoms of Schizophrenia. Prior to the hospital stay the order read:Invega Sustena Intramuscular Suspension Prefilled Syringe 156 MG/ML (Paliperidone Palmitate) Inject 1 ml intramuscularly one time a day every 30 day(s) for schizophrenia. R10 was due for the injection on 12/19/25, due to her hospital stay this was not given on time. R10 returned to the facility on [DATE] with orders for the Invega Sustena that read:Invega Sustena Intramuscular Suspension Prefilled Syringe 117 MG/ 0.75 ML (Paliperidone Palmitate) Inject 0.75 ml intramuscularly one time a day every 30 day(s) for schizophrenia.A review of the MAR (Medication Administration Record) revealed that the resident was not given Invega Sustena during the month of December 2025 and was given the incorrect dosage of 156 MG/ML on 1/21/26. The dose was also incorrectly ordered on the MAR for the month of February, and the resident also did not receive the medication in the month of February. On the morning of 3/11/26 an interview with the DON was conducted and she stated that it is the expectation of our nurses that they follow the physicians orders, and use [NAME] as the professional standard. The DON stated that the nurses are supposed to go by the rights of medication administration. (Nursing Centrer.com, 2026)Rights of Medication Administration1. Right patient2. Right medication3. Right dose4. Right route.5. Right time6. Right documentation7. Right reason8. Right response On 3/12/26 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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Petersburg Healthcare Center	287 East South Boulevard Petersburg, VA 23805

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and clinical record review, the facility staff failed to ensure proper foot care was provided to one resident (Resident # 94) in a survey sample of 53 residents.The findings included:For Resident # 94, the facility staff failed to ensure proper nail care was provided.Resident # 94 was admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included but were not limited to: hypertension, legal blindness, schizoaffecrive disorder, bipolar type, seizures and bipolar disorder current episode manic without psychotic features and generalized anxiety disorder.The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 1/12/2026. Resident # 94's BIMS (Brief Interview for Mental Status) Score was a 00 out of 15, indicating severe cognitive impairment. Resident # 94 required assistance with Activities of Daily Living.Review of the clinical record was conducted 2/24/2026 to 2/27/2026.During the initial tour of the facility on 2/24/2026 at 11:30 a.m., Resident # 94 was observed lying in bed. Both feet were uncovered. Observation of the toenails on both feet revealed thick and long toenails. The toenail on the great toe on the right foot was dark in color, approximately an inch and half in length, pointed and curved to the right over the second toe. The left great toenail was approximately a half inch to one half inch long, thick and dark in color.On 2/25/2026 during rounds at 9 a.m., 11 a.m., and 1:30 p.m., Resident # 94 was observed lying in bed with feet uncovered. The toenails remained the same.On 2/26/2026 at approximately 2:30 p.m., an interview was conducted with Certified Nursing Assistant # 2 who stated the expectation was for the nursing assistants to cut the toenails of residents unless they were Diabetics. She stated the nurses should be notified if the residents refuse to allow the staff to provide nail care.Review of the Podiatry records revealed that Resident # 94 was not listed as one of the residents to be seen by the podiatrist from November 2025 to February 2026. Review of the clinical record revealed no documentation that the resident was treated by the Podiatrist nor any documentation regarding toenails being cut by the staff during those months. On 2/26/2026 at 2:50 p.m., an interview was conducted with Licensed Practical Nurse # 3 who stated proper nail care should be provided to residents. Licensed Practical Nurse # 3 stated Resident # 94 needed footcare. On 2/26/2026 at 9:30 a.m., an interview was conducted with the Director of Nursing who stated the facility staff should provide nail care to the residents. The Director of Nursing stated that Resident # 94 often refused care. The Director of Nursing observed the toenails of Resident # 94 and stated that the right great toe nail was very long and needed to be trimmed.On 2/26/2026 during the end of day meeting, the Administrator and Director of Nursing were made aware of the findings. No further information was provided.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observations and staff interview and facility documentation review, the facility failed to properly post nurse staffing information at 2 of 2 units with an up-to-date and current nursing sheet for resident, staff, and public view.The findings included: The facility staff failed to post up-to-date nurse staffing to reflect the actual staff working for public view. On 2/26/2026, during a facility tour an observation of the daily nursing staffing sheets noted the staffing wase posted at the front desk and outside of the Staffing Managers office near nursing station on unit wing 1. On 2/26/2026 at 1:00 PM, an interview with the staffing manager (Other #2) was conducted. The staffing manager stated the daily nursing staff sheets were located in two locations. Observation of nursing staffing sheet for the day was located at the entrance near the front desk window and outside of Other #2 office on the wall in a see through case. On 2/26/2026 at approximately 1:15 PM, the staffing manager was asked, if there are changes to nursing staffing schedules what happens? The staffing manager stated that if staff calls out or are a no show for their shift they are marked off of an additional sheet located behind the counter at the nursing station, outside of the the staffing managers office. When the staffing manager was asked if the nursing staffing sheets located in the facility were updated with call outs or no shows, she stated that those sheets are not updated just the sheet behind the desk at the nursing station, which was not available for public view. On 2/26/2026 at approximately 1:20 PM, during an observation an updated nursing staff sheet was unable to be seen in plain sight at the nursing desk at unit wing 1. On 2/27/2026 at approximately 10:30 AM, the above findings were reviewed with the facility Administrator and Director of Nursing. No additional information was provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on staff interview, facility document review, and clinical record review, the facility staff failed to respond to a pharmacy recommendation for one of fifty three residents in the survey sample. Resident # 54. The findings included:The physician did not respond to a pharmacy recommendation regarding scheduled vital signs for Resident #54 (R54). Diagnoses for R54 included cerebrovascular disease, hypertension, and edema related to fluid retention. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/6/26. R54 was assessed with long and short-term memory problems and severely cognitively impaired. Medication Regimen Review (MRR) for R54 indicated that the pharmacist had made a recommendation on 12/26/25. On 2/26/26 at 10:11 a.m. the director of nursing (DON) presented the recommendation. The recommendation listed three medications: Metoprolol (given for hypertension, Amlodipine (given for hypertension), and furosemide (given for fluid retention). The recommendation was asking to consider adding an order for scheduled vitals. The recommendation form titled Note to Attending Physician/Provider had an area on the form for the physician/provider to complete a response to the recommendation. This part of the form was not filled out by the provider and was left blank. The DON verbalized the physician did not respond to the recommendation and no orders were implemented. On 2/26/2026 at 3:54 p.m. the above information was presented to the DON and administrator. The facilities policy titled Medication Regimen Review read in part The resident's medical practitioner must document in the medical record that the identified irregularity has been reviewed, and what, if any action has been taken to address it. No other information was presented prior to exiting the facility on 2/27/26.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility documentation, the facility staff failed to ensure residents were free from significant medication errors for 1 Resident (# 10) in a survey sample of 53 residents.For Resident #10 (R10) the facility staff failed to administer Invega Sustena (a psychotropic medication) during the month of December 2025, gave the incorrect dosage in January of 2025 and did not give it in February of 2025.R10 was admitted to the facility on [DATE] with diagnoses that included but were not limited to bipolar disorder, major depressive disorder, schizophrenia, chronic kidney disease, heart failure, and history of falls. Resident #10's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/21/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 13 out of 15 indicating moderate cognitive impairment. Resident #10 was coded as needing moderate to fully dependent on staff for all aspects of ADL and personal care apart from eating. R10 was able to self-propel her wheelchair for ambulation in the facility. The MDS section E0200 Behavioral Symptoms coded R10 as follows: Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) (E0200A) 1-3 days. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) (E0200B) 1-3 days. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) (E0200C) 1-3 days. E0900. Wandering - Presence & Frequency Has the resident wandered? (E0900) 1-3 days.On 3/11/26 a review of the clinical record revealed that R10 had gone out to the hospital on [DATE] and returned on 12/29/25. R10 had orders for Invega Sustena (an anti-psychotic) administered one a month for management of the symptoms of Schizophrenia. Prior to the hospital stay the order read:Invega Sustena Intramuscular Suspension Prefilled Syringe 156 MG/ML (Paliperidone Palmitate) Inject 1 ml intramuscularly one time a day every 30 day(s) for schizophrenia. Resident #10 was due for the injection on 12/19/25, due to her hospital stay this was not given on time. R10 returned to the facility on [DATE] with orders for the Invega Sustena that read:Invega Sustena Intramuscular Suspension Prefilled Syringe 117 MG/ 0.75 ML (Paliperidone Palmitate) Inject 0.75 ml intramuscularly onetime a day every 30 day(s) for schizophrenia. A review of the MAR (Medication Administration Record) revealed that the resident was not given Invega Sustena during the month of December 2025, and was given the incorrect dosage of 156 MG/ML on 1/21/26. The dose was also incorrectly ordered on the MAR for the month of February, and the resident also did not receive the medication in the month of February.On the morning of 3/11/26 an interview with LPN 6 was conducted and she stated that when the facility receives an admission or readmission the nurse on the floor gets the discharge summary and goes over the med list and notifies the provider or the on call to get the medications verified. LPN 6 also stated that if a resident who recieves monthly injections of Invega Sustena skips a month or is not given the correct dosage it can have an effect on their behaviors. It can cause an escalation or increase in behavioral symptoms.On 3/11/26 at approximately 1:00 pm an interview was conducted with the DON who stated that it is the expectation of the nurses that they verify the orders on admission or readmission to the facility. She stated the nurse is supposed to reconcile the meds with the physician or on call provider using the discharge summary from the hospital. A review of the discharge summary revealed the change in dosage of Invega Sustena to 117 mg / 0.75 ml upon admission. The DON further stated that if medication is not given for any reason the provider must be notified. When asked about the significance of not receiving anti-psychotic on a routine schedule as ordered by the physician, she stated the behaviors could change and the symptoms exacerbate.On 3/13/26 the Administrator was made aware of the findings, and no further information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and facility document record review, the facility failed to ensure that medications were stored correctly for one of two medication carts inspected.The findings include:On 2/25/26 at 2:04 PM, an inspection was conducted on two facility medication carts, cart #1 and cart #2. During this inspection, an opened vial of Lispro (an insulin medication) 100mL (milliliters) was noted in the top drawer of medication cart #1 inside a transparent plastic bag. A sticker was affixed to the bag stating, Discard by: 2/24/26. Further inspection of this medication revealed an opened date transcribed on the vial of 12/25/25. A review of facility policy demonstrated that the facility is to discard immediately any outdated medications. A review of the facility med cart sheet showed that Lispro has a discard date of 4 weeks after opening.An interview was conducted on 2/25/26 at 2:04 PM with LPN (Licensed Practical Nurse) #2. LPN #2 stated that Lispro should be good for 30 days after it is opened and they will discard this medication.No further information was provided prior to exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for two residents (Resident #117-R117 and Resident #64-R64), in a survey sample of 53 residents. The findings included: 1. For R117 who had an incident which resulted in the police being called, the facility staff failed to document details of the incident within the clinical record. On 3/11/26, during a review of facility documentation it was noted in a facility incident synopsis that on 10/21/22 there was an allegation of abuse involving R117. According to the incident summary signed by the director of nursing (DON) and dated 10/26/22, it noted that on 10/21/22, R117 was attempting to retrieve linen from linen closet. [LPN #9's name redacted] approached [R117's name redacted] and asked him to wait for assistance due to cross contamination . [R117's name redacted] approached [LPN #9's name redacted] and proceeded to push her and hit her with towels. Staff were able to intervene and assist [R117] back to his room, where he calmed down . [LPN #9's name redacted] called law enforcement to report resident for assaulting her . Review of R117's progress notes, revealed no progress note entries dated 10/21/22 or the following day. On 3/11/26, an interview was conducted with the facility administrator who said that she would expect when incidents occur, they are clearly documented within the resident's clinical record. According to an undated facility policy titled, Clinical Documentation Standards it read in part, Maintaining the integrity, quality, and safety of medical records can help to provide an effective communication between practitioner that may serve to enhance resident outcomes . Nurses will follow the basic standard of practice for documentation including but not limited to providing a timely and accurate amount of resident information in the medical record . On 3/11/26 during an end of day meeting the above findings were reviewed with the facility administrator and director of nursing. No additional information was received. 2. For Resident #64 (R64) the facility staff failed to maintain an accurate clinical record to include the details of R64's debit card being taken and used by other residents. On 3/10/26, a review was conducted of R64's clinical record and facility investigation documents. This review revealed that R64's clinical record had no recorded details of the incident of misappropriation and financial exploitation that R64 was victim of. On 3/10/26, according to the facility's investigation synopsis, on 12/30/25 R64 reported to the social services director that she wanted to change rooms and reported that her roommate had stolen her debit card information several months prior. R64 reported that several months prior, while asleep when she awakened R64 observed her roommate placing her debit card back into her purse. According to the facility investigation summary and investigation synopsis, R64 dismissed the incident at the time. When R64 was asked by facility staff why she was bringing up the incident at (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that time, R64 reported since that incident she has consistently lacked funds in her bank account. During the facility's investigation of R64's allegation, the roommate confirmed she had provided R64's debit card information to another resident. According to R64's clinical record there was no documentation within the record about the incident, facility investigation, or actions taken during and following the investigation. On 3/12/26 at 2 PM, an interview was conducted with R64. R64 recalled the incident and confirmed the details as documented in the facility investigation summary and investigation synopsis. On 3/12/26, during and end of day meeting, the facility Administrator, Director of Nursing, and Regional Director of Clinical Services were made aware of the above findings. The Administrator agreed that she would expect documentation within a resident's clinical record of such incidents. No additional information was provided prior to conclusion of the survey.