STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure there was a self-administration of medication assessment prior to leaving medications at the bedside for one (1) of 74 residents (Resident #91) in survey sample. Findings included: For Resident # 91, the facility staff failed to ensure there was a self-administration of medication assessment prior to leaving medications at the bedside. Resident # 91 was admitted to the facility on [DATE]. Diagnoses included but were not limited to: Cerebral Infarction, Hypertension, Anxiety Disorder, Hemiplegia and Vascular Dementia. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 11/3/2024. Resident # 91's BIMS (Brief Interview for Mental Status) Score was a 14 out of 15, indicating no cognitive impairment. Resident # 91 required assistance with Activities of Daily Living. Review of the clinical record was conducted on 12/10/2024-12/19/2024. During the initial tour on 12/10/2024 at approximately 2:10 p.m., a medication cup with two white pills was observed on the overbed table by the bed by the window. The pills were white in color; one was oval and the other was round in shape. The resident was not in the room when the surveyor walked into the room. There was no nursing staff member in the hallway when the surveyor looked for someone to ask about the medications. After approximately eight (8) minutes, a facility staff member was observed in the hallway. She identified herself as the Admissions Coordinator. She was asked if she knew who resided in the room. She identified the resident's name as Resident # 91. The Admissions Coordinator stated she would find a nursing staff member. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 2:23 p.m., Resident # 91 entered the room as the Admissions Coordinator was leaving the room. When asked about the medication in the cup, Resident # 91 stated that was the medicine from this morning. He stated that he told the nurse he was going to take it. Resident # 91 stated he wanted to take his time taking his medications. He stated he was not sure of the kind of pills but thought one was Trazadone. On 12/10/2024 at 2:34 p.m., an interview was conducted with the Unit Manager, LPN (Licensed Practical Nurse)- # 1 who stated there was no self administration by any residents on the unit. She stated none of the residents on the unit had assessments with orders for self administration of medications. On 12/10/2024 at 2:39 p.m. an interview was conducted with the nurse (LPN-3) scheduled to pass medications on that day. LPN-3 stated she administered the morning medications for Resident # 91. LPN-3 stated the medications in the medication cup were not the medications scheduled for administration in the mornings. LPN-3 stated she did not see the medication cup with medications on the overbed table when she administered the medications that morning. LPN-3 stated medications should not be left at the bedside. The Administrator came to Resident # 91's room with the surveyor. The Administrator observed the medication cup on the overbed table and asked Resident # 91 where the medications had come from. Resident # 91 told the Administrator that medications were from that morning and that he would take them right then. The Unit Manager informed Resident # 91 that the staff needed to determine which medications were in the medicine cup. The Unit Manager and Administrator removed the medications from the room. LPN # 3 and the Unit Manager reviewed the December 2024 Medication Administration Record and the Medication pill cards to compare with those found at the bedside. They determined that the two pills were two medications that were scheduled to be administered at bedtime at 2100 (9:00 p.m.): Atorvastatin 40 mg (milligrams) give one tablet by mouth at bedtime for hyperlipidemia and Melatonin 3.1 mg (milligrams) give one tablet by mouth at bedtime for insomnia. Review of the December 2024 Medication Administration Record revealed the two medications had been documented as administered every night except when refused by the resident on 12/4/2024 and 12/6/2024. The Unit Manager discarded the medications that were in the medication cup. She stated she did not know when the medications had been left at the bedside. During the end of day debriefings on 12/10/2024 and 12/11/2024, the Administrator, Director of Nursing and Regional Nurse Consultant were informed of the findings. They stated medications should not be left at the bedside unless a resident has been assessed for self administration of medications. A copy of the medication administration policy was requested. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Policy dated 11/01/2020, reviewed and revised 12/1/2022 revealed the following policy statement: Medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . Under Policy Explanation and Compliance Guidance were the following excerpts: 15. Observe resident consumption of medication. and 17. Sign MAR after administered . and 19. Report and document any adverse side effects or refusals. No further information was provided.

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F 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect a residents' right to refuse some types of non-requested transfers within the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility staff failed to afford a resident the ability to refuse a transfer affecting one (1) resident (Resident #226) in a survey sample of 74 Residents. The findings included: For Resident #226, who refused a transfer to the locked memory care unit for Residents with dementia and behaviors, the facility staff failed to honor the Resident's request. The staff moved him against his will, for staff convenience. Resident #226 was admitted to the facility on [DATE] with diagnoses including: End stage renal disease with hemodialysis, history of stroke, anemia, chronic congestive heart failure, hypertension, and diabetes type 2. The Resident did not have a diagnosis of dementia and was his own responsible party and by facility agreement cognitively intact and able to make his own decisions. Three MDS (minimum data set) federal assessments were reviewed since the resident's admission through the time of survey on 12-10-24. Those follow below: 1. The first MDS admission assessment was dated 6-10-24 and indicated the Resident had a Brief Interview for Mental Status BIMs score of 8 of a possible 15 points upon admission after Acute hospitalization for encephalopathy from a fall and missing hemodialysis. He was coded in the document as able to understand and be understood, no aberrant behaviors, needed only limited assistance with most (activities of daily living) ADLs such as toileting, ambulating, hygiene, transferring, and bed mobility, and was dependant on staff only for bathing, however needed only tray set up and clean up for meals. 2. The second MDS was a quarterly assessment dated [DATE] which indicated the Resident had a Brief Interview for Mental Status BIMs score of 11 of a possible 15 points after a rehospitalization for septic shock due to hypovolemia, as no infection was found to support septic shock, nor sedation as narcan had no effect. He was coded in the document as able to understand and be understood, no aberrant behaviors, and functional abilities were not coded. 3. The third MDS was a quarterly assessment dated [DATE] indicated the Resident had a Brief Interview for Mental Status BIMs score of 10 of a possible 15 points. He was coded in the document as able to understand and be understood, no aberrant behaviors, needed only set up and clean up for bathing, otherwise, was completely independent for all (activities of daily living) ADLs such as toileting, ambulating, hygiene, transferring, and bed mobility, and eating. (continued on next page)

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F 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9-26-24 at 4:42 PM the Resident was moved to the memory care locked unit and the resident's son was notified according to the room change notification document in the clinical record, however, the document stated that the resident's brother agreed to the room change even though these individuals were only emergency contacts and the resident refused and was his own responsible party. The reason given for the move, was elopement risk. The resident had never eloped and on the one occasion that he went outside to sit in the sun after dialysis he did not leave, even though he could have walked away, he simply sat there until staff came to take him back to his room. When asked about this incident the resident stated there is no reason that I can't sit outside for awhile and get some fresh air. I am not a prisoner. During an initial interview on 12-10-24, at 11:40 AM, Resident #226 was found to be alert and oriented to person, place, time, and situation. He stated that he had requested to stay in his current room after learning that the facility planned to move him rather than discharge him home. Resident #226 stated he was told his son and grandson were not able or willing to care for him in the home that the three of them had formerly shared. The resident insisted on planning a discharge back to the community, or an assisted Living Facility as soon as possible, however, he stated no one listened, no one came to talk to me about it, and nothing ever happened even though I kept telling them. During this interview, Resident #226 verbalized that he is a dialysis patient and that he received dialysis there in the facility. He further stated he hates the memory care unit because everyone is crazy in here, they wander into my room and take things, my room mate yells and cries all night for something to drink, I don't even get food every meal, the room is nasty and falling apart, and I can't even get a shower in here because the showers are so nasty dirty. He went on to say I like to walk around, it makes the time go faster, if I don't walk now I won't be able to leave, but locked in here I have no where to walk, I don't even have a TV to watch and I love TV, being in here will make you crazy with nothing to do. The surveyor and resident then immediately walked to the shower room for an initial observation and found it to be dirty, mildewed/moldy, foul smelling, had a strong odor of urine and feces, trash and debris littered the floor, used brown stained wet linens were on the floor, a white crusted substance was on the floor and walls, used soap and shampoo bottles were crusted on the shelves and hand rails in the shower, and the room was being used as a storage area as well for boxes of supplies and durable medical equipment. The resident asked would you want to take a shower in here? It is notable to mention that no activities were noted to be conducted in the secured unit from 12-10-24 until 12-18-24. The staff were asked why no activities were being conducted for the residents and they replied that we only have one activity person for the whole 150 bed facility. Facility CNA (Certified nursing Assistant) and LPN (Licensed Practical Nurse) staff on the memory care unit and other units were interviewed, and stated the reason that Resident #226 had been placed on the memory unit was wandering and behaviors When asked what his behaviors were, they were only able to say he went outside and sat in his wheel chair one time after dialysis, and further stated he would wander up and down the halls and that will get you put in here for sure. The surveyor asked why he walked, and there was no response. (continued on next page)

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F 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social worker was interviewed on 12-10-24 and revealed that she had just been hired on 11-19-24. The former Social worker resigned on 6-28-24, and there had been no social worker in the facility from 6-28-24 until 11-19-24. She stated she would be putting in a progress note for Resident #226 on this same day, and she stated that she didn't really know much about him. On 12-11-24 the social work note was reviewed and revealed a progress note that documented the Resident as long term care during a care planning meeting, and nothing about discharge planning or his desire to be discharged . On 12-12-24 the Social worker's license and curriculum vitae were requested for verification and vetting as part of the employee records review for competency of staff. It was noted that the required course work and degree required by state and federal regulation for this employee was not sufficient for the role. The Director of Nursing and Administrator were asked for a policy or procedural guidance for moving a Resident onto the memory care locked unit. Both stated that they did not have one, and could not describe a pathway to the decision for moving a resident into the secure unit. On 12-11-24, through 12-19-24 a clinical record review was conducted. There was no evidence in the clinical record that the physician had been called and notified of the resident's move, nor was a request made for assessment and told that the resident wished to discharge. On 12-5-24 a PHQ-9 (the only one during his stay) evaluation for depression was conducted and gave a score of 3 which equaled minimal or not at all suffering from depression. The Resident was not ordered to have any psychoactive medications, nor did he have any diagnoses to support the use of them. On 12-12-24, during an end of day debriefing with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns and that the Resident had requested to stay in his room, and to be planned for discharge, which was denied and there was no evidence that the physician was notified of this request. Further they were notified that no Social Worker was providing care during the Resident's stay which compounded the incident further, which culminated in the withholding of a resident's rights, and involuntary seclusion. On 12-19-24, prior to the survey exit the Director of Nursing informed surveyors that Resident #226 and his room mate had been moved back onto regular units last night (12-18-24). At the time of survey exit on 12-19-24 the facility Administrator, and Director of Nursing stated they had nothing further to provide.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 40026 Based on interview, observation, and facility documentation the facility staff failed to promptly act upon the grievances and recommendations of regularly attending Resident council members. The findings included: The facility staff failed to promptly address the concerns brought forth by the Resident council group members. On 12/11/24 at 3 p.m. a Resident Council meeting was held with the Resident Council President and 6 other members who regularly attended. During the meeting it was discussed that the facility fails to act, in a timely manner, on suggestions, or concerns brought forth by the Resident Council. On 12/12/24 a review of the Resident council minutes revealed that several issues were repeatedly brought up in Resident council. Excerpts from the Resident council minutes revealed the following: On 8/14/24, 9/26/24, and 10/24/24 - Resident council minutes reflected complaints of needing more linens, (towels, sheets), long turnaround time for getting laundry back from housekeeping, and personal items missing from laundry, as well as bathrooms needing to be cleaner (unclean bathrooms / shower rooms were also noted during survey). On 8/14/24 and 9/26/24 - Resident council minutes reflected complaints that there were no clocks in the hallway or the activity room (identified during the survey). On 10/24/24 and 11/25/24 - Resident council minutes reflect that Nursing staff make Residents feel as if they are In the way. Complaints of Unit 4 included staff not giving medications on night shift, and Nursing staff are on the cell phones. Resident council also claimed Nursing staff Talking about other Residents in common areas where others can hear them. Resident council also complained that Administration is not following up or following through on grievances. On 12/17/24 at approximately 2:00 p.m. an interview was conducted with Other Employee #4 who stated that there has been a Turn over in Activity Staff as well as the Social Worker so this slowed things down a bit. On 12/19/24 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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on a resident personal funds review, the resident interview, staff interview and facility document review, the facility staff failed to ensure that one (1) resident out of 74 residents in the survey sample, Resident #24, was afforded the right to receive quarterly statements. The findings included; Resident #24 was originally admitted to the facility 11/17/22 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included Schizoaffective Disorder, Bipolar type. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 09/19/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #24 was moderatly impaired for the cognitive abilities for daily decision making. The care plan dated 11/24/23 read that Resident #24 has impaired thought processes as evidenced by delusions secondary to schizoaffective/bipolar disorder. The goal for the resident was for the resident will be able to communicate basic needs on a daily basis through the review date 10/01/24. The Interventions: Present just one thought, idea, question or command at a time and monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. On 12/11/24 at approximately 1:23 PM., during the initial tour Resident #24 said that the facility was not given her money and that she was not receiving quarterly statements. On 12/18/24 at approximately 2:35 PM., an interview was conducted with the Business Office Manager (BOM) and with the Regional BOM. The BOM said that the resident's funds come to the facility to her resident funds account and to resident's guardian services. The BOM also mentioned that the facility is the Representative Payee (RP). The Regional BOM said that the resident must come to the business office to request funds. The Regional BOM also mentioned that Letters (quarterly statements) are mailed to the Guardian Services and the resident must come to us first to ask for the statement. We're still going to send the statements to her Guardian Services. On 12/19/24 at approximately 2:56 PM, a meeting was conducted with the BOM concerning the above issues. The BOM said that to her knowledge the Resident requested funds for first time on 12/18/24. The BOM also said that she will give the Resident a statement every month and a quarterly statement. On 12/19/24 at approximately 5:55 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on staff interview, clinical record review, the facility staff failed to ensure the physician was notified of pertinent information regarding two (2) residents (Resident # 327 and # 326) in a survey sample of 74 residents. Findings included: 1. For Resident # 327, the facility staff failed to notify the Physician that medications were not available and not administered as ordered. Resident # 327 was a [AGE] year old admitted to the facility on [DATE], with diagnoses that included but were not limited to: Asthma, emphysema, Pulmonary Fibrosis, Seizure disorder, Chronic anxiety and depression, Hypothyroidism and Gastroesophageal reflux disease, history of Pulmonary Embolism, orthostatic hypotension and chronic hypoxic respiratory failure-on oxygen at 4 liters per minute via nasal cannula, Congestive Heart Failure. Cerebral Vascular Accident. The most recent MDS (Minimum Data Set) assessment was coded as an Admission assessment with an ARD (Assessment Reference Date) of [DATE]. The BIMS (brief interview for mental status) assessment was coded as 15 out of possible 15, indicating no cognitive impairment. The assessment also coded Resident # 327 as requiring assistance with activities of daily living; and frequently incontinent of bowel and always incontinent of bladder. The resident was readmitted to the facility on [DATE] and expired in the facility on [DATE]. Review of the clinical record was conducted [DATE]-[DATE]. Note Text : Lidocaine HCl (PF) Injection Solution 1 % Inject 3.5 ml intramuscularly one time a day for UTI for 2 Days awaiting from rx- The medication was prescribed for 2 days. Review of the MAR revealed only one dose was given on [DATE]. There was no documentation of the second dose being given as ordered. There was no documentation that the physician was notified the second dose of Lidocaine was not administered as ordered. Topiramate Tablet 100 MG (milligrams) Give 1 tablet by mouth three times a day for Seizure three times per day Review revealed that 4 doses of Topiramate were not available on: [DATE] at 8 a.m. [DATE] at 8 a.m. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at midnight [DATE] at 8 a.m. There was no documentation of the physician being informed of 2 consecutive doses of Topiramate not being administered. Adderall XR Capsule Extended Release 24 Hour 15 MG Give 1 capsule by mouth two times a day for ADHD (Attention Deficient Hyperactivity Disorder) (scheduled at 9 a.m. and 9 p.m. Review revealed that 3 doses of Adderall were not available on: [DATE] at 9 a.m. [DATE] at 9 p.m. [DATE] at 9 a.m. There was no documentation of the physician being informed of 2 consecutive doses of Adderall not being administered on [DATE] and another missed morning dose on [DATE]. Therefore, there were 3 missed doses in 36 hours. On [DATE] at 3:05 p.m., an interview was conducted with LPN (Licensed Practical Nurse) # 3 who stated if the medication was not available, the nurse was expected to check the Cubex (in house Stat box) for an available supply of the medication and to notify the Pharmacy that the medication was not available. The nurse would order the medication from the Pharmacy so it would be available for the next scheduled dose and notify the physician that the medication was not available for administration as ordered. On [DATE] at 10:20 a.m., an interview was conducted with the Director of Nursing who stated medications should be available for administration as ordered by the physician. She stated the nurses should call the Pharmacy to inform them that the medication was not available in the medication cart, order the medication and check the Cubex. The Director of Nursing stated the nurses should notify the physician if the medication was not available to be administered in case the physician might want to order another medication or change the treatment plan. On [DATE] at 11 a.m., an interview was conducted with the Regional Nurse Consultant (Corporate # 1) who stated medications should be available for administration as ordered by the physician. Corporate # 1 stated the Pharmacy should have ensured the medication was available for administration. She also stated the nurses should have checked the Cubex (in house Stat box) for an available supply of the medication. During the end of day debriefing on [DATE], the Facility Administrator, Regional Nurse Consultant and and Director of Nursing were informed of the findings. No further information was provided. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident # 326, the facility staff failed to notify the physician that wound care was not provided as ordered by the physician. Resident # 326 was a [AGE] year old admitted to the facility on [DATE], with diagnoses that included but were not limited to: Calciphylaxis a rare serious disease that involves build up of calcium in small blood vessels of fat tissue and skin. People with the disease usually have kidney failure or receive dialysis. The most recent MDS (Minimum Data Set) assessment was coded as an Admission assessment with an ARD (Assessment Reference Date) of [DATE]. The BIMS (brief interview for mental status) was coded as 15 out of possible 15 indicating no cognitive impairment. The assessment also coded Resident # 326 as requiring assistance with activities of daily living; Review of the clinical record was conducted on [DATE] to [DATE]. Review of the clinical record revealed documentation of wound care not being provided for Resident # 326 as ordered by the physician. There was missing documentation of wound care being administered 6 times during the stay at the facility. The missing documentation of wound care included the following dates: [DATE] at 8 p.m., [DATE] at 8 a.m. and 8 p.m., [DATE] at 8 a.m. and 8 p.m., and [DATE] at 8 a.m. Left breast wound cleanse with DWC (Dakin's Wound Cleanser) pack BID (twice a day) with Dakin's solution cover with Mepilex or Border gauze two times a day for wound care -Start Date- [DATE] 2000 -D/C Date- [DATE] 1315 Scheduled BID (twice a day) for 8 a.m. and 8 p.m. On [DATE] at 9:45 a.m., an interview was conducted during Medication Pour and Pass Observation with Licensed Practical Nurse # 1 who stated medications and treatments should be signed off at the time of administration. She stated there should be no blanks in the documentation because there was a code for refusals. Any blanks would be an indication the administration did not occur. She stated the nurse could also write a progress note about any refusals. On [DATE] at 2:10 p.m., an interview was conducted with the Director of Nursing who stated the Wound care specialist made rounds weekly on the residents with wounds. The Director of Nursing stated wound care was expected to be provided as ordered by the Physician. Review of the Weekly skin Assessments revealed assessments were done on [DATE] and [DATE]. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound care Specialist's notes revealed wound care assessments were done on [DATE] and [DATE]. Review of note of the Wound Care Specialist's evaluation on [DATE] at 8:34 a.m. revealed the following description: Location: left breast Wound ID:____ (redacted) Measurements Length: 2.67 cm (centimeters) -- Red: 13.23 cm^2 -- Width: 7.70 cm -- Black: 0.00 cm^2 -- LxW: 20.56 cm^2 -- Yellow: 0.21 cm^2 -- Depth: -- -- Pink: 3.11 cm^2 -- Total: 16.56 cm^2 -- Other: 0.00 cm^2 -- Observations % granulation 100.00 Depth (cm) 0.20 ---------- Calciphylaxis Other Normal saline wet to dry gauze BID Wound Status Present on admission Acquired in House? No Etiology Other Margin Detail Attached edges Drain Amount Moderate Drain Description Serosanguinous Odor No Odor Periwound Intact Pain 4 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dressing Change Frequency BID Cleanse Wound With Wound Cleanser Dressings Other: See Notes Secondary Dressing Bordered gauze PUSH Score 0 Signature Review of note of the evaluation on [DATE] at 8:11 a.m. revealed the following description: Length: 9.77 cm (+265.7) Red: 25.99 cm^2 (+96.4) Width: 3.80 cm (-50.7) Black: 0.00 cm^2 (+0.0) LxW: 37.13 cm^2 -- Yellow: 0.00 cm^2 (-100.0) Depth: -- -- Pink: 2.01 cm^2 (-35.5) Total: 28.00 cm^2 (+69.1) Other: 0.00 cm^2 (+0.0) Observations % granulation 100.00 Depth (cm) 0.20 ---------- Calciphylaxis Other Normal saline wet to dry gauze BID Wound Status Worsening Acquired in House? No Etiology Other Additional woundbed details Bleeding Margin Detail Attached edges Drain Amount Heavy Drain Description Sanguinous (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Odor No Odor Periwound Intact Pain 4 Dressing Change Frequency BID Cleanse Wound With Wound Cleanser Dressings Other: See Notes Secondary Dressing Bordered gauze PUSH Score 0 Review revealed the Wound Care Specialist evaluated the wound on [DATE] and described it as worsening and with heavy sanguinous drainage. Resident # 326 was transferred emergently to the emergency roiagnom on [DATE] with complaints of bleeding from the left breast and hypotension, Resident # 326 ultimately expired in the hospital on that same day. There was no documentation that wound care was provided as ordered by the physician. Documentation revealed that two days prior to the day Resident # 326 was transferred emergently to the hospital, wound care was not provided three times consecutively ([DATE] at 8 a.m., [DATE] at 8 p.m. and [DATE] at 8 a.m.) The documentation during the week prior revealed there had been three consecutive times when wound care was not provided ([DATE] at 8 p.m., [DATE] at 8 a.m. and 8 p.m.) There was no documentation that the physician was notified that wound care had not been provided as ordered. During the end of day debriefing on [DATE], the Facility Administrator and Director of Nursing were informed of the findings. No further information was provided.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on observation, staff interview and clinical record review, the facility staff failed to maintain the confidentiality of medical records for two residents (Residents #'s 39, 74) in a survey sample of 74 residents. Findings included: 1. For Resident # 39, the facility staff failed to honor the resident's right to privacy and maintain confidentiality of medical records when the screen for documentation of Activities of Daily Living was left open for others to easily view on 12/10/2024. Resident # 39 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Chronic Obstructive Pulmonary Disease, Emphysema, Primary Hypertension, Anxiety, Depression, Gastrpesophageal Reflux Disease, Barrett's Esophagus, Dysphagia and Insomnia. The most recent Minimum Data Set (MDS) was a Quarterly Assessment Quarterly with an Assessment Reference Date (ARD) of 11/17/2024. Resident # 161's BIMS (Brief Interview for Mental Status) Score was a 15 out of 15, indicating no cognitive impairment. Review of the clinical record was conducted on 12/10/2024-12/19/2024. While the survey team was entering the facility for the initial tour on 12/10/2024 at approximately 11:40 a.m., the Point of Care Kiosk where the Certified Nursing Assistants document the Activities of Daily Living into the electronic health records was observed to be open and unattended by a staff member. The personal information for a resident was openly displayed on the screen. The surveyors could read the information clearly. There was no staff member observed in the hallway. The Kiosk was located on Unit One at the end of the hallway nearest to the lobby entrance to the unit. The resident was identified and placed in the sample as Resident # 39. The surveyor waited at the Kiosk until a staff member was observed walking toward the nurses station. The staff member identified herself as the Unit Manager, LPN (Licensed Practical Nurse) # 1 on Unit one. An interview was conducted with LPN # 1 who stated the facility staff should not leave the Kiosk unattended. LPN # 1 stated she would determine who left the Kiosk unattended. While the surveyor was talking with LPN # 1, a nursing staff member -CNA (Certified Nursing Assistant) # 1- came out of one of the rooms near the end of the hall close to the Kiosk. She identified herself as the one who had left the screen open for viewing. CNA# 1 apologized and stated that she thought she had closed the screen prior to going to help another resident. On 12/10/2024 at 2:25 p.m., an interview was conducted with CNA # 1 who stated that she normally would stay at the Kiosk until the screen closes but that she responded to the call light in the room of another patient who needed help immediately. CNA # 1 stated she understood that it was important to keep the residents' information confidential and to protect their privacy. Review of the facility census revealed that Resident # 39 was a resident on Unit One. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the end of day debriefing on 12/11/2024, the Facility Administrator and Director of Nursing were informed of the findings. They stated that residents information should be kept confidential and privacy protected. No further information was provided. 2. For Resident # 74, the facility staff failed to honor the resident's right to privacy and maintain confidentiality of medical records when the screen for documentation of Activities of Daily Living was left open for others to easily view on 12/12/2024. Resident # 74 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Dementia, Diabetes, Major Depressive Disorder, Anxiety, Depression, Vitamin B 12 deficiency and Dysphagia. The most recent Minimum Data Set (MDS) was a Quarterly Assessment Quarterlywith an Assessment Reference Date (ARD) of 11/7/2024. Resident # 74's BIMS (Brief Interview for Mental Status) Score was a 00 out of 15, indicating severe cognitive impairment. Review of the clinical record was conducted on 12/13/2024-12/19/2024. While the survey team was exiting the facility on 12/12/2024 at 5:40 p.m., the Point of Care Kiosk where the Certified Nursing Assistants document the Activities of Daily Living was observed to be open and unattended by a staff member. The personal information for a resident was openly displayed on the screen. The surveyors could read the information clearly. There was no staff member observed in the hallway. The Kiosk was located on Unit One at the end of the hallway nearest to the lobby entrance to the unit. There were meal serving carts in the hallway. There were visitors observed walking in the hallway at the other end of the hall. The resident was identified and placed in the survey sample as Resident # 74. Review of the facility census revealed that Resident # 74 did not reside on Unit One where the Kiosk was open. Resident # 74 resided on the locked Memory Care unit which was down the other end of the hallway. On 12/16/2024 at 10:50 a.m., an interview was conducted with the Director of Nursing who stated the staff should not leave the Kiosks open and unattended where others can view the information. The Director of Nursing was asked to determine who was assigned to work with Resident # 74 on 12/12/2024 and was documenting in the record around the time the surveyors were leaving. During the end of day debriefing on 12/18/2024, the facility Administrator and Director of Nursing were informed of the findings. The information about who was had been documenting in the clinical record on 12/12/2024 was not provided by the end of the survey. No further information was provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility staff failed to maintain a safe, clean comfortable homelike environment for 4 of 4 nursing units to include the entire locked memory care unit and the direct care of five Residents (Resident #226, #117, #91, #69, and #280) in a survey sample of 74 Residents, resulting in a Substandard Quality of Care. The findings included: 1. For Resident #226, the entire memory care unit was dirty, in disrepair, was not safe, not clean, nor homelike. 2. For Resident #117, the entire memory care unit was dirty, in disrepair, was not safe, not clean, nor homelike. 1. Resident #226 was admitted to the facility on [DATE] with diagnoses including: End stage renal disease with hemodialysis, history of stroke, anemia, chronic congestive heart failure, hypertension, and diabetes type 2. The Resident did not have a diagnosis of dementia and was his own responsible party and by facility agreement cognitively intact and able to make his own decisions. The Resident had a room mate, Resident #117. 2. Resident #117 was admitted to the facility on [DATE] with diagnoses including: Dementia without behavioral disturbance, hypertension, major recurrent depression. dysphagia, chronic kidney disease, cardiac disease, malignant cancer of nasal cavity, and congestive heart failure. The Resident had a room mate, Resident #226. During an initial interview on 12-10-24, at 11:40 AM, Resident #226 was found to be alert and oriented to person, place, time, and situation. He stated that he had requested to stay in his current room after learning that the facility planned to move him rather than discharge him home. During this interview, Resident #226 verbalized that he is a dialysis patient and that he received dialysis there in the facility. He further stated he hates the memory care unit because everyone is crazy in here, they wander into my room and take things, my room mate yells and cries all night for something to drink, I don't even get food every meal, the room is nasty and falling apart, and I can't even get a shower in here because the showers are so nasty dirty. He went on to say I like to walk around, it makes the time go faster, if I don't walk now I won't be able to leave, but locked in here I have no where to walk, I don't even have a TV to watch and I love TV, being in here will make you crazy with nothing to do. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor and Resident then immediately walked to the shower room for an initial observation and found it to be dirty, mildewed/moldy, foul smelling, had a strong odor of urine and feces, trash and debris littered the floor, used brown stained wet linens were on the floor, a white crusted substance was on the floor and walls, used soap and shampoo bottles were crusted on the shelves and hand rails in the shower, and the room was being used as a storage area as well for boxes of supplies and durable medical equipment. The Resident asked would you want to take a shower in here? Immediately following the shower room observation the Resident's room was examined. The Resident's room was shared with a second Resident. The room tour included but was not limited to the following being observed; broken vinyl window blinds, no curtains, a urine soaked bathroom, a pervasive smell of urine and feces in the room and on the entire unit. The free standing broken armoire closets in the rooms were swollen and splitting, with rotten splinters and chunks of disintegrating wood and wood particles all over the Residents few items in the closet, and in the rooms. The sink vinyl laminate countertop area was water damaged and swollen and separated revealing particle board disintegration with the sink partially separated from the wall in a downward unstable dropped position, and wood dust everywhere. Under the sink a cabinet door was ajar as it would not close because of the downward sloping sink, and the inside compartment was an open hole with what appeared to be a black concrete floor. Inside was found mildew, mold, trash, a pair of urine stained white tennis shoes, and 2 shirts that were stuck together with an unknown substance, all thrown in onto the floor. The floor of the room was sticky and made a sucking sound as one walked across it, and the base board was peeling and drooping over in places. The floor was crusted with crumbs, brown debris, and black particles. The bed divider curtain had brown stains and smeared feces on it. The PTAC (air conditioning wall unit) was not secured and had fallen forward into the room approximately 12 inches revealing light around it and cold air coming into the room from the outside of the building. The front cover of the unit was also missing and the sharp metal grill was exposed. The Resident's room mate's bed (#117) was pushed against the PTAC holding it in place so it would not completely fall out of the hole in the outside facing wall. Resident #117 was in bed covered with only a bed sheet with no blanket and wore no clothing nor gown, and only an incontinence brief under the bed sheet. During the entire survey Resident #117 was never observed during the day out of bed, and asked the surveyors often for something to drink stating Please, Please bring me some water I'm so thirsty. The Residents lips were noted to be cracked and dry. The Residents had no television, no clock, no telephone, no radio and the room had no personal items in it nor on the walls. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #226 had no shoes, no coat, 2 pairs of pants, and 2 shirts (the Resident was wearing one of each). When asked about his clothing he stated I had more, but they have been stolen. The same number of clothing articles were found for Resident #117. Each room on the unit was then inspected by all surveyors and found to be in the same condition as Resident #226's room. There were no televisions in any room, and no water to drink in any room. There was also noted in the hallway the air conditioning main vent in the ceiling and air return on the wall were so dusty that they had the appearance of brown fur coating them. The walls were marked and smeared and had paint scraped off in places. There was no soap nor paper towels in the Resident rooms for hand washing of staff or Residents. On 12-13-24 the Director of Maintenance and Director of Environmental Services (house keeping) were interviewed and agreed that staffing for the 2 departments had been tight. Environmental services had 13 total employees. That number was responsible for house keeping, laundry and floor machine technicians. This number culminated in daily staffing dispersal of 3 staff in laundry, and 1 floor tech, which left 1 housekeeper on each of the 4 nursing units, and 1 housekeeper in common areas such as dining rooms on each unit, the main kitchen, activities, offices, therapy, bathrooms, conference rooms, the dialysis center, and main hallways/entrances. The added 4 staff positions would be trade outs for the other staff members days off during a seven day schedule. With 123 resident rooms total each of the nursing units housed approximately 20 to 35 Resident rooms for one house keeper to clean each day in an 8 hour shift allowing for 16 minutes to clean each room. Two of the 3 dryers in the laundry had been broken since June 2024, so linens and privacy curtains and resident personal laundry was not being washed and returned timely even though the staff was washing and drying around the clock. The only working dryer was being operated 24 hours per day. The dirty linen storage on the units was backed up as a result, and creating some of the pervasive urine and feces odors in the facility. Linens, bedding, and privacy curtains were not being changed as often as necessary due to the inability to have enough on hand to change them out more frequently. The maintenance Director stated they were starting to get some priorities taken care of in the facility now as staffing had improved just recently, and he began painting the memory unit and new cabinets began to be installed on 12-13-24. On 12-12-24, and 12-13-24 during a meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns and that the entire memory care unit was not safe, clean and comfortable. On 12-19-24, prior to the survey exit the Director of Nursing informed surveyors that Resident #226 and his room mate had been moved back onto regular units last night (12-18-24). At the time of survey exit on 12-19-24 the facility Administrator, and Director of Nursing stated they had nothing further to provide. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	34894 3. For Resident # 91 residing on Unit 1, the facility staff failed to ensure bugs/insect/gnats were not in sandwiches stored on top of the light fixture over the bed. There were no sheets on the mattress nor linens on the bed during the entire survey. Resident # 91 was admitted to the facility on [DATE]. Diagnoses included but were not limited to: Cerebral Infarction, Hypertension, Anxiety Disorder, Hemiplegia and Vascular Dementia. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 11/3/2024. Resident # 91's BIMS (Brief Interview for Mental Status) Score was a 14 out of 15, indicating no cognitive impairment. Resident # 91 required assistance with Activities of Daily Living. Review of the clinical record was conducted on 12/10/2024-12/19/2024. On 12/10/2024 during the initial tour of Unit 1, clutter was observed in Resident # 91's room. There were several items on the nightstand, on the window sill and clutter around the bed. There were 4 sandwiches wrapped individually in sandwich bags lying on top of the ledge of the light fixture above the bed. Numerous bugs/insects were observed swarming in one of the sandwich bags. There were dozens of bugs/insects in the sandwich bag. Closer observation of the room revealed there were bugs/insects flying in the room. The Facility Administrator came into the room while the surveyor was inspecting the area. The Administrator picked up the four sandwiches and noticed the bugs/insects. The Administrator stated the insects they might have been black gnats. She stated that was unacceptable and that insects should not be in residents rooms. She stated she was going to take care of the problem. The Administrator took all four sandwiches to the soiled utility room at the end of the hall. The Administrator returned to Resident # 91's room and asked why he had so many sandwiched. Resident # 91 stated he was keeping them to eat later. The Administrator informed Resident # 91 that he could not keep several sandwiches at the bedside because they were attracting bugs/insects. The Administrator told Resident # 91 stated the Dietary Staff would provide sandwiches whenever he requested them. On 12/10/2024 at 2:30 p.m., an interview was conducted with CNA (Certified Nursing Assistant)-1 who stated that Resident # 91 liked to keep snacks at the bedside and did not want staff members to remove them. CNA-1 stated bugs/insects should not be in residents rooms. On 12/11/2024 at 9:15 a.m., black insects were noted in Resident # 91's room near the sink at the entrance to the room and on items on Resident # 91's side of the room. Resident # 91 was sitting on the side of the bed. On 12/11/2024 at 9:45 a.m an interview was conducted with the Dietary Manager who stated the sandwiches were placed on each meal tray as requested by the resident. The Dietary Manager stated she was not aware that Resident # 91 was collecting the sandwiches and not eating them. The Dietary Manager stated she was not aware that bug/insects were in the sandwiches at the bedside. On 12/11/2024 at 12:40 p.m. an interview was conducted with the DON (Director of Nursing) who stated bugs/insects should not be in residents rooms. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy entitled Resident Environmental Quality, implemented 11/1/2020, revised 12/1/2022 revealed a policy statement which read The facility should be designed, constructed, equipped and maintained to Provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The policy explanation and guidance included the following excerpts: 5. The facility must provide each resident with a. A separate bed of proper and height and size for the convenience of the resident b. A clean comfortable mattress c. Bedding appropriate to the weather and climate . During all of the days of the survey, there were observations of no sheet on the mattress at any time. Resident # 91 was observed lying in the bed with no sheet or bedding covering the mattress. The resident was lying on the uncovered vinyl mattress. On 12/17/2024, at approximately 03:45 PM, Resident #91 was observed walking into his room. Bed observed unmade no sheets. Air condition unit set at 62 degrees. Resident states I don't want sheets on my bed its too hot. Everyone here knows not to put sheets on my bed and to keep my curtain drawn. On 12/18/2024 during the end of day debriefing, the Administrator and Director of Nursing were informed of the findings of failure to provide a clean, comfortable, homelike environment. There was no documentation that the resident refused to allow the staff to provide bedding for the mattress No further information was provided. 34306 Upon walking up the sidewalk into the facility on [DATE] at approximately 11:15 AM, an observation was made of a large mat along the walkway leading to the front door entrance. Viewable at the corners of the mat were many broken and loose tiles in the sidewalk. Overhead under the awning were large pieces of plaster missing and hanging plaster about to fall. As the Team was escorted to the conference room through the corridor of Unit 1, unpleasant lingering odors reeked to the end of the corridor and much debris and clutter was observed. Immediately upon getting seated in the conference room several windows had sections of missing blinds on Unit 3, observable from the conference room. Residents and staff were viewable through the broken blinds. 4. Resident #69 was originally admitted to the facility 1/2/2024. The current diagnoses included end stage renal disease requiring hemodialysis, and a history of strokes. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/23/2024 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #69's cognitive abilities for daily decision making were intact. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/10/24 at approximately 2:39 PM an interview was conducted with Resident 69. Resident #69 stated he was dissatisfied with his room primarily because of episodes of water dripping from the ceiling onto his head and face. The resident pointed out many water-stained ceiling tiles. The resident further stated that the light over the sink has been extremely dim for months, and he had reported it to several staff but, no one would replace it. Resident #69 also stated that his room floor is not mopped consistently, and the sink is usually soiled, and the bathroom was not clean because of lack of general cleaning. Resident #69 adamantly stated he refuses to go to the shower room because it is not clean or homelike. The resident also stated there are not always towels and washcloths for bathing and his soiled clothes were running over in his room because of problems in the laundry. He stated the environment saddens him and he would like to move but, he does not have a place to live outside the facility. On 12/10/24 at 2:39 PM observations were made of the concerns the resident identified, it was validated that the bathroom did not have a freshness and there were multiple stained ceiling tiles overhead, as well as the light over the sink was barely projecting light. It was also identified that the floor lacked gloss and had a stickiness to it, the sink was with multiple items and lacked cleanliness. The trash can was without a liner and used gloves were observed on the floor next to it and soiled laundry was over in the corner beneath the television. On 12/19/24 at approximately 4:45 PM the above information was shared with the Environmental Services Director and Maintenance. At approximately 5:00 PM four staff were observed in Resident #69's room, one was on a ladder working on the ceiling tiles, the dim light bulb had been removed from over the sink and a super bright light was in place. On 12/19/24 at approximately 6:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, the Owner and three Corporate Nurse Consultants. They voiced no concerns regarding the above findings. 5. Resident #280 was originally admitted to the facility 12/3/24 after an acute care hospital stay. The resident's current diagnoses included a possible TIA, chronic pain fibromyalgia, and Raynaud's phenomena. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) 12/10/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #280's cognitive abilities for daily decision making were moderately impaired. On 12/13/24 at approximately 12:55 PM an interview was conducted with Resident #280. The resident stated she was not satisfied with the cleanliness of the room. She stated the floors may appear clean, but she sees how black her socks are when she gets in the bed. The resident stated that she was in the room most of the time and she had not seen anyone clean the floors or the bathroom, but they had removed the trash daily. Resident #280 also stated there was a dead bug in the floor near the door for two days before a nurse decided to sweep it up. Resident #280 stated her focus was to be discharged home very soon because nothing was going well in the facility. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/19/24 at approximately 6:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, the Owner and three Corporate Nurse Consultants. They voiced no concerns regarding the above findings. 40711 6. On 12/13/24 at approximately 12:30 PM., an observation of Unit 3 was made on the Memory Care Unit. Fourteen residents were observed sitting, standing and or walking around in the dining room. Some residents were observed leaving from out of the dining room near a metal door plate that was separating in an outward position from the door approximately 1 inch. Staff were also observed coming and going from the dining area. On 12/19/24 at approximately 11:35 AM.,an observation was made on unit 3, to the dining room area. The metal door plate was still extending outward from the door leading into the dining room. On 12/19/24 at approximately 1:07 PM., an observation was made on Unit 2, room [ROOM NUMBER]. Buckling ceiling tiles, a hole in the ceiling and a brown substance was noticed on the privacy curtain (32-A). Resident #88 was resting quietly in her bed. Her Brief Interview for Mental Status (BIMS) score was a 3 out of a possible 15. This indicated Resident #88 cognitive abilities for daily decision making were severely impaired. Resident #88 was not able to respond to questions asked concerning the condition of her room. On 12/19/24 at 12:25 PM., an interview was conducted with the Maintenance Assistant/Other Staff Member (OSM) #11, concerning the ceiling tiles, and hole in the ceiling in room [ROOM NUMBER] on unit 2. OSM #11 said, The new ceiling tiles came in today. The privacy curtain was observed visible soiled with a brown substance. On 12/19/24 at approximately 1:00 PM., an interview was conducted with the IP concerning the brown substance observed on the privacy curtain on unit 2, room [ROOM NUMBER]. The IP said that she had spoken to the Environmental Services Department (ESD) and said, It's an infection control issue. On 12/19/24 at approximately 5:30 PM., an interview was conducted with the Administrator and with OSM #8 concerning the privacy curtain room, the ceiling tiles and the hole present in the ceiling in room [ROOM NUMBER]. On 12/19/24 at approximately 5:45 PM., OSM #8 informed surveyor that he was replacing the privacy curtain (32-A), and confirmed that it looked like Bowel Movement (BM) smeared on it. On 12/19/24 at approximately 5:55 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided. 40026 7. For the facility, the facility staff failed to ensure clean comfortable and sanitary environment for Residents, staff and the public. The following observations were made during the course of the survey: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hallway bathroom on Unit 2 cove base pulled off wall since survey started on 12/10/24, not repaired. Strong urine odor on hall Unit 1 noticed on the morning of 12-10-24, 12-16-24 and 12-17-24. On 12/18/24 8:47 AM used glove noted outside of room [ROOM NUMBER] and linens in floor. Soiled linens were observed on the floor in room [ROOM NUMBER]. Shower room Unit 1 - used pull ups, gloves and plastic cups on the floor, 1st shower stall floor was dirty and used washcloth left on railing. Shower stall 2 - dirty washcloth on floor as well as one on handrail. Hoyer lift in middle of the room blocking the shower stalls chair scale had resident clothing and soiled brief laid across it. On 12/18/24 10:00 AM - room [ROOM NUMBER] soiled linens observed on the floor. On 12/18/24 at approximately 10:10 a.m. an interview conducted with LPN #2 (Unit Manager) who was asked if it was an acceptable practice to place soiled linens on the floor, she stated, It is not ok to have soiled linens on the floor and it is an infection control risk to leave soiled linens on the floor. On 12/18/24 10:20 a.m. Shower room Unit 2 - toilet unflushed with urine and feces, bathroom smelled of urine, Cove base peeling off of the shower room walls, shower stall dirty and soiled linen in shower room floor. The resident council minutes dated 8/14, 9/26 and 10/24/24 reflected complaints of needing more linens, (towels, sheets), as well as dirty bathrooms. On 12/18/24 an interview was conducted with Other Employee #1 stated that they have had issues with linens being available due to 2 of the 3 dryers being broken and unavailable for use. When asked if this has impacted the staff she stated that they did not have enough clean linens to bathe the residents. They stated they had to cut towels to make wash cloths. Other Employee #1 stated that the facility would no longer allow them to use disposable wipes so they have to use the linens for incontinent care. Review of the facility policy entitled Resident Environmental Quality revealed the following excerpts: The facility should be designed, constructed, equipped and maintained to Provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. 5. The facility must provide each resident with: a. A separate bed of proper and height and size for the convenience of the resident b. A clean comfortable mattress (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. Bedding appropriate to the weather and climate . On 12/19/24 during the end of day debriefing meeting the Administrator was made aware of the findings and no further information was provided.

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F 0586 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not prohibit or in any way discourage a resident from communicating with federal, state, or local officials. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on resident interview and staff interview, the facility staff prohibited and discouraged a resident from communicating with the state surveyor for one (1) of 74 residents (Resident #226), in the survey sample. The findings included: Resident #226 was originally admitted to the facility 6/6/2024 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included end stage renal disease requiring hemodialysis, dementia and atrial fib. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/13/2024 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #226's cognitive abilities for daily decision making were moderately impaired. On 12/12/24 at approximately 12:20 PM an interview was conducted with Resident 226. Resident #226 stated he did not know why he had to continue to live on the Memory Care unit. The resident pointed out that no one who resided on the unit wore shoes and it was his desire to no longer be confined to the locked unit for he enjoyed going outside for fresh air and buying coffee from the 7/11 store. A review of the resident's care plan revealed a care plan problem dated 10/16/2024 which stated (name of the resident) has little or no activity involvement related to disinterest and physical limitations. The goal stated (name of the resident) will participate in activities of choice 2-3 times per week by review date, 3/18/25. The interventions included explain to (name of the resident) the importance of social interaction, leisure activity time, encourage the resident's participation by inviting him to games, crafts, and listening to music. There was no intervention to ensure the resident is offered the opportunity to go outside for fresh air. On 12/13/24 at approximately 12:03 PM the resident stated he was informed by a staff member, who he was unable to name, that if approached by a surveyor that he could not talk to the surveyors anymore because he had told the state surveyor too much and it would cause them (the facility) trouble. On 12/19/24 at approximately 6:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, the Owner and three Corporate Nurse Consultants. The Corporate Nurse Consultant stated they were aware that residents should not be discouraged from talking with the surveyors.

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F 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on observations, Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility staff involuntarily secluded one (1) Resident (Resident #226) in a survey sample of 74 Residents, resulting in psychosocial harm. The findings included: For Resident #226, who refused a transfer to the locked memory care unit (for residents with dementia and behaviors), the facility staff failed to honor the resident's request. The staff moved him against his will, into the secured unit with no access codes to afford him independent egress. The resident did not meet the criteria for the move as no criteria was ever derived in the facility by way of policy or procedure, which resulted in a move for staff convenience. Resident #226 was admitted to the facility on [DATE] with diagnoses including: End stage renal disease with hemodialysis, history of stroke, anemia, chronic congestive heart failure, hypertension, and diabetes type 2. The Resident did not have a diagnosis of dementia and was his own responsible party and by facility agreement cognitively intact and able to make his own decisions. Three MDS (minimum data set) federal assessments were reviewed since the resident's admission through the time of survey on 12-10-24. Those follow below: 1. The first MDS admission assessment was dated 6-10-24 and indicated the resident had a Brief Interview for Mental Status BIMs score of 8 of a possible 15 points upon admission after Acute hospitalization for encephalopathy from a fall and missing hemodialysis. He was coded in the document as able to understand and be understood, no aberrant behaviors, needed only limited assistance with most (activities of daily living) ADLs such as toileting, ambulating, hygiene, transferring, and bed mobility, and was dependant on staff only for bathing, however needed only tray set up and clean up for meals. 2. The second MDS was a quarterly assessment dated [DATE] which indicated the Resident had a Brief Interview for Mental Status BIMs score of 11 of a possible 15 points after a rehospitalization for septic shock due to hypovolemia, as no infection was found to support septic shock, nor sedation as narcan had no effect. He was coded in the document as able to understand and be understood, no aberrant behaviors, and functional abilities were not coded. 3. The third MDS was a quarterly assessment dated [DATE] indicated the Resident had a Brief Interview for Mental Status BIMs score of 10 of a possible 15 points. He was coded in the document as able to understand and be understood, no aberrant behaviors, needed only set up and clean up for bathing, otherwise, was completely independent for all (activities of daily living) ADLs such as toileting, ambulating, hygiene, transferring, and bed mobility, and eating. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	On 9-26-24 at 4:42 PM the Resident was moved to the memory care locked unit and the Resident's son was notified according to the room change notification document in the clinical record, however, the document stated that the Resident's brother agreed to the room change even though these individuals were only emergency contacts and the Resident refused and was his own responsible party. The reason given for the move, was elopement risk. The Resident had never eloped and on the one occasion that he went outside to sit in the sun after dialysis he did not leave, even though he could have walked away, he simply sat there until staff came to take him back to his room. When asked about this incident the Resident stated there is no reason that I can't sit outside for awhile and get some fresh air. I am not a prisoner. During an initial interview on 12-10-24, at 11:40 AM, Resident #226 was found to be alert and oriented to person, place, time, and situation. He stated that he had requested to stay in his current room after learning that the facility planned to move him rather than discharge him home. Resident #226 stated he was told his son and grandson were not able or willing to care for him in the home that the three of them had formerly shared. The Resident insisted on planning a discharge back to the community, or an assisted Living Facility as soon as possible, however, he stated no one listened, no one came to talk to me about it, and nothing ever happened even though I kept telling them. During this interview, Resident #226 verbalized that he is a dialysis patient and that he received dialysis there in the facility. He further stated he hates the memory care unit because everyone is crazy in here, they wander into my room and take things, my room mate yells and cries all night for something to drink, I don't even get food every meal, the room is nasty and falling apart, and I can't even get a shower in here because the showers are so nasty dirty. He went on to say I like to walk around, it makes the time go faster, if I don't walk now I won't be able to leave, but locked in here I have no where to walk, I don't even have a TV to watch and I love TV, being in here will make you crazy with nothing to do. The surveyor and Resident then immediately walked to the shower room for an initial observation and found it to be dirty, mildewed/moldy, foul smelling, had a strong odor of urine and feces, trash and debris littered the floor, used brown stained wet linens were on the floor, a white crusted substance was on the floor and walls, used soap and shampoo bottles were crusted on the shelves and hand rails in the shower, and the room was being used as a storage area as well for boxes of supplies and durable medical equipment. The Resident asked would you want to take a shower in here? Immediately following the shower room observation the Resident's room was examined. The Resident's room was shared with a second Resident. Resident #226's room tour included but was not limited to the following environmental observations: Broken vinyl window blinds, no curtains, a urine soaked bathroom, a pervasive smell of urine and feces in the room and on the entire unit. The free standing broken armoire closets in the rooms were swollen and splitting, with rotten splinters and chunks of disintegrating wood and wood particles all over the Residents few items in the closet, and in the rooms. The sink vinyl laminate countertop area was water damaged and swollen and separated revealing particle board disintegration with the sink partially separated from the wall in a downward unstable dropped position, and wood dust everywhere. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	Under the sink a cabinet door was ajar as it would not close because of the downward sloping sink, and the inside compartment was an open hole with what appeared to be a black concrete floor. Inside was found mildew, mold, trash, a pair of urine stained white tennis shoes, and 2 shirts that were stuck together with an unknown substance, all thrown in onto the floor. The floor of the room was sticky and made a sucking sound as one walked across it, and the base board was peeling and drooping over in places. The floor was crusted with crumbs, brown debris, and black particles. The bed divider curtain had brown stains and smeared feces on it. The PTAC (air conditioning wall unit) was not secured and had fallen forward into the room approximately 12 inches revealing light around it and cold air coming into the room from the outside of the building. The front cover of the unit was also missing and the sharp metal grill was exposed. The Resident's room mate's bed was pushed against the PTAC holding it in place so it would not completely fall out of the hole in the outside facing wall. The Residents had no television, no clock, no telephone, no radio and the room had no personal items in it nor on the walls. Resident #226 had no shoes, no coat, 2 pairs of pants, and 2 shirts (the Resident was wearing one of each). When asked about his clothing he stated I had more, but they have been stolen. Each room on the unit was then inspected by all surveyors and found to be in the same condition as Resident #226's room. There were no televisions in any room, and no water to drink in any room. There was also noted in the hallway the air conditioning main vent in the ceiling and air return on the wall were so dusty that they had the appearance of brown fur coating them. The walls were marked and smeared and had paint scraped off in places It is notable to mention that no activities were noted to be conducted in the secured unit from 12-10-24 until 12-18-24. The staff were asked why no activities were being conducted for the residents and they replied that we only have one activity person for the whole 150 bed facility. Facility CNA (Certified nursing Assistant) and LPN (Licensed Practical Nurse) staff on the memory care unit and other units were interviewed, and stated the reason that Resident #226 had been placed on the memory unit was wandering and behaviors When asked what his behaviors were, they were only able to say he went outside and sat in his wheel chair one time after dialysis, and further stated he would wander up and down the halls and that will get you put in here for sure. The surveyor asked why he walked, and there was no response. The Social worker was interviewed on 12-10-24 and revealed that she had just been hired on 11-19-24. The former Social worker resigned on 6-28-24, and there had been no social worker in the facility from 6-28-24 until 11-19-24. She stated she would be putting in a progress note for Resident #226 on this same day, and she stated that she didn't really know much about him. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	On 12-11-24 the social work note was reviewed and revealed a progress note that documented the Resident as long term care during a care planning meeting, and nothing about discharge planning or his desire to be discharged . On 12-12-24 the Social worker's license and curriculum vitae were requested for verification and vetting as part of the employee records review for competency of staff. It was noted that the required course work and degree required by state and federal regulation for this employee was not sufficient for the role. The Director of Nursing and Administrator were asked for a policy or procedural guidance for moving a Resident onto the memory care locked unit. Both stated that they did not have one, and could not describe a pathway to the decision for moving a resident into the secure unit. On 12-11-24, through 12-19-24 a clinical record review was conducted. There was no evidence in the clinical record that the physician had been called and notified of the Resident's move, nor was a request made for assessment and told that the Resident wished to discharge. On 12-5-24 a PHQ-9 (the only one during his stay) evaluation for depression was conducted and gave a score of 3 which equaled minimal or not at all suffering from depression. The Resident was not ordered to have any psychoactive medications, nor did he have any diagnoses to support the use of them. Resident #226 refused the move to the secured unit and was moved against his will. Resident #226 was unable to bathe in a safe, clean environment, and his room was not a safe, clean environment. The room was cold with the heating unit out of the wall. The Residents personal items and clothing were missing and not available to him. Confused Residents wandered in and out of his room affording him no private space. The Resident was unable to sleep as his roommate called out all night for water to drink, and food was found to be insufficient. The Resident kept a jar of peanut butter by his bed and a loaf of bread so that I can eat something when they forget my tray like they do my roommate's tray. The Resident repeatedly told staff he wanted to be let out of the unit and wanted to be discharged . There were no activities being held on the unit, and there was no television for any of the Residents. Resident #226 received no care planning by an interdisciplinary team, no social work for room moves or discharge assistance, and he received no psychosocial support. The Resident stated no one listened to him, he felt locked in, unable to walk or go outside, and he felt like a prisoner that was going crazy with nothing to do but stare at the walls. On 12-12-24, during the end of day debriefing meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns and that the Resident had requested to stay in his room, and to be planned for discharge, which was denied and there was no evidence that the physician was notified of this request. Further they were notified that no Social Worker was providing care during the Resident's stay which compounded the incident further, and culminated in the withholding of a resident's rights, and involuntary seclusion resulting in psychosocial harm. On 12-19-24, prior to the survey exit the Director of Nursing informed surveyors that Resident #226 and his roommate had been moved back onto regular units last night (12-18-24). This indicated that the involuntary seclusion was borne out by the fact that the day before survey exit the Resident was moved back to a regular unit. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	At the time of survey exit on 12-19-24 the facility Administrator, and Director of Nursing stated they had nothing further to provide.

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	495150	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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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 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** 40711 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to report an accident hazard which resulted in bodily harm, to the State Survey and Certification Agency for one (1) or 74 residents, (Resident #56) in the survey summary. The findings included: Resident #56 was originally admitted to the facility 08/22/19 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Unsteadiness on feet and Impulsiveness, Burn of first degree of left forearm, initial encounter. Burn of unspecified degree of single right finger (nail) except thumb, initial encounter. Unspecified dementia without behavioral disturbance. Unsteadiness on feet. Impulsiveness. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/01/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #56 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities and Goals) the resident was coded as independent with eating, oral care, toileting hygiene, personal hygiene, bathing/showering self. Sub section: GG0120 coded resident as using a walker as a Mobility Device. The care plan focus dated 10/14/24 read that Resident #56 has actual impairment to skin integrity of the left third finger and right forearm burn r/t impaired safety awareness. The Goal was that resident will have no complications r/t burn of the right forearm and left third finger through the review date. The interventions: Encourage good nutrition and hydration in order to promote healthier skin, follow facility protocols for treatment of injury, identify/document potential causative factors and eliminate/resolve where possible and Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. During the initial rounds on 12/11/24 at approximately 10:27 AM., an interview was conducted with another resident, Resident #5 concerning warming her foods. Resident #5 mentioned We had a communal microwave in the break room. They took it away after a lady burned herself. Resident #5 also said that she didn't know the resident but after she was burned the microwave was removed and they could no longer warm their foods. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the synopsis of event report revealed the following: Date of incident: 6/03/24. Time: 6:00 PM. Location: Dining Area., Type of Injury: Burn to include redness, swelling and pain. Assessment: Redness, blistering, and swelling noted to left forearm, and right middle finger. Description of event: Resident was heating up coffee in a microwave in the Unit 2 dining area. When attempting to pick the coffee up, resident spilled hot coffee on her hand. According to the investigative document, Resident #56 was interviewed by staff at 10:00 AM., then Unit 2 manager, now currently, the Infection Preventionist (IP) OSM #5. The resident confirmed that she reheated the coffee in the microwave and spilled the hot coffee on her hand. According to the staff interview, the resident was heard yelling out from the dining room. A review of the June 2024 Treatment Administration Record revealed daily wound care of the Right-Hand 3rd Digit. Cleanse with wound cleanser, apply bacitracin and cover with dry bandage every day shift for wound care -Start Date= 06/08/2024 0700. Discontinue Date =06/19/2024. Apply Skin Prep and LOA to Left Forearm every day and evening shift for Blister. Start Date= 06/07/2024 3:00 PM. discharge date =06/12/2024. A review of the Nurse Practitioner's Skin and Wound note on 06/05/2024 at 12:46 PM., read: Patient being evaluated for new left dorsal forearm burn and right middle finger burn secondary to coffee spill by the patient. Right middle finger with pink epithelial tissue and left dorsal forearm with intact blister. Recommend skin prep to forearm and bacitracin to right middle finger. WOUND ASSESSMENTS: Date wounds were acquired: 6/03/24 6/05/24- Wound #1 Location: right middle finger, Primary Etiology: Burn, Stage/Severity: Partial Thickness, Wound Status: New, Odor Post Cleansing: None, Size: 2.2 cm x 0.9 cm x 0.1 cm. Calculated area is 1.98 sq cm. Wound Base: 100% epithelial, Wound Edges: Attached, Peri wound: Intact, Exposed Tissues: Epithelium, Exudate: Scant amount of Serosanguineous, Wound Pain at Rest: 6. Wound: 2=6/04/24 Location: left forearm, Primary Etiology: Burn, Stage/Severity: Partial Thickness, Wound Status: New, Odor Post Cleansing: None, Size: 1.2 cm x 1.1 cm x 0.1 cm. Calculated area is 1.32 sq cm., Wound Base: 100% epithelial, Wound Edges: Attached, Peri wound: Intact, Exposed Tissues: Epithelium, Exudate: None amount of None, Wound Pain at Rest: 5. PLAN: Wound #1 right middle finger Burn Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Bacitracin ointment to base of the wound. 3. secure with Bordered gauze. 4. change BID, and PRN. PLAN: Wound #2 left forearm Burn. Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Skin Prep to base of the wound. 3. secure with Leave open to air. 4. change BID. PLAN: Wound #1=6/12/24 Location: right middle finger Burn, Partial Thickness, Improving without complications. Size: 1.0 cm x 0.20 cm x 0.10. 100% epithelial, wound edges attached, peri wound intact, scant exudate, serosanguinous, no odor. Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Bacitracin ointment to base of the wound. 3. secure with Bordered gauze. 4. change Daily and PRN. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PLAN: Wound #2=6/12/24-24 Location: left forearm, Primary Etiology: Burn, Stage/Severity: Partial Thickness, Wound Status: Improving without complications: None, Size: 1.2 cm x 0.60 cm x 0.10 cm. Wound Base: 100% epithelial, Wound Edges: Attached, Peri wound: Intact, Exposed Tissues: Epithelium, Exudate: scant, serosanguineous, no odor. Treatment recommendations: Change dressing daily, Cleanse with wound Cleanser, apply bacitracin ointment use bordered gauze. PLAN: Wound #1=6/19/24 Location: right middle finger Burn. Wound Resolved. PLAN: Wound #2=6/19/24-24 Location: left forearm. Wound Resolved. On 12/12/24 at approximately 5:00 PM., during the end of day meeting. The Director of Nursing (DON), the Administrator and Corporate Staff #2., were asked if they had a Communal Microwave on Unit 2, and requested accident hazard reports on residents receiving burns. The DON said that she remembered an accident that took place months ago. The DON was asked if the microwave was still in the communal dining room. The DON said that the microwave had been removed since the resident burn, but she did not remember when it was removed. On 12/13/24 at approximately 10:10 AM., the DON and Corporate Staff #1 informed surveyor of Resident #56 receiving a coffee burn months ago. Documents of the incident were given to the survey staff. The DON said that a Facility Synopsis of the event was not completed and sent to the State Survey and Certification Agency. On 12/13/24 at approximately 3:55 PM., Resident #56 was not available to interview. Staff states the resident was on Leave of Absence with activities. On 12/17/24 at approximately 11:15 AM., Resident not available to interview. Staff states resident was at an appointment. On 12/17/24 at approximately, 11:15 AM., an interview was conducted with Other Staff Member (OSM) #5. OSM #5 said that the room was for staff to heat up food, but the residents would use the microwave also. OSM #2 said that she took the microwave off the unit to keep everyone safe after the resident was burned. OSM #2 said they provided First aide to Resident #56. The forearm looked red and was swollen. Nurse didn't physically see the resident as she was warming up her coffee who used a walker for mobility on and off the unit. On 12/17/24 at approximately 3:25 PM., an interview was conducted with Certified Nursing Assistant (CNA) #11. CNA #11 said that she heard about the incident but didn't witness it. CNA #11 also mentioned that the incident occurred in the dining room on Unit 2. CNA #11 also said that initially a resident had the microwave in his room, but it was removed and put in the dining room. Licensed Practical Nurse (LPN) #7 wrapped her hand. On 12/17/24 at approximately 4:25 PM., an interview was conducted with Resident #56 concerning her incident. Resident #56 said that after she heated and removed her cup of coffee from the microwave, she spilled it on her hand and arm as she was using her walker. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Abuse Policy Revised on 12/01/22 read: It is the policy of the facility to provide protection of health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of property. Reporting: The facility will have written procedures that include: Reporting all alleged violations to the administrator, state agency's or adult protective services and to all other required agencies with in specified timeframes. Immediately but no more than 2 hours. If the events that caused serious bodily injury or not later than 24 hours if the injury did not result in serious bodily injury. On 12/19/24 at approximately 5:55 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided prior to survey exit.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on resident record review, staff interviews and facility document reviews, the facility staff failed to notify the Office of the State Long-Term Care Ombudsman in writing of discharges for one (1) resident (Resident #32) in the sample of 74 residents. The findings included: Resident #32 was originally admitted to the facility 11/17/22 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Peripheral Vascular Disease, unspecified. The significant change, annual quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 06/29/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #32 cognitive abilities for daily decision making were severely impaired. According to the Admission/Discharge Report Resident #32 was discharged to the hospital on 6/10/24. The Discharge MDS assessment was dated for 06/10/24 - discharged assessment - return anticipated. The Re-entry MDS assessments was dated for 06/29/24 - return from local hospital. On 12/19/24 at approximately 3:38 PM., an interview was conducted with the Social Services Worker (SSW) concerning Resident #32. The SSW said that no Ombudsman notifications were sent out due to the facility not having a Social Worker at the time and it was the SSW responsibility. On 12/19/24 at approximately 5:55 P.M., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided prior to survey exit.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview, facility documentation review, and clinical record review the facility staff failed to complete a Comprehensive 14 day full Admission assessment and submit it to CMS (Centers for Medicare and Medicaid Services) in a timely manner for one (1) Resident (Residents #117) in a survey sample of 74 Residents. The findings included: For Resident #117, the facility staff did not complete and submit a Comprehensive Admission MDS assessment timely. Resident #117 was originally admitted to the facility on [DATE]. Resident #117 had a medical diagnosis history including; Congestive heart failure with diuretic use, unspecified dementia without behaviors, hypertension, depression, anxiety, dysphagia, gastro-esophageal reflux disease, and cardiac disease. Resident #117's most recent Minimum Data Set (MDS) assessment was a Significant change assessment with an assessment reference date of 11-28-24. Resident #117 had a Brief Interview of Mental Status score of 99 indicating severe cognitive impairment. He was dependant on staff for eating, bathing and personal hygiene. He was coded to have no skin impairment, and at risk for skin impairment. He was coded with no weight loss (which was incorrect), a weight of 123 pounds, no swallowing difficulty, and having a mechanically altered diet. The only previous MDS assessment completed in the facility was dated 9-23-24, and was the Resident's Comprehensive MDS admission assessment. This MDS had not been signed as completed until 11-23-24, and submitted over 2 months late and found during the 7 day look back time the second (significant change) MDS was being completed. The document revealed that the Resident's weight at that time to be 139 pounds. This indicated a greater than 10% weight loss in the 2 prior months before the significant change MDS was derived. It is notable to mention that the Resident was admitted with a weight of 145.3 pounds on 9-6-24. This revealed a significant weight loss of 22.3 pounds since admission, equaling a greater weight loss than 15% in the 3 month period from admission to the current survey which was well documented in the clinical record. On 12-13-24, and 12-18-24 during a meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns of late MDS submissions, and incorrect submissions, leading to failures in care planning for the Resident. At the time of survey exit on 12-19-24 the facility Administrator, and Director of Nursing stated they had nothing further to provide.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview, facility documentation review, and clinical record review the facility staff failed to complete a correct Significant Change full MDS assessment for two (2) Residents (Residents #117 & #105) in a survey sample of 74 Residents. The findings included: 1. For Resident #117, the facility staff did not complete and submit a correct Significant Change MDS assessment, with significant weight loss identified. Resident #117 was originally admitted to the facility on [DATE]. Resident #117 had a medical diagnosis history including; Congestive heart failure with diuretic use, unspecified dementia without behaviors, hypertension, depression, anxiety, dysphagia, gastro-esophageal reflux disease, and cardiac disease. Resident #117's most recent Minimum Data Set (MDS) assessment was a Significant change assessment with an assessment reference date of 11-28-24. Resident #117 had a Brief Interview of Mental Status score of 99 indicating severe cognitive impairment. He was dependant on staff for eating, bathing and personal hygiene. He was coded to have no skin impairment, and at risk for skin impairment. He was coded with no weight loss (which was incorrect), a weight of 123 pounds, no swallowing difficulty, and having a mechanically altered diet. The only previous MDS assessment completed in the facility was dated 9-23-24, and was the Resident's Comprehensive MDS admission assessment. This MDS had not been signed as completed until 11-23-24, and submitted over 2 months late and found during the 7 day look back time the second (significant change) MDS was being completed. The document revealed that the Resident's weight on 9-23-24 was 139 pounds. This indicated a greater than 10% weight loss in the 2 prior months before the significant change MDS was derived. It is notable to mention that the Resident was admitted with a weight of 145.3 pounds on 9-6-24. This revealed a significant weight loss of 22.3 pounds since admission, equaling a greater weight loss than 15% in the 3 month period from admission to the current survey which was well documented in the clinical record. On 12-13-24, and 12-18-24 during a meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns of late MDS submissions, and incorrect submissions, leading to failures in care planning for the Resident. At the time of survey exit on 12-19-24 the facility Administrator, and Director of Nursing stated they had nothing further to provide. 34306 2. The facility's staff failed to complete a significant change Minimum Data Set (MDS) assessment within 14 days after a determination of Resident #105's discontinuation of hospice services. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #105 was originally admitted to the facility 10/27/23 and he was readmitted [DATE] after an acute care hospital stay. The current diagnoses included a major neurocognitive disorder with Lewy Bodies dementia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/17/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 4 out of a possible 15. This indicated Resident #105's cognitive abilities for daily decision making were severely impaired. A review of Resident #105's clinical record revealed an election of hospice services was identified as beginning on 11/13/23 and on 5/20/24 hospice services were discontinued due to his extended prognosis but a significant change in condition MDS assessment was not completed within 14 days after a determination The CMS RAI Version 3.0 Manual, Page 2-25-26 stated a Significant Change in Status Assessment (SCSA) is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill. On 12/17/24 at 2:40 PM an interview was conducted with the MDS Coordinator. The MDS Coordinator stated the interdisciplinary team missed the significant change assessment for the resident's discharged from hospice services and when they realized it, they completed the significant change assessment on 7/17/24. The MDS Coordinator stated the significant change MDS assessment was not completed within CMS's specified timeframe. On 12/19/24 at approximately 5:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, the Owner and three Corporate Nurse Consultants. The Consultant Reimbursement stated the required timeframe was within 14 days.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on observation, clinical record review and staff interview, the facility staff failed to ensure a Pre-admission Screening and Resident Review (PASARR) was completed prior to admission or shortly thereafter for 4 Residents (Residents #49, #24, #47, and #80) in a sample of 74 residents. The findings include: 1. For Resident #49, facility staff failed to ensure a Preadmission Screening and Resident Review (PASARR) was completed correctly prior to admission or shortely thereafter. Resident #49 was admitted on [DATE] with diagnoses including: Major depressive disorder with psychotic symptoms, anxiety disorder, and Post Traumatic Stress Disorder (PTSD). Physicians orders for medications were reviewed and revealed psychotropic medications actively being administered for anxiety, and ongoing behavior monitoring. On 12-10-24, an observation was conducted of Resident #49. The Resident was sitting in her room and refused to respond to the surveyor who had entered the room and addressed her in a greeting while attempting conversation and interview. The Resident was talking to herself with questions and answers to an apparent inner monolog with herself. On 12-12-24 a review of Resident #49's clinical record was conducted. No previous to admission PASARR (preadmission screening & resident review) for mental illness or intellectual disability was found in the Electronic Health Record (EHR). Facility staff were asked to locate any previous PASARR documents, and they stated none had been completed. On 12-17-24 the new social worker completed a PASARR document for the Resident, however there were errors and the document was incomplete. It was signed by the new social worker and dated 12-17-24. It is notable to mention that the new Social worker was interviewed on 12-10-24 and revealed that she had just been hired on 11-19-24. The former Social worker resigned on 6-28-24, and there had been no social worker in the facility from 6-28-24 until 11-19-24. On 12-12-24 the Social worker's license and curriculum vitae were requested for verification and vetting as part of the employee records review for competency of staff. It was noted that the required course work and degree required by state and federal regulation for this employee was not sufficient for the role. The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 12-18-24. The Administrator stated, we will correct this immediately and indicated they would be auditing residents' PASARR's. No further documents were provided. 40711 2. The facility staff failed to complete a PASARR assessment for Resident #24. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #24 was originally admitted to the facility 11/17/22 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included Schizoaffective Disorder, Bipolar. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 09/19/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #24 cognitive abilities for daily decision making were intact. The care plan dated 11/24/23 read that Resident #24 has impaired thought processes as evidenced by delusions secondary to schizoaffective/bipolar disorder. The goal for the resident was for the resident will be able to communicate basic needs on a daily basis through the review date 10/01/24. The Interventions: Present just one thought, idea, question or command at a time and monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. A review of the resident's medical record reveal that no PASARR assessment was completed. On 12/17/24 at approximately 3:39 PM., an interview was conducted with the Social Services Director (SSD). The SSD said that she will complete a PASARR assessment today for Resident #24. On 12/19/24 at approximately 5:55 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided. 34306 3. The facility's staff failed to ensure Resident #47 was screened through the PASARR process prior to admission to the facility or shortly thereafter. Resident #47 was originally admitted to the facility 11/14/2024. The current diagnoses included a subarachnoid hemorrhage and a bipolar disorder. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/21/2024 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated Resident #47's cognitive abilities for daily decision making were severely impaired. Review of the clinical record failed to reveal the resident was screened for a possible serious mental disorder, intellectual disability and related conditions through the PASARR process. The resident is ordered Effexor and Lamictal for a bipolar disorder, yet the Level 1 screening could not be in located the clinical record. An interview was conducted with the Social Services Director (SSD) on 12/18/24 at approximately 1:03 PM. The SSD stated the Level 1 was not sent with the resident at the time of admission, but she would complete the screening. The SSD completed the Level 1 screening for Resident #47 on 12/18/24 and presented it to the Team. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/24 at approximately 6:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, the Owner and three Corporate Nurse Consultants. They voiced no concerns regarding the above findings. 34894 3. The facility's staff failed to ensure Resident #80 was screened through the PASARR process prior to admission to the facility or shortly thereafter. Resident # 80 was admitted on [DATE] with diagnoses including but not limited to: Bipolar Disorder,Vascular Dementia, Diabetes, Depression, anxiety disorder, and Post Traumatic Stress Disorder. Resident #80's most recent MDS (Minimum Data Set) was a Quarterly Assessment with an ARD (Assessment Reference Date) of 11/22/2024 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 12 out of 15 indicating moderate cognitive impairment. Review of the clinical record revealed that Resident #80 did not have a PASARR level 1 completed prior to admission to the facility from the acute care hospital. Physicians orders for medications were reviewed and revealed the following psychotropic medications actively being administered and ongoing behavior monitoring: Escitalopram 5 milligrams one tablet per day for depression Olanzapine 5 milligrams one tablet at bedtime for psychotic disturbance Further review of Resident # 80's clinical record was conducted on 12/17/2024. No previous to admission PASARR (preadmission screening & resident review) for mental illness or intellectual disability was found in the Electronic Health Record (EHR). Facility staff were asked to locate any previous PASARR documents, and they stated none had been completed prior to that date. On 12/17/2024 at approximately 1:00 p.m., an interview was conducted with the Social Worker who stated that she was aware that PASARRs should be done prior to admission. She stated that if the PASARR was not done prior to admission, she would complete them once the residents were admitted to the facility. On 12/17/2024 at approximately 2:15 p.m., an interview was conducted with the Director of Nursing (DON) and the Administrator who stated that PASARRs should be completed prior to admission to the facility. On 12/18/2024 at approximately 10:00 a.m, the Director of Nursing and Administrator presented a copy of the PASSAR that was completed on 12/17/2024 by the Social Worker for Resident # 80 and uploaded into the clinical record. On 12/18/2024 during the end of day meeting, the Administrator and Director of Nursing were made aware of the issues. No further information was provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed to develop and implement a comprehensive care plan for 4 Residents (Residents #117, #379, #91 and #39) in a survey sample of 74 Residents. The findings included: 1. For Resident #117, the facility staff failed to derive and implement a comprehensive care plan for prevention of significant weight loss and dehydration, Pressure sores, Hospice, and provision of ADL (Activities of Daily Living) care. Resident #117 was originally admitted to the facility on [DATE], and was hospitalized 10 days later on [DATE] for a colonic hemorrhage caused by a Stercoral ulcer (impacted hard stool at the anus and distal rectum) which pierced the bowel wall, after having had no bowel movements. The ulcer/perforation of the bowel wall resulted in blood loss requiring 2 blood transfusions according to hospital records. The Resident was again sent out to the hospital on [DATE] through [DATE] for a severe urinary tract infection causing sepsis and septic shock, and acute kidney injury which was reversed successfully in the hospital with IV (intravenous) fluids for dehydration and IV antibiotics. Resident #117 had a medical diagnosis history including; Congestive heart failure with diuretic use, unspecified dementia without behaviors, hypertension, depression, anxiety, dysphagia, gastro-esophageal reflux disease, and cardiac disease. Resident #117's most recent Minimum Data Set (MDS) assessment was a Significant change assessment with an assessment reference date of [DATE]. Resident #117 had a Brief Interview of Mental Status score of 99 indicating severe cognitive impairment. He was dependant on staff for eating, bathing and personal hygiene. He was coded to have no skin impairment, and at risk for skin impairment. He was coded with no weight loss (which was incorrect), a weight of 123 pounds, no swallowing difficulty, and having a mechanically altered diet. The only previous MDS assessment to the [DATE] MDS was dated [DATE], and was the Resident's admission assessment. This MDS had not been signed as completed until [DATE], and submitted late. The document revealed the Resident's weight at that time to be 139 pounds. This indicated a greater than 10% weight loss in the previous 2 months. It is notable to mention that the Resident was admitted with a weight of 145.3 pounds on [DATE]. This revealed a significant weight loss of 22.3 pounds since admission, equaling a greater weight loss than 15% in the 3 month period from admission to the current survey which was well documented in the clinical record. Before hospitalization and after hospitalization the Resident's diet remained the same. Regular diet, Dysphagia pureed texture, thin consistency. On [DATE] mighty shakes 4 ounces was ordered at bedtime for a supplement. No other diet changes nor supplements were ever ordered during the Resident's stay. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident was observed during initial tour of the facility on [DATE] immediately following a shower room observation with Resident #117's room mate. The room tour included but was not limited to the following being observed; A urine soaked bathroom, a pervasive smell of urine and feces in the room and on the entire unit. The floor of the room was sticky and made a sucking sound as one walked across it, and the base board was peeling and drooping over in places. The floor was crusted with crumbs, brown debris, and black particles. The bed divider curtain had brown stains and smeared feces on it. Resident #117 was in bed covered with only a bed sheet with no blanket and wore no clothing nor gown, and only an incontinence brief under the bed sheet. The fitted bed sheet under the Resident had a yellow halo around the Resident which appeared to be dried urine with a strong odor. The Residents incontinence brief was obviously soaked with urine and wrinkled down at the waist with the heaviness of the liquid it contained. The Residents hair was matted to his head, greasy, dandruff lay in his bed and on his pillow, and body odor/sweat could be clearly smelled. During the entire survey Resident #117 was never observed during the day shift out of bed, and asked the surveyors often for something to drink stating Please, Please bring me some water I'm so thirsty. The Residents lips were noted to be cracked and dry, and his eyes were sunken. His skin was flaking and dry and when the skin on his hand was examined it tented when pulled gently in an upward fashion and stayed that way. His mucus membranes were sticky and when he spoke his lips would stick together with thick saliva briefly. He constantly complained my butt hurts, my butt hurts. Staff were made aware that the Resident was thirsty, and complaining of butt pain. Staff stated they would have the NP look at him. On [DATE] the Resident was assessed by the Registered Nurse Practitioner (NP) and found to have a stage 3 sacral pressure sore. Each day of survey the Resident was visited and observed to be in bed lying on his back or right side facing the window. No support devices and repositioning was ever observed. The Residents had no television, no clock, no telephone, no radio and the room had no personal items in it nor on the walls. Each room on the unit was then inspected by all surveyors and found to be in the same condition as Resident #117's room. There were no televisions in any room, and no water to drink in any room. Staff on the memory care unit were interviewed and asked why Resident #117 was not clean, they stated well, he refuses a lot, and (name) Resident #117 is hospice now and doesn't like to be moved much. Staff were taken to the Residents' room and #117 was asked if he would like a shower or bath, and he simply shook his head yes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADL (activities of daily living) care records were reviewed for Resident #117 and revealed that the Resident was totally dependant on one staff member. The document indicated that a bath was given every morning, however, the Resident was observed every day during survey and found to be dirty and unkempt with flaking skin, dandruff, greasy hair, and in a soiled bed with soiled linens. At times the Resident was found wearing only an incontinence brief, and at other times wearing a white stained T-shirt and also an incontinence brief. The Resident was never seen out of bed during daytime hours for the entire survey. On [DATE] A Certified Nursing Assistant (CNA) was found in the hallway after Resident #117 was found begging for water. The CNA brought in 120 milliliters of tea for the Resident, and was again told he asked for water. She stated oh he just wants to drink, not eat. The CNA was asked if she was aware that the caffeine in tea was a diuretic and could further dehydrate the Resident. She did not respond. On [DATE] the Kitchen manager was interviewed and stated that they did not keep track of percentages of meals and fluids consumed, and stated that the nursing staff were responsible for that. She was asked if she had decaffeinated tea on hand, and she stated she had decaf coffee but not tea. On [DATE] A CNA was interviewed and stated, he (Resident #117) went out to the hospital with altered mental status, low blood pressure, dehydration and a UTI (urinary tract infection), and when he came back he went on hospice. He's been in bed now since then. The Resident had actually returned on [DATE], and was not placed on hospice until [DATE] (one month later). The CNA was asked for his hospice notes, and she went to the LPN (Licensed Practical Nurse) unit manager with the surveyor accompanying her and asked for the notes. The LPN stated I will look for them, and later stated I don't have any. The entire clinical record was reviewed and no hospice notes were in the clinical record. Staff were then asked if hard copy notes could be located in a binder, and they stated they had no such binder. There was an observed notice taped to the Resident's closet door from the new social worker addressed to the hospice staff. The document instructed that the Resident's hospice supplies had been found in the general supply closet in the facility with normal inventory. The document instructed hospice staff to inform the nurses on the unit when hospice supplies were brought in for the Resident. It appeared that the facility staff and hospice staff were not communicating. On [DATE] from 11:30 AM until 1:00 PM a second surveyor was observing lunch service on the memory care secured unit until the meal was finished. Resident #117 was never fed, and his tray was removed from his room. The tray was placed back on the tray cart to return to the kitchen for disposal, untouched. The CNA was asked why he was not fed, and she replied oh he's hospice he don't want it. The Resident received no food, and no fluids from 9:00 AM breakfast to 5:00 PM dinner (8 hours). No water was in any Resident room on the secured unit during the entire survey. Resident #117's clinical record was reviewed. Weight documents all completed by chair scale revealed the following; [DATE] - 145.3 pounds on admission. [DATE] - 143.0 pounds out to hospital on [DATE] with bleeding, returned [DATE]. [DATE] - 139.0 pounds (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] - 139.0 pounds [DATE] - 123.0 pounds [DATE] - 122.6 pounds No further weights were being recorded as staff stated well, he's hospice now, so no need really. The Resident was not placed on hospice until [DATE], (2 weeks later with no weights completed) and remained a Full Code CPR status. The Registered Dietician (RD) was called via cellular phone for interview and was unable to be contacted. A message was left on voicemail, however, surveyors received no call back. No RD notes were found in the clinical record, however, on [DATE] at 12:11 PM, the Administrator and Director of Nursing (DON) supplied the only note they had received from the RD dated [DATE] (8 days after returning from the hospital with sepsis and dehydration). The RD note was reviewed and revealed continued weight loss and the following 4 recommendations, none of which were followed: 1. Consider benefit of appetite stimulant medication due to poor oral intake. 2. when poor oral intake less than 50% offer alternate meal options. 3. weekly weights for one month due to readmit. 4. RD to monitor for significant changes in weight poor oral intake or skin integrity and follow up as needed. Staff were interviewed on [DATE] and asked what interventions could be offered to a Resident to prevent significant weight loss. The Director of Nursing (DON) provided two policies on Nutritional Management, and Weight Monitoring that documented the following; 1. Nutritional Management. Nutritional Status includes both nutrition and hydration status. The document describes a systematic approach to optimize a Resident's nutritional status. Staff are to identify risk factors, evaluate and analyze assessment information, develop and consistently implement approaches, and monitor the effectiveness of interventions and to revise interventions as necessary which would be reflected in the Resident's plan of care. The document goes on to describe that a comprehensive assessment will be completed by the Registered Dietician (RD) within 72 hours of a change in condition to include persistent hunger, poor intake, or continued weight loss, or evidence of fluid loss. One intervention included diet liberalization, and feeding assistance. 2. Weight Monitoring. Significant unintended changes in weight (loss or gain) .may indicate a nutritional problem. A comprehensive nutritional assessment, The Nutritional Data Collection Tool will be completed and that information would identify risk which would then drive the care planning process development to include; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1). Administer medications as ordered, observe for side effects and effectiveness alert MD (doctor) as needed. (2). Provide, serve diet as ordered. Monitor intake and record every meal. (3). RD to evaluate and make diet change recommendations as needed. (4). Receives a mechanical soft pureed diet, related to diagnosis. (5). weight per facility protocol/MD order. 2. (Pressure sores), The Resident has actual impairment to skin integrity created on [DATE] with a goal to have no complications related to skin impairment through the review date of [DATE]. The Care plan was reviewed and included focuses, goals and interventions for potential for pressure ulcer development created on [DATE] related to Dementia and bowel and bladder incontinence. A new care plan entry was created on [DATE] which identified the first actual impairment to skin integrity with interventions for the (3) following items; No treatments were ever specified. (1). Follow facility protocols for treatment of injury. (2). Use caution during transfers and bed mobility to prevent striking arms, legs, and hands to avoid striking any sharp or hard surface. (3). Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, and any other notable changes or observations. 3. Hospice, (Resident name) is receiving hospice services from (name of company) and phone number, created on [DATE] with a goal of (Resident name) needs will be met through the next review period [DATE]. Interventions were for the following (2) items. No specific care was specified to be given by the hospice agency, nor by the facility to direct staff in the care required to be performed by each participant, and no collaboration/communication was ever documented between the 2 care givers. (1). Collaborate with all disciplines, family, Hospice to meet (Resident name) needs. (2). (Resident name) will be made comfortable. 4. ADL Care, Has bladder incontinence related to dementia, unsteady gait, diuretic use created on [DATE], with a goal of The Resident will remain free of skin breakdown due to incontinence through the review date [DATE]. Interventions were for the following (4) items. The Resident was also incontinent of bowel, fluids were not encouraged leading to dehydration, bowel impaction, and hospitalization . The Resident was non-ambulatory, and only diagnostic testing ordered by a physician could be conducted to diagnose the causes of incontinence in the #(4) intervention. (1). Clean peri-area with each incontinence episode. (2). Encourage fluids during the day to promote prompted voiding responses. (3). Ensure the Resident has unobstructed path to the bathroom. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(4). Observe/report as needed any possible causes of incontinence, bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects. The care plan was not Resident specific and did not specify feeding needs, supplements, diet changes, alternate diet changes, nor RD interventions. It did not specify any measures/interventions to be instituted to prevent a pressure sore from forming/worsening, like treatments, positioning devices and moisture barrier creams, or support devices. No treatments were specified for the care of a pressure sore after it developed and was identified at a stage 3. Hospice services were never care planned, and ADL care was never care planned for bathing, feeding, hygiene, and toileting as an interdisciplinary care plan team would be expected to produce. It is also notable to mention that the care plan was not derived by an interdisciplinary team and the only 2 individuals who were present for the most recent care plan update was the LPN (Licensed Practical Nurse) unit manager, and the Social Worker who was found to not have been vetted properly, and had insufficient qualifications for the Role. On [DATE] at 11:15 a.m., the Administrator, Director of Nursing, and Corporate Nurse were notified that the care planning for Resident #117 was insufficient to inform and drive care, not interdisciplinary, and not comprehensive per diagnosis and need of the Resident. The facility staff was given the opportunity to provide any further information or explanation. They stated they had no further information. On [DATE], prior to the survey exit the Director of Nursing informed surveyors that Resident #117 and his room mate had been moved back onto regular units last night ([DATE]). At the time of survey exit on [DATE] the facility Administrator, and Director of Nursing stated they had nothing further to provide. 40026 2. For Resident #379 the facility staff failed to ensure the Resident had a care plan that included interventions for prevention of pressure ulcers. Resident #379 was admitted to the facility on [DATE] with diagnoses that included but was not limited to sepsis, CVA malnutrition, metabolic encephalopathy, dysphagia, Alzheimer's disease, dementia, acute kidney failure, atherosclerotic heart disease, hypothyroidism, hypertension and insomnia. Resident #379 was dependent on g-tube feedings for nutrition. The discharge instructions stated that the Resident skin on discharge was warm and dry with no mention of open areas, wounds or pressure sores. On [DATE] a review of the clinical record revealed that the Admission Screening done on [DATE] section C showed skin normal, dry and no open areas. His Braden Scale for Predicting Pressure Sore Risk score was 13 indicating he was a moderate risk for development of pressure sores. The MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of [DATE] coded Resident # 379 as being dependent on staff for turning repositioning and all aspects of ADL (Activities of Daily Living) care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] a review of the clinical record revealed that Daily Skin Assessment document dated [DATE] was not filled out. The Weekly Skin Assessment document dated [DATE] was not filled out, however the following pressure injuries were documented in the clinical record: Left Heel DTI (Deep Tissue Injury) Left Lateral Ankle DTI Right Foot DTI Right Lateral Ankle DTI On [DATE] a review of the clinical record revealed that the comprehensive care plan was started on [DATE] read as follows: FOCUS: (Name redacted) has DTI pressure ulcer to left hell, [sic] left lateral ankle, right later ankle pressure or potential for pressure ulcer and potential for skin breakdown development r/t Dehydration, disease process, incontinence, Hx of ulcers, Immobility. Date Initiated: [DATE] Created on: [DATE]. GOAL: Pressure ulcer will show signs of healing and remain free from infection by/through review date. Date Initiated: [DATE] Target Date: [DATE] INTERVENTIONS: Administer medications as ordered. Observe/document for side effects and effectiveness. Date Initiated: [DATE] Created on: [DATE] Administer treatments as ordered and observe for effectiveness. Date Initiated: [DATE]Created on: [DATE] Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: [DATE] Created on: [DATE] If the resident refuses treatment, confer with the resident, IDT and family to determine why and try alternative methods to gain compliance. Document alternative methods. Date Initiated: [DATE] Created on: [DATE] Inform the resident/family/caregivers of any new area of skin breakdown. Date Initiated: [DATE] Created on: [DATE] (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] an interview was conducted with the DON who was asked the purpose of a care plan. The DON answered that the care plan should direct all aspects of the Residents care. When asked if this included pressure ulcer prevention for a non ambulatory Resident who is dependent on staff for all aspects of ADL care. She stated that all Resident who have limited mobility should have pressure ulcer prevention in the care plan. When asked if that was done in the case of Resident #379 she stated that according to the care plan Resident #379 did not have interventions in place until after he developed pressure areas. On [DATE] during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 34894 3. For Resident # 91, the care plan was not resident-centered to describe issues or behaviors related to Resident # 91 refusing to allow bedding/linens to be placed on the bed. Resident # 91 was admitted to the facility on [DATE]. Diagnoses included but were not limited to: Cerebral Infarction, Hypertension, Anxiety Disorder, Hemiplegia and Vascular Dementia. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of [DATE]. Resident # 91's BIMS (Brief Interview for Mental Status) Score was a 14 out of 15, indicating no cognitive impairment. Resident # 91 required assistance with Activities of Daily Living. Review of the clinical record was conducted on [DATE]-[DATE]. During observations on all of the days of the survey, there was no sheet on the mattress nor linens on the bed at any time. Resident # 91 was observed lying in the bed with no sheet or bedding covering the mattress. The resident was lying on the uncovered vinyl mattress. On [DATE], at approximately 03:45 PM, Resident #91 was observed walking into his room. Bed observed unmade no sheets. Air condition unit set at 62 degrees. Resident states I don't want sheets on my bed its too hot. Everyone here knows not to put sheets on my bed and to keep my curtain drawn. Review of the care plan revealed no documentation of a concern or problem regarding Resident # 91 not wanting sheets or any bedding/linens on the bed. Review of the Progress Notes revealed no documentation about Resident # 91 refusing to allow the staff to put sheets/linens on the bed. During the end of day debriefing on [DATE], the Administrator and Director of Nursing were informed of the findings that the care plan was not resident specific for Resident # 91. The Director of Nursing stated the care plan should represent any concerns or issues involving the resident and should have had documentation about the resident refusing to allow linens on the bed. No further information was provided. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. For Resident # 39, the facility staff failed to develop and implement a resident-centered care plan regarding the problem of a Candida infection. Resident # 39 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Chronic Obstructive Pulmonary Disease, Emphysema, Primary Hypertension, Anxiety, Depression, Gastrpesophageal Reflux Disease, Barrett's Esophagus, Dysphagia and Insomnia. The most recent Minimum Data Set (MDS) was a Quarterly Assessment Quarterlywith an Assessment Reference Date (ARD) of [DATE]. Resident # 39's BIMS (Brief Interview for Mental Status) Score was a 15 out of 15, indicating no cognitive impairment. Review of the clinical record was conducted on [DATE]-[DATE]. Review of the care plan revealed documentation of a problem stating the resident has Candida infection. The location of the infection was not noted. The Goal was written as will remain free from infection through the review date. The intervention was Observe, document report PRN (as needed) signs and symptoms of infection, fever, redness, drainage or swelling around wounds or catheter sites, cough, dysuria, hematuria, flank pain, and foul smelling urine. Review of the Progress Notes revealed documentation of the following: [DATE]- Nurse Practitioner note- On page 591 of 702 seen for follow up of complaints of burning and itching. Patient was recently checked for UTI (urinary tract infection) discussed with patient her recent lab results and negative findings. However, patient complained of discharge itching and irritation to her groin area discussed with patient starting medications for concerns with the yeast she verbalized understanding . The note documented on page 597 of 702 a genitourinary exam was deferred due to positive suprapubic tenderness to palpation. On page 598 of 702, the diagnosis was listed as Candida Infection. The plan was listed patient start with Diflucan for Candida Infection 150 mg by mouth x 3 days monitor closely notify provider if any persistent complications maintain adequate hygiene assist patient with her laundry continue supportive care . The note was signed by the Nurse Practitioner on [DATE] at 7:04 p.m [DATE] at 10:56 a.m. the Nursing Progress note was written stating- resident complaining of itching in private area, Patient completed Fluconazole today [DATE] as prescribed by doctor. Patient stated it is not helping I feel like I could itch my privates with a hairbrush. After I use the bathroom in the morning, it feels like a relief but only briefly. I am itching and uncomfortable. Reassured resident that NP will be notified of persistent discomfort. NP notified, will continue to monitor at this time. [DATE] at 6:12 p.m., Nursing Progress Note Patient states 'The problem in my vagina area is 60% better than it was yesterday. Notified NP that the issue is getting better. [DATE] at 8:43 p.m.-Nurses Progress Note stated the Resident complained of severe vaginal itching with some light-yellow discharge. Encourage fluid intake and personal hygiene. Notified NP-awaiting assessment. Resident accepting. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] at 1:00 a.m.-NP encounter visit- stated resident was seen for follow up of vaginal itching and irritation. The note stated the resident had complications of a Candida infection and had been treated with Diflucan for 3 days. However, patient complains of some ongoing itching and irritation. Discussed with patient will recommend possibly a topical agent- On assessment she does not have any odorous discharge she does have some redness externally,,, On [DATE] at 3:20 p.m., an interview was conducted with Licensed Practical Nurse # 1 who stated the care plan should reflect the problems affecting the resident. Licensed Practical Nurse # 1 stated the nursing staff use the care plan as a guide for providing care to the residents. She also stated interventions should be written that would help to resolve the problem. Licensed Practical Nurse # 1 stated the nurses should monitor the residents to see if the interventions were helpful and if the issue was resolved. The care plan did not specifically address the location of the Candida Infection. There was no mention of the severe vaginal itching and irritation that Resident # 39 was experiencing. There were no specific interventions related to resolving the problem. The care plan appeared to be from a template but not resident specific. During the end of day debriefing on [DATE], the Administrator and Director of Nursing were informed of the issues of the care plan not being person-centered. The Director of Nursing stated the care plan should represent any concerns or issues involving the resident and should have interventions to address the issue/problem. No further 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation, the facility staff failed to review and revise a care plan for two (2) Residents (#'s 78 and 105) in a survey sample of 74 Residents. The findings included: 1. For Resident #78 the facility staff failed to review and revise care plan to include add each actual fall and update or add new interventions. On 12/11/24 a review of the clinical record revealed that Resident #78 was admitted to the facility on [DATE] with diagnoses that included but were not limited to cognitive communication deficit, dysphagia, muscle weakness, dementia, severe without behavioral disturbance, psychotic mood disturbance and anxiety, abnormalities of gait and mobility, hypertension, hx (history) of renal cancer, and hx of repeated falls. Resident #78 had a BIMS (Brief Interview of Mental Status) score of 13/15 on admission indicating mild cognitive impairment. On 2/13/24 (one month prior to falls) Resident #78 BIMS was assessed at 5/15 indicating severe cognitive impairment. A review of Resident #78's complete care plan revealed that on admission the Resident was identified as being a high fall risk as evidenced by the following entry in the initial comprehensive care plan dated 4/30/23: FOCUS: [Resident #78 name redacted] is High, risk for falls r/t Confusion, Gait/balance problems, Incontinence, Unaware of safety needs Date Initiated: 04/30/2023 Created on: 04/30/2023 GOAL: [Resident #78 name redacted] will be free of falls through the review date. Date Initiated: 03/05/2024 Revision on: 04/18/2024 Target Date: 10/09/2023 INTERVENTION: Anticipate and meet her needs. Date Initiated: 04/30/2023 Created on: 04/30/2023 Be sure call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 04/30/2023 Created on: 04/30/2023 Follow facility fall protocol. Date Initiated: 04/30/2023 Created on: 04/30/2023 Pt evaluate and treat as ordered or PRN. Date Initiated: 04/30/2023 Created on: 04/30/2023. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record revealed that Resident #78 had 6 falls from 3/23/24 through 11/24/24 (3/23/24, 3/30/24, 7/1/24, 8/5/24, 11/23/24 and 11/24/24). The care plan update was not updated, reviewed and revised after the falls on 3/23, 3/30, 7/1, 11/23 & 11/24/24. The following revision to the care plan was made after the fall on 8/5/24. FOCUS: [Resident #78 name redacted] has had an actual fall with no injury, R/T Poor communication/comprehension Date Initiated: 08/05/2024 Created on: 08/05/2024 GOAL: [Resident #78 name redacted] will resume usual activities without further incident through the review date. Date Initiated: 08/05/2024 Revision on: 08/05/2024 INTERVENTIONS: Continue interventions on the at-risk plan. Low bed, Rt & Lt fall mats, repositioning every shift Date Initiated: 08/05/2024 Created on: 08/05/2024 Observe and report PRN to MD for s/sx: Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. Date Initiated: 08/05/2024 Created on: 08/05/2024 Neuro checks per protocol. Date Initiated: 08/05/2024 Created on: 08/05/2024. On 12/18/24 an interview with LPN 1 (Unit Manager), who was asked what the expectation is for nursing staff after a fall occurs and she stated that Nurses are expected to assess the Resident for injuries, notify physician and family, follow any new orders from physician pertaining to the incident, and document the fall as well as the post fall follow up, and the care plan should be updated to add new interventions after a fall. When asked if this was done after each fall, she stated that it was not. On 12/18/24 a review of the facility FALL POLICY revealed the following excerpts: 9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a Post fall review and a Post fall follow up note in PCC [the electronic health record] c. Complete an incident report in PCC d. Notify physician and family. e. Review the resident's care plan and update as indicated f. Document all assessments and actions (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. Obtain witness statements in the case of injury h. If there are signs of serious injury or there are concerns about the circumstances of the fall notify the Director of Nursing and or the Administrator. i. Begin neurologic assessment using Neurological Record assessment tool in PCC On 12/18/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 34306 2. The facility's staff failed to review and revise Resident #105's care plan after hospice services were discontinued. Resident #105 was originally admitted to the facility 10/27/23 and he was readmitted [DATE] after an acute care hospital stay. The current diagnoses included a major neurocognitive disorder with Lewy Bodies dementia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/17/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 4 out of a possible 15. This indicated Resident #105's cognitive abilities for daily decision making were severely impaired. On 11/13/23 hospice services were elected for Resident #105. On 5/20/24 hospice services were discontinued due to an extended prognosis. A review of the person-centered care plan revised on 10/24/24 stated (name of resident) has a problem or potential nutritional problem related to diagnoses of dementia, CHF, advanced age and hospice. The goal stated (name of resident) will maintain adequate nutritional status as evidenced by no significant weight changes, no signs/symptoms of malnutrition, and consuming greater than/equal to 50 percent of most meals daily through review date,1/24/25. The interventions included provide, serve diet as ordered. Monitor intake and record after each meal. On 12/19/24 at approximately 6:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, the Owner and three Corporate Nurse Consultants. They voiced no concerns regarding the above findings.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to follow the professional standards of quality for four (4)residents (Resident #'s 326, 91, 128 and 48) in survey sample of 74 residents. Findings included: 1. For Resident # 326, the facility staff failed to ensure wound care was provided as ordered by the physician. Resident # 326 was a [AGE] year old admitted to the facility on [DATE], with diagnoses that included but were not limited to: Calciphylaxis a rare serious disease that involves build up of calcium in small blood vessels of fat tissue and skin. People with the disease usually have kidney failure or receive dialysis. The most recent MDS (Minimum Data Set) assessment was coded as an Admission assessment with an ARD (Assessment Reference Date) of [DATE]. The BIMS (brief interview for mental status) was coded as 15 out of possible 15 indicating no cognitive impairment. The assessment also coded Resident # 326 as requiring assistance with activities of daily living; Review of the clinical record was conducted on [DATE] to [DATE]. Review of the clinical record revealed documentation of wound care not being provided for Resident # 326 as ordered by the physician. There was missing documentation of wound care being administered 6 times during the stay at the facility. The missing documentation of wound care included the following dates: [DATE] at 8 p.m., [DATE] at 8 a.m. and 8 p.m., [DATE] at 8 a.m. and 8 p.m., and [DATE] at 8 a.m. Left breast wound cleanse with DWC (Dakin's Wound Cleanser) pack BID (twice a day) with Dakin's solution cover with Mepilex or Border gauze two times a day for wound care -Start Date- [DATE] 2000 -D/C Date- [DATE] 1315 Scheduled BID (twice a day) for 8 a.m. and 8 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:45 a.m., an interview was conducted during Medication Pour and Pass Observation with Licensed Practical Nurse # 1 who stated medications and treatments should be signed off at the time of administration. She stated there should be no blanks in the documentation because there was a code for refusals. Any blanks would be an indication the administration did not occur. She stated the nurse could also write a progress note about any refusals. On [DATE] at 2:10 p.m., an interview was conducted with the Director of Nursing who stated the Wound care specialist made rounds weekly on the residents with wounds. The Director of Nursing stated wound care was expected to be provided as ordered by the Physician. Review of the Weekly skin Assessments revealed assessments were done on [DATE] and [DATE]. Wound care Specialist's notes revealed wound care assessments were done on [DATE] and [DATE]. Review of note of the Wound Care Specialist's evaluation on [DATE] at 8:34 a.m. revealed the following description: Location: left breast Wound ID:____ (redacted) Measurements Length: 2.67 cm (centimeters) -- Red: 13.23 cm^2 -- Width: 7.70 cm -- Black: 0.00 cm^2 -- LxW: 20.56 cm^2 -- Yellow: 0.21 cm^2 -- Depth: -- -- Pink: 3.11 cm^2 -- Total: 16.56 cm^2 -- Other: 0.00 cm^2 -- Observations % granulation 100.00 Depth (cm) 0.20 ---------- Calciphylaxis Other Normal saline wet to dry gauze BID Wound Status Present on admission Acquired in House? No Etiology Other (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Margin Detail Attached edges Drain Amount Moderate Drain Description Serosanguinous Odor No Odor Periwound Intact Pain 4 Dressing Change Frequency BID Cleanse Wound With Wound Cleanser Dressings Other: See Notes Secondary Dressing Bordered gauze PUSH Score 0 Signature Review of note of the evaluation on [DATE] at 8:11 a.m. revealed the following description: Length: 9.77 cm (+265.7) Red: 25.99 cm^2 (+96.4) Width: 3.80 cm (-50.7) Black: 0.00 cm^2 (+0.0) LxW: 37.13 cm^2 -- Yellow: 0.00 cm^2 (-100.0) Depth: -- -- Pink: 2.01 cm^2 (-35.5) Total: 28.00 cm^2 (+69.1) Other: 0.00 cm^2 (+0.0) Observations % granulation 100.00 Depth (cm) 0.20 ---------- Calciphylaxis Other Normal saline wet to dry gauze BID Wound Status Worsening (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Acquired in House? No Etiology Other Additional woundbed details Bleeding Margin Detail Attached edges Drain Amount Heavy Drain Description Sanguinous Odor No Odor Periwound Intact Pain 4 Dressing Change Frequency BID Cleanse Wound With Wound Cleanser Dressings Other: See Notes Secondary Dressing Bordered gauze PUSH Score 0 Review revealed the Wound Care Specialist evaluated the wound on [DATE] and described it as worsening and with heavy sanguinous drainage. Resident # 326 was transferred emergently to the emergency roiagnom on [DATE] with complaints of bleeding from the left breast and hypotension, Resident # 326 ultimately expired in the hospital on that same day. There was documentation that there was a lack of wound care provided as ordered by the physician. Two days prior to the day Resident # 326 was transferred emergently to the hospital, wound care was not provided three times consecutively ([DATE] at 8 a.m., [DATE] at 8 p.m. and ,d+[DATE]/ 2023 at 8 a.m.) The documentation during the week prior revealed there had been three consecutive times when wound care was not provided (on [DATE] at 8 p.m., [DATE] at 8 a.m. and 8 p.m.) During the end of day debriefing on [DATE], the Facility Administrator and Director of Nursing were informed of the findings. No further information was provided. 2. For Resident # 91, the facility staff failed to follow professional standards regarding Medication Administration by leaving medications at the bedside. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 91 was admitted to the facility on [DATE]. Diagnoses included but were not limited to: Cerebral Infarction, Hypertension, Anxiety Disorder, Hemiplegia and Vascular Dementia. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of [DATE]. Resident # 91's BIMS (Brief Interview for Mental Status) Score was a 14 out of 15, indicating no cognitive impairment. Resident # 91 required assistance with Activities of Daily Living. Review of the clinical record was conducted on [DATE]-[DATE]. During the initial tour on [DATE] at approximately 2:10 p.m., a medication cup with two white pills was observed on the overbed table by the bed by the window. The pills were white in color; one was oval and the other was round in shape. The resident was not in the room when the surveyor walked into the room. There was no nursing staff member in the hallway when the surveyor looked for someone to ask about the medications. After approximately 8 minutes, a facility staff member was observed in the hallway. She identified herself as the Admissions Coordinator. She was asked if she knew who resided in the room. She identified the resident's name as Resident # 91. The Admissions Coordinator stated she would find a nursing staff member. At 2:23 p.m., Resident # 91 entered the room as the Admissions Coordinator was leaving the room. When asked about the medication in the cup, Resident # 91 stated that was the medicine from this morning. He stated that he told the nurse he was going to take it. Resident # 91 stated he wanted to take his time taking his medications. He stated he was not sure of the kind of pills but thought one was Trazadone. On [DATE] at 2:34 p.m., an interview was conducted with the Unit Manager, LPN (Licensed Practical Nurse)-# 1 who stated there was no self administration by any residents on the unit. She stated none of the residents on the unit had assessments with orders for self administration of medications. The Unit Manager stated medications should be documented at the time of administration and/or any refusals should be documented immediately. She stated the nurse should observe the resident consume the medications and that medications should never be left at the bedside for the resident to consume later. On [DATE] at 2:39 p.m. an interview was conducted with the nurse (LPN-3) scheduled to pass medications on that day. LPN-3 stated she administered the morning medications for Resident # 91. LPN-3 stated the medications in the medication cup were not the medications scheduled for administration in the mornings. She stated she observed Resident # 91 consume the medications she prepared for him that morning. LPN-3 stated she did not see that medication cup with those two medications on the overbed table when she administered the medications that morning. LPN-3 stated that the expectation was for medications to be documented at the time of administration. She stated that if the resident refuses to take the medication, the medication should be taken back to the medication cart, discarded and the nurse should document the refusal in the clinical record. LPN-3 stated medications should not be left at the bedside. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator came to Resident # 91's room with the surveyor. The Administrator observed the medication cup on the overbed table and asked Resident # 91 where the medications had come from. Resident # 91 told the Administrator that medications were from that morning and that he would take them right then. The Unit Manager informed Resident # 91 that the staff needed to determine which medications were in the medicine cup. The Unit Manager and Administrator removed the medications from the room. LPN # 3 and the Unit Manager reviewed the [DATE] Medication Administration Record and the Medication pill cards (blister packs) to compare with those medications found at the bedside. They determined that the two pills were two medications that were scheduled to be administered at bedtime at 2100 (9:00 p.m.): Atorvastatin 40 mg (milligrams) give one tablet by mouth at bedtime for hyperlipidemia and Melatonin 3.1 mg (milligrams) give one tablet by mouth at bedtime for insomnia. Review of the [DATE] Medication Administration Record revealed the two medications had been documented as administered every night except when refused by the resident on [DATE] and [DATE]. The Unit Manager discarded the medications that were in the medication cup. She stated she did not know when the medications had been left at the bedside. During the end of day debriefings on [DATE] and [DATE], the Administrator, Director of Nursing and Regional Nurse Consultant were informed of the findings. They stated medications should not be left at the bedside unless a resident has been assessed for self administration of medications. A copy of the medication administration policy was requested. The copy of Medication Administration Policy was received on [DATE]. Review of the Medication Administration Policy dated [DATE], reviewed and revised [DATE], on page 1 of 2, revealed the following policy statement: Medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . Under Policy Explanation and Compliance Guidance were the following excerpts: 15. Observe resident consumption of medication. and 17. Sign MAR after administered . and 19. Report and document any adverse side effects or refusals. According to Lippincott Nursing Procedures, Eighth Edition, Chapter 2, Standards of Care, Ethical and Legal Issues, on page 17 read, Common Departures from the Standards of Nursing Care. Claims most frequently made against professional nurses include failure to make appropriate assessments, follow physician orders, follow appropriate nursing measures, communicate information about the patient, follow facility policy and procedures, document appropriate information in the medical record . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Guidance from the National Institutes of Health in the article The nurses medication day stated that Nurses serve as a barrier, protecting residents from potential hazards. Calls were also common to request 'missing meds' (medications) followed by waits until they were delivered. Waiting reflected system failures ncbi.nlm.nih.gov accessed [DATE]. During the end of day debriefings on [DATE], the Administrator, Director of Nursing and Regional Nurse Consultant were informed of the findings. No further information was provided. 49917 3. Resident #128 was no longer a resident of the facility; therefore, a closed record review was conducted. Resident #128 was originally admitted to the facility [DATE]. The diagnoses included; unspecified dementia, chronic kidney disease, essential hypertension, anorexia, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of [DATE] coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 01 out of a possible 15. This indicated Resident #128's cognitive abilities for daily decision making were severely impaired. A review of Resident #128's nurses note dated [DATE] at 9:50 AM read that Resident #128 was found on the floor in the dining room. The nurses note further read that a 1.5cm open area to the left forehead was cleansed and the area was covered with a 2x2 adhesive dressing. On [DATE] at 12:45 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that no neuro-checks were conducted for Resident #128 following the unwitnessed fall that occurred on [DATE]. The ADON also stated that it is standard nursing protocol for neuro-checks to be conducted after a resident has an unwitnessed fall and neuro-checks should have been conducted on Resident #128 after the unwitnessed fall on [DATE]. The Facility's Fall Prevention Program document with a revision date of [DATE] read: When any resident experiences a fall, the facility will: i. Begin neurologic assessment using Neurological Record assessment tool in PCC Tool 3N: Postfall Assessment, Clinical Review: Record vital signs and neurologic observations at least hourly for 4 hours and then review. Continue observations at least every 4 hours for 24 hours, then as required. Notify treating medical provider immediately if any change in observations (https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/postfall-assessment.html). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at approximately 6:25 p.m., a final interview was conducted with the Regional [NAME] President of Operations, Administrator, Regional Nursing Consultant, Regional MDS Consultant, Director of Nursing, Assistant Director of Nursing, and Owner. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information. 34306 4. The facility's staff failed to obtain vital signs prior to transferring Resident #48 to a local hospital's emergency room (ER). Resident #48 was originally admitted to the facility [DATE] and readmitted [DATE] after an acute care hospital stay. The current diagnoses included a stroke with right hemiparesis, dysphagia causing pulmonary aspiration, enteral feedings are required. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of [DATE] coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #14's cognitive abilities for daily decision making were intact. A review of a nurse's notes dated [DATE] 9:30 PM stated Resident #48 was admitted to a local hospital for pneumonia. A further review of the nurse's note revealed that on [DATE] at 1:04 PM the resident experienced a change in condition and the following vital signs were charted, the resident's weight was obtained by a Hoyer lift scale on [DATE] at 7:04 PM and it was 172.0 pounds, all of the following vital signs were obtained on [DATE] at 11:59 PM; blood pressure in the left arm while lying down was ,d+[DATE], the pulse was regular at 89 beats per minute, his respirations were 18 breaths per minute, a non-contact temperature of his forehead was 98.6 a pulse oximetry reading of 98.0 % on room air, and a blood glucose reading of 139 obtained on [DATE] at 6:27 AM. The nurse did not document any vital signs were obtained at the time the resident's change in condition was identified and the above vital signs were recorded on the document conveyed to the receiving hospital's emergency room staff. A review was also conducted of the primary Nurse Practitioner's (NP) documentation dated [DATE] 1:45 PM. The NP's note stated Resident #45 was found leukocytosis and poor oral intake. The NP's note included a chronological review of vital signs but, there were not a set of vital signs obtained on [DATE] prior to the resident's transfer to a local hospital. Under the NP's Assessment and Plan was the following data, elevated white blood cell count, unspecified; resident continues to have leukocytosis despite negative chest x-ray, urine, and blood cultures. Kidney, Ureter, and Bladder (KUB) was negative for ileus. Discussed with patient's daughter who requested transfer to ER. Patient being sent to ER per family request for further evaluation and management of persistent leukocytosis. Further down in the NP note, she stated tachycardia unspecified, heart rate noted to be tachycardic on examination. No chest pain or discomfort reported. Discussed with resident's daughter who requested transfer to ER. Patient being sent to ER per family request for further evaluation and management of tachycardia. The tachycardia rate per minute was not documented so increases or decreases could not be evaluated. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the NP on [DATE] at 2:04 PM. The NP stated that she assessed the resident, and she considered Resident #48 ongoing issues were stable with acute issues therefore she simply charted the tachycardia. The NP further stated all the test she had requested came back negative and she was continuing to monitor the resident's poor nutritional intake, the leukocytosis and the failure to thrive. The NP did not obtain vital signs at the time of her assessment of resident or prior to the transfer to the local ER for evaluation. On [DATE] at approximately 2:50 P.M., a final interview was conducted with the Administrator, Director of Nursing, and three Corporate Nurse Consultants. The above information was conveyed to the administrative staff, they all looked at each other but voiced no comments/concerns regarding the above findings. An interview was also conducted with the Medical Director (MD) on [DATE] at 1:55 PM. The MD stated the NP would make an addendum to the progress note dated [DATE] to add in the tachycardia numbers. The MD also stated it is a professional standard which has not changed to obtain real time vital signs at the time of a change in condition and when a transfer to the hospital is necessary.

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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** 31199 Based on Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility staff failed to provide Activity of Daily Living (ADL) care to four (4) dependant Residents (Resident #226, #117, #18, and #48) in a survey sample of 74 Residents. The findings included: 1. For Resident #226, the Resident was dirty and unkempt. 2. For Resident #117, the Resident was dirty, unclothed, and unkempt. 1. Resident #226 was admitted to the facility on [DATE] with diagnoses including: End stage renal disease with hemodialysis, history of stroke, anemia, chronic congestive heart failure, hypertension, and diabetes type 2. The Resident did not have a diagnosis of dementia and was his own responsible party and by facility agreement cognitively intact and able to make his own decisions. The Resident had a room mate, Resident #117. 2. Resident #117 was admitted to the facility on [DATE] with diagnoses including: Dementia without behavioral disturbance, hypertension, major recurrent depression. dysphagia, chronic kidney disease, cardiac disease, history of malignant cancer of nasal cavity, and congestive heart failure. The Resident had a room mate, Resident #226. During an initial interview on 12-10-24, at 11:40 AM, Resident #226 was found to be alert and oriented to person, place, time, and situation. During this interview, Resident #226 verbalized that he is a dialysis patient and that he received dialysis there in the facility. He further stated he hates the memory care unit because everyone is crazy in here, they wander into my room and take things, my room mate yells and cries all night for something to drink, I don't even get food every meal, the room is nasty and falling apart, and I can't even get a shower in here because the showers are so nasty dirty. The Resident was noted to have food debris and crumbs firmly stuck to his shirt and pants. His hair was greasy and stuck to his head, He exhibited dandruff flakes all over this shoulders and back. His bed smelled of urine, and in fact the entire room had a pervasive odor of urine, feces, and body odor. The Resident wore socks which were meant to be white, however had brown stains on them which were dried on. The Resident wore flat surgical walking shoes and not regular closed toe shoes. He stated he had a pair of tennis shoes but they had gotten wet and the staff had thrown them under the sink. The surveyor and Resident then immediately walked to the shower room for an initial observation and found it to be dirty, mildewed/moldy, foul smelling, had a strong odor of urine and feces, trash and debris littered the floor, used brown stained wet linens were on the floor, a white crusted substance was on the floor and walls, used soap and shampoo bottles were crusted on the shelves and hand rails in the shower, and the room was being used as a storage area as well for boxes of supplies and durable medical equipment. The Resident asked would you want to take a shower in here? (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #117 was in bed covered with only a bed sheet with no blanket and wore no clothing nor gown, and only an incontinence brief under the bed sheet. The fitted bed sheet under the Resident had a yellow halo around the Resident which appeared to be dried urine with a strong odor. The Residents incontinence brief was obviously soaked with urine and wrinkled down at the waist with the heaviness of the liquid it contained. The Residents hair was matted to his head, greasy, dandruff lay in his bed and on his pillow, and body odor/sweat could be clearly smelled. During the entire survey Resident #117 was never observed during the day out of bed, and asked the surveyors often for something to drink stating Please, Please bring me some water I'm so thirsty. The Residents lips were noted to be cracked and dry. Resident #226 had no shoes, no coat, 2 pairs of pants, and 2 shirts (the Resident was wearing one of each). When asked about his clothing he stated I had more, but they have been stolen. The same number of clothing articles were found for Resident #117. There was no soap nor paper towels in the Resident rooms for hand washing of staff or Residents. Staff on the memory care unit were interviewed and asked why Resident's #226, and #117 were not clean, they stated well, they refuse a lot, and (name) Resident #226 doesn't want to go into the shower room, and (name) Resident #117 is hospice and doesn't like to be moved much. Staff were taken to the Residents' room and both Residents were asked if they would like a shower or bath, and Resident #226 said yes if I can use a different shower room that is clean. Resident #117 simply shook his head yes. ADL (activities of daily living) care records were reviewed and revealed for Resident #226 during the time of survey no baths were documented as given for 12-11-24, and 12-12-24, and surveyors observed daily, every day, that the Resident was not bathed, and wore the same clothing until 12-19-24 (after the Resident was moved). The Resident was visited in his new room and was very happy. ADL care records were reviewed for Resident #117 and revealed that the Resident was totally dependant on one staff member. The document indicated that a bath was given every morning, however, the Resident was observed every day during survey and found to be dirty and unkempt with flaking skin, dandruff, greasy hair, and in a soiled bed with soiled linens. At times the Resident was found wearing only an incontinence brief, and at other times wearing a white stained T-shirt wearing also an incontinent brief. The Resident was never seen out of bed during daytime hours for the entire survey. On 12-12-24, and 12-13-24, and 12-18-24 during a meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns and that the entire memory care unit was not clean and comfortable. Furthermore they were made aware that Residents were not being bathed and given hygiene timely, nor as often as needed, as this was the observation on days during the survey with both Residents being soiled and unkempt, in a dirty room with dirty linens and clothing. On 12-19-24, prior to the survey exit the Director of Nursing informed surveyors that Resident #226 and his room mate had been moved back onto regular units last night (12-18-24). At the time of survey exit on 12-19-24 the facility Administrator, and Director of Nursing stated they had nothing further to provide. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40711 3. The facility staff failed to ensure the Certified Nursing Assistant (CNA) provided incontinent care/peri care correctly for Resident #18 that was dependent in Activity of Daily Living (ADL) care. Resident #18 was originally admitted to the facility 10/14/24 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Urinary Tract Infection. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/24/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #18 cognitive abilities for daily decision making were moderately impaired. In sectionGG(Functional Abilities Goals) the resident was coded as requiring dependence with eating, oral hygiene, toileting hygiene, shower/bathing and personal hygiene. The care plan dated 12/12/24 read that Resident #18 had an ADL (Activity of Daily Living) self-care performance deficit r/t Activity Intolerance. The Goal for the resident is that they will maintain their current level of function. The interventions are as follows: PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on (1) staff for personal hygiene and oral care, TOILET USE: The resident is totally dependent on (2) staff for toilet use, the resident will maintain current level of function, provide sponge bath when a full bath or shower cannot be tolerated. On 12/18/24 at approximately 4:30 PM., Resident #18 was observed during peri care/incontinent care. The Infection Preventionist (IP) and Certified Nursing Assistant (CNA) #13 were present. CNA #13 was observed filling two basins and placing them on the bedside table. 1 basin had water inside with a bar of soap, and the other basin had just (clear) rinse water in it. Several clean washcloths were available. Peri care was observed without difficulty. CNA #13 placed a washcloth in the soapy water and started wiping the resident, noticed Stool like substance was observed on the washcloth, placed the soiled washed cloth in the rinse water, grabbed a clean washed cloth placed it in the rinse water that now had the soiled wash cloth and proceeded to rinse the resident's vaginal area. Shortly thereafter the peri care was complete, CNA #13 was asked by the surveyor if he had noticed a soiled washcloth in the rinse water. CNA #13 said that he hadn't noticed the soiled washcloth in the rinse water. The IP said that she had noticed it and will provide education and training on peri care. On 12/19/24 at approximately 5:55 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided. 34306 4. The facility's staff failed to provide ongoing and consistent oral care to a dependent resident receiving enteral feedings, Resident #48. Resident #48 was originally admitted to the facility 12/15/2023 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included a stroke with hemiparesis, dysphagia causing pulmonary aspiration, enteral feedings are required. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/17/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #14's cognitive abilities for daily decision making were intact. The resident's care plan dated 10/19/22 stated (name of resident) has an ADL self-care performance deficit related to a CVA with hemiparesis. The goal stated (name of resident) will improve current level of function in ADLs through the review date, 2/17/25. The intervention dated 7/22/22 stated Or al care routine (AM, PC, HS): brush (name of resident) teeth, rinse dentures, CNA clean gums with toothette, rinse mouth with wash. An observation was made of Resident #48 on 12/10/24 at approximately 3:36 PM. The resident was in bed and attempted to answer when spoken to, but his mouth was full of dry mucus and his lips had a dry glaze over them. The resident's response was not verbalized. On 12/11/24 at approximately 11:05 PM an observation was made of Resident #48. Again, he was in bed, Glucerna was infusing at 60 milliliters per hour. Again, the resident attempted to speak but only sounds were audible. The resident's mouth was with a large amount of dried mucus and his lips were glazed over with a dry matter. On 12/19/24 at approximately 6:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, the Owner and three Corporate Nurse Consultants. They voiced no concerns regarding the above findings. Good oral hygiene is important for tube feeders to prevent infections such as tooth decay and gum disease 1. Regular dental cleanings are recommended to protect oral health 2. Routine oral care reduces the potential for aspiration of oral materials. (https://www.[NAME].com/search?q=mayo+clinic+the+importance+of+good+oral+hygiene+for+tube+feeders&qs=n&form=QBRE&sp=-1&lq=0&pq=mayo+clinic+the+importance+of+good+oral+hygiene+for+tube+feeders&sc=0-64&sk=&cvid=ED99509A56CC44C5A78D379EB87EACEA&ghsh=0&ghacc=0&ghp)

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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 - Many	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility staff failed to maintain an activities program to meet the needs and preferences of each resident to include the entire locked memory care unit and for four individual Residents (Resident #226, #117, #77, and #105) in a survey sample of 74 Residents, resulting in a Substandard Quality of care. The findings included: 1. For Resident #226, the entire memory care unit was without a television, or activities from the commencement of survey on 12-10-24 through 12-18-24, and some activity planning did occur on 12-19-24 just prior to exit. 2. For Resident #117, the entire memory care unit was without a television, or activities from the commencement of survey on 12-10-24 through 12-18-24, and some activity planning did occur on 12-19-24 just prior to exit. 1. Resident #226 was admitted to the facility on [DATE] with diagnoses including: End stage renal disease with hemodialysis, history of stroke, anemia, chronic congestive heart failure, hypertension, and diabetes type 2. The Resident did not have a diagnosis of dementia and was his own responsible party and by facility agreement cognitively intact and able to make his own decisions. The Resident had a room mate, Resident #117. 2. Resident #117 was admitted to the facility on [DATE] with diagnoses including: Dementia without behavioral disturbance, hypertension, major recurrent depression. dysphagia, chronic kidney disease, cardiac disease, malignant cancer of nasal cavity, and congestive heart failure. The Resident had a room mate, Resident #226. During an initial interview on 12-10-24, at 11:40 AM, Resident #226 was found to be alert and oriented to person, place, time, and situation. He stated that he had requested to stay in his current room after learning that the facility planned to move him rather than discharge him home. During this interview, Resident #226 verbalized that he is a dialysis patient and that he received dialysis there in the facility. He further stated he hates the memory care unit because everyone is crazy in here, they wander into my room and take things, my room mate yells and cries all night for something to drink, I don't even get food every meal, the room is nasty and falling apart, and I can't even get a shower in here because the showers are so nasty dirty. He went on to say I like to walk around, it makes the time go faster, if I don't walk now I won't be able to leave, but locked in here I have no where to walk, I don't even have a TV to watch and I love TV, being in here will make you crazy with nothing to do. An observation the Resident's room was conducted. The Resident's room was shared with a second Resident (Resident #117). The room tour included but was not limited to the following being observed; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	broken vinyl window blinds, no curtains, a urine soaked bathroom, a pervasive smell of urine and feces in the room and on the entire unit. The free standing broken armoire closets in the rooms were swollen and splitting, with rotten splinters and chunks of disintegrating wood and wood particles all over the Residents few items in the closet, and in the rooms. The sink vinyl laminate countertop area was water damaged and swollen and separated revealing particle board disintegration with the sink partially separated from the wall in a downward unstable dropped position, and wood dust everywhere. Under the sink a cabinet door was ajar as it would not close because of the downward sloping sink, and the inside compartment was an open hole with what appeared to be a black concrete floor. Inside was found mildew, mold, trash, a pair of urine stained white tennis shoes, and 2 shirts that were stuck together with an unknown substance, all thrown in onto the floor. The floor of the room was sticky and made a sucking sound as one walked across it, and the base board was peeling and drooping over in places. The floor was crusted with crumbs, brown debris, and black particles. The bed divider curtain had brown stains and smeared feces on it. The PTAC (air conditioning wall unit) was not secured and had fallen forward into the room approximately 12 inches revealing light around it and cold air coming into the room from the outside of the building. The front cover of the unit was also missing and the sharp metal grill was exposed. The Resident's room mate's bed (#117) was pushed against the PTAC holding it in place so it would not completely fall out of the hole in the outside facing wall. Resident #117 was in bed covered with only a bed sheet with no blanket and wore no clothing nor gown, and only an incontinence brief under the bed sheet. During the entire survey Resident #117 was never observed during the day out of bed, and asked the surveyors often for something to drink stating Please, Please bring me some water I'm so thirsty. The Residents lips were noted to be cracked and dry. The Residents had no television, no clock, no telephone, no radio and the room had no personal items in it nor on the walls. Resident #226 had no shoes, no coat, 2 pairs of pants, and 2 shirts (the Resident was wearing one of each). When asked about his clothing he stated I had more, but they have been stolen. The same number of clothing articles were found for Resident #117. Each room on the unit was then inspected by all surveyors and found to be in the same condition as Resident #226's and #117's room. There were no televisions in any room, and no water to drink in any room. There was no soap nor paper towels in the Resident rooms for hand washing of staff or Residents. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	It is notable to mention that no activities were noted to be conducted during day shift in the secured unit from 12-10-24 until 12-18-24. The staff were asked why no activities were being conducted for the residents and they replied that we only have one activity person for the whole 150 bed facility. Observations continued daily with multiple surveyors taking turns continuously and it was found that from 10:00 AM until 4:00 PM every day from 12-10-24 until 12-18-24 that no activities were noted to be conducted in the secured unit. The staff were asked why no activities were being conducted for the residents and they replied that we only have one activity person for the whole facility, and if we let them have TV's they will just pull them off the wall. When asked which Residents had done this none could attest that they had actually seen this in practice, it had simply been assumed. Facility CNA (Certified nursing Assistant) and LPN (Licensed Practical Nurse) staff on the memory care unit and other units were interviewed, and stated the reason that Resident #226 had been placed on the memory unit was wandering and behaviors When asked what his behaviors were, they were only able to say he went outside and sat in his wheel chair one time after dialysis, and further stated he would wander up and down the halls and that will get you put in here for sure. The surveyor asked why he walked, and there was no response. On 12-18-24, during a meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the concerns that the entire memory care unit was not receiving any activity programming, and that the calendar of events document that had been received as requested from staff, had not been observed happening on the unit as was written on the calendar. On 12-19-24, prior to the survey exit the Director of Nursing informed surveyors that Resident #226 and his room mate had been moved back onto regular units last night (12-18-24). At the time of survey exit on 12-19-24 the facility Administrator, and Director of Nursing stated they had nothing further to provide. 34306 3. The Activity Directors (AD) failed to conduct activity assessments for Resident #77 from 11/15/23 through 9/18/24 and after the assessment was completed the resident's preferences were not incorporated in the person-centered care plan. Resident #77 was originally admitted to the facility 11/3/23 and she was readmitted [DATE] after an acute care hospital stay. The current diagnoses included Epilepsy, ESRD requiring dialysis, depression, and behavior problems with hallucinations and fabricating stories. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/27/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #77's cognitive abilities for daily decision making were moderately impaired. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/19/24 at 2:49 PM an interview was conducted with Resident #77. The resident stated she does not attend activities, and she did not remember a choir coming to her room to sing Christmas carols. The resident stated she would have enjoyed the singing because she loves music. A review of the resident's activity assessments revealed assessments were conducted on 11/14/23 for her initial admission, 9/19/24 after return to the facility from a hospital stay and on 10/30/24 with the annual MDS assessment. This indicated activity assessment were only conducted for this resident upon admission/readmission and annually. The 10/30/24 activity assessment revealed that it was very important to the resident to listen to music she likes, to be around animals such as pets, to keep up with the news and to participate in religious services or practices, yet the information was not incorporated in the person-centered care plan A person-centered care plan was developed for resident #77 initially on 10/21/24 and the problem read, (name of resident) has no group activity involvement related to immobility and physical limitations. She enjoys reading and coloring in her room. The goal read, the resident will participate in 1:1 activities of choice such as talking and receiving new materials 2-3 times per week by review date 2/3/25. The interventions included establish and record the resident's prior level of activity involvement and interest by talking with the resident, caregivers, and family on admission and as necessary. The resident can color large print pictures. The resident's preferred activities are art and movies. The above-mentioned preferred activities were not documented on the 10/30/24 activity assessment. On 12/19/24 at approximately 6:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, the Owner and three Corporate Nurse Consultants. They had no further comments and voiced no concerns regarding the above findings. 4. The Activity Directors (AD) failed to conduct activity assessments for Resident #105 from 12/27/23 through 12/19/24 and the preferences included on the activities assessment dated [DATE] were not incorporated in the person-centered care plan. Resident #105 was originally admitted to the facility 10/27/23 and he was readmitted [DATE] after an acute care hospital stay. The current diagnoses included a major neurocognitive disorder with Lewy Bodies dementia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/17/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 4 out of a possible 15. This indicated Resident #105's cognitive abilities for daily decision making were severely impaired. The person-centered care plan was developed for resident #105 initially on 7/31/24 and the problem read, (name of resident) has little or no activity involvement related to cognitive deficits, chronic health conditions. The goal read, (name of resident) will express satisfaction with type of activities and level of activity involvement when asked through the review date 1/24/25. The interventions included explain to (name of the resident) the importance of social interaction, leisure activity time. Remind (name of the resident) that he may leave activities at any time and is not required to stay for entire activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The person-centered care plan also included activity interventions for behaviors; 11/1/23 Distract (name of the resident) from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. 7/31/24 Provide a program of activities that is of interest and accommodates the resident's status. On 12/13/24 at 12:55 PM an interview was conducted with Licensed Practical Nurse (LPN) #8. LPN #8 stated Resident #105 does not communicate in English and prior to his decline could not focused, remain seated or concentrate long enough to participate in group activities. On 12/19/24 at approximately 6:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, the Owner and three Corporate Nurse Consultants. They had no further comments and voiced no concerns regarding the above findings.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 34306 Based on staff interviews, clinical record reviews, and review of facility documents, the facility staff failed to ensure the activities program was directed by a qualified professional who could direct the provision of activities to the residents which resulted in Substandard Quality of Care. The findings included: During a recertification survey conducted 12/10/24 through 12/13/24 and 12/16/24 through 12/19/24 residents were identified who could benefit from meaningful and individualized activity programs. A further review of the activities program revealed that the current Director of Activities (AD) had been employed at the facility since July 23, 2024, and her previous experience in a similar role was with an assisted living community, (assisted living facilities are not classified as health care settings). An interview was conducted with the current AD on 12/12/24 at approximately 4:50 PM. The AD stated she had a special love for enrichment through various activities and it was her desire to become an Activities Director Certified not an Activities Professional. The facility's AD stated she was not completing the activity section of the comprehensive Minimum Data Set Assessment, but she was developing the care plan goals. The facility's AD further stated she obtained a degree in gerontology and had worked greater than 700 hours in an activities program, therefore she had contacted a representative with the National Certification Council for Activity Professionals (NCCAP) about the Professional Equivalency Track for certification as an ADC. A review of the correspondence between the AD and the representative revealed the representative requested that the facility's AD proceed to upload specific documents for review. The facility's AD stated NCCAP requirements were for her to complete and pass two test which cost $60.00 each, then she would be allowed to pay $80.00 to take the test for certification as an Activities Director. On 12/13/24 at approximately 1:10 PM the Regional [NAME] President requested additional information and provided the surveyors with a copy of the state and federal regulations regarding the qualifications of an AD. She asked if she was reading the regulation correctly because the current AD had years of experience. On 12/13/24 at approximately 12:45 PM, the Human Resource Director (HRD) stated the activity department had three employees, the Director and two assistants and neither was certified as an AD or AP. The HRD provided a summation of the facility's AD from 8/15/2023 to current. The findings revealed all the ADs between 8/15/2023 and 12/19/2024 were unqualified based upon the facility's job description below: (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Activities Director job requirements dated December 2018 stated the Activities Director must meet at least one (1) of the following criteria: Degree and certification as a therapeutic recreation specialist; or Certified Activity Director by the National Certification Council for Activity Professionals; or two (2) years' experience in a social or recreational program within the past five (5) years, in which one (1) year was full time in a resident activities program in a health care setting; or prior completion of a state approved training course. The Activities Director job requirements also stated that the individual must have one (1) to two (2) years management/supervisory experience, effective verbal and written English communication skills, excellent creative and communication skills and skill at working with individuals who have cognitive, physical or sensory disabilities. The Activities Director job requirements further stated that the individual must have practical knowledge of how an Activity Department functions in a nursing facility. General knowledge of regulatory requirements for an activity program in a long-term care facility, outstanding interpersonal skills with a high level of energy and enthusiasm, experience in working with volunteers and the ability to organize and develop a volunteer program. On 12/19/24 at approximately 6:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, the Owner and three Corporate Nurse Consultants. They had no further comments and voiced no concerns regarding the above findings.

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F 0686 Level of Harm - 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** 31199 Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed to prevent, assess, identify timely, and treat avoidable pressure ulcers resulting in harm for two Residents, (Resident #117, and Resident #379) in a survey sample of 74 Residents. The findings included: 1. For Resident #117, the facility staff did not assess, nor identify an avoidable sacral pressure ulcer prior to it becoming a stage 3 full thickness ulcer with 80 % slough (dead stringy yellow tissue) in the wound bed, first identified during survey on [DATE]. The Resident was also suffering from significant weight loss, malnutrition, and meals were not provided, which would impact his skin and ability to heal. The Resident did not receive timely ADL care, did not receive preventative skin care and pressure reduction devices, and was not gotten out of bed during the entire 2 week survey. Resident #117 was originally admitted to the facility on [DATE], and was hospitalized 10 days later on [DATE] for a colonic hemorrhage caused by a Stercoral ulcer (impacted hard stool at the anus and distal rectum) which pierced the bowel wall, after having had no bowel movements. The ulcer/perforation of the bowel wall resulted in blood loss requiring 2 blood transfusions according to hospital records. The Resident was again sent out to the hospital on [DATE] through [DATE] for a severe urinary tract infection causing sepsis and septic shock, and acute kidney injury which was reversed successfully in the hospital with IV (intravenous) fluids for dehydration and IV antibiotics. Resident #117 had a medical diagnosis history including; Congestive heart failure with diuretic use, unspecified dementia without behaviors, hypertension, depression, anxiety, dysphagia, gastro-esophageal reflux disease, and cardiac disease. Resident #117's most recent Minimum Data Set (MDS) assessment was a Significant change assessment with an assessment reference date of [DATE]. Resident #117 had a Brief Interview of Mental Status score of 99 indicating severe cognitive impairment. He was dependant on staff for eating, bathing and personal hygiene. He was coded to have no skin impairment, and at risk for skin impairment. He was coded with no weight loss (which was incorrect), a weight of 123 pounds, no swallowing difficulty, and having a mechanically altered diet. The only previous MDS assessment to the [DATE] MDS was dated [DATE], and was the Resident's admission assessment. This MDS had not been signed as completed until [DATE], and submitted late. The document revealed the Resident's weight at that time to be 139 pounds. This indicated a greater than 10% weight loss in the previous 2 months. It is notable to mention that the Resident was admitted with a weight of 145.3 pounds on [DATE]. This revealed a significant weight loss of 22.3 pounds since admission, equaling a greater weight loss than 15% in the 3 month period from admission to the current survey which was well documented in the clinical record. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Before hospitalization and after hospitalization the Resident's diet remained the same. Regular diet, Dysphagia pureed texture, thin consistency. On [DATE] mighty shakes 4 ounces was ordered at bedtime for a supplement. No other diet changes nor supplements were ever ordered during the Resident's stay. The Resident was observed during initial tour of the facility on [DATE] immediately following a shower room observation with Resident #117's room mate. The room tour revealed a dirty and unsafe room environment which included but was not limited to the following being observed; broken vinyl window blinds, no curtains, a urine soaked bathroom, a pervasive smell of urine and feces in the room and on the entire unit. Under the sink a cabinet door was ajar as it would not close because of the downward sloping sink, and the inside compartment was an open hole with what appeared to be a black concrete floor. Inside was found mildew, mold, trash, a pair of urine stained white tennis shoes, and 2 shirts that were stuck together with an unknown substance, all thrown in onto the floor. The floor of the room was sticky and made a sucking sound as one walked across it, and the base board was peeling and drooping over in places. The floor was crusted with crumbs, brown debris, and black particles. The bed divider curtain had brown stains and smeared feces on it. The PTAC (air conditioning wall unit) was not secured and had fallen forward into the room approximately 12 inches revealing light around it and cold air coming into the room from the outside of the building. The front cover of the unit was also missing and the sharp metal grill was exposed. Resident #117's bed was pushed against the PTAC unit holding it in place so it would not completely fall out of the hole in the outside facing wall. Resident #117 was in bed covered with only a bed sheet with no blanket and wore no clothing nor gown, and only an incontinence brief under the bed sheet. The fitted bed sheet under the Resident had a yellow halo around the Resident which appeared to be dried urine with a strong odor. The Residents incontinence brief was obviously soaked with urine and wrinkled down at the waist with the heaviness of the liquid it contained. The Residents hair was matted to his head, greasy, dandruff lay in his bed and on his pillow, and body odor/sweat could be clearly smelled. During the entire survey Resident #117 was never observed during the day shift out of bed, and asked the surveyors often for something to drink stating Please, Please bring me some water I'm so thirsty. The Residents lips were noted to be cracked and dry, and his eyes were sunken. His skin was flaking and dry and when the skin on his hand was examined it tented when pulled gently in an upward fashion and stayed that way. His mucus membranes were sticky and when he spoke his lips would stick together with thick saliva briefly. He constantly complained my butt hurts, my butt hurts. Staff were made aware that the Resident was thirsty, and complaining of butt pain. Staff stated they would have the NP look at him. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] the Resident was assessed by the Registered Nurse Practitioner (NP) and found to have a stage 3 sacral pressure sore. Each day of survey the Resident was visited and observed to be in bed lying on his back or right side facing the window. No pressure reduction support devices and repositioning was ever observed. Each room on the unit was then inspected by all surveyors and found to be in the same condition as Resident #117's room. There were no televisions in any room, no personal items, and no water to drink in any room. There was no soap nor paper towels in the Resident rooms for hand washing of staff or Residents. Staff on the memory care unit were interviewed and asked why Resident #117 was not clean, they stated well, he refuses a lot, and (name) Resident #117 is hospice now and doesn't like to be moved much. Staff were taken to the Residents' room and #117 was asked if he would like a shower or bath, and he simply shook his head yes. ADL (activities of daily living) care records were reviewed for Resident #117 and revealed that the Resident was totally dependant on one staff member. The document indicated that a bath was given every morning, however, the Resident was observed every day during survey and found to be dirty and unkempt with flaking skin, dandruff, greasy hair, and in a soiled bed with soiled linens. At times the Resident was found wearing only an incontinence brief, and at other times wearing a white stained T-shirt and also an incontinence brief. The Resident was never seen out of bed during daytime hours for the entire survey. On [DATE] A Certified Nursing Assistant (CNA) was found in the hallway after Resident #117 was found begging for water. The CNA brought in 120 milliliters of tea for the Resident, and was again told he asked for water. She stated oh he just wants to drink, not eat. The CNA was asked if she was aware that the caffeine in tea was a diuretic and could further dehydrate the Resident. She did not respond. On [DATE] the Kitchen manager was interviewed and stated that they did not keep track of percentages of meals and fluids consumed, and stated that the nursing staff were responsible for that. She was asked if she had decaffeinated tea on hand, and she stated she had decaf coffee but not tea. On [DATE] A CNA was interviewed and stated, he (Resident #117) went out to the hospital with altered mental status, low blood pressure, dehydration and a UTI (urinary tract infection), and when he came back he went on hospice. He's been in bed now since then. The Resident had actually returned on [DATE], and was not placed on hospice until [DATE] (one month later). The CNA was asked for his hospice notes, and she went to the LPN (Licensed Practical Nurse) unit manager with the surveyor accompanying her and asked for the notes. The LPN stated I will look for them, and later stated I don't have any. The entire clinical record was reviewed and no hospice notes were in the clinical record. Staff were then asked if hard copy notes could be located in a binder, and they stated they had no such binder. There was an observed notice taped to the Resident's closet door from the new social worker addressed to the hospice staff. The document instructed that the Resident's hospice supplies had been found in the general supply closet in the facility with normal inventory. The document instructed hospice staff to inform the nurses on the unit when hospice supplies were brought in for the Resident. It appeared that the facility staff and hospice staff were not communicating. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] from 11:30 AM until 1:00 PM a second surveyor was observing lunch service on the memory care secured unit until the meal was finished. Resident #117 was never fed, and his tray was removed from his room. The tray was placed back on the tray cart to return to the kitchen for disposal, untouched. The CNA was asked why he was not fed, and she replied oh he's hospice he don't want it. The Resident received no food, and no fluids from 9:00 AM breakfast to 5:00 PM dinner (8 hours). No water was in any Resident room on the secured unit during the entire survey. Resident #117's clinical record was reviewed. Weight documents all completed by chair scale revealed the following; [DATE] - 145.3 pounds on admission. [DATE] - 143.0 pounds out to hospital on [DATE] with bleeding, returned [DATE]. [DATE] - 139.0 pounds [DATE] - 139.0 pounds [DATE] - 123.0 pounds [DATE] - 122.6 pounds No further weights were being recorded as staff stated well, he's hospice now, so no need really. The Resident was not placed on hospice until [DATE], (2 weeks later with no weights completed) and remained a Full Code CPR status. The Registered Dietician (RD) was called via cellular phone for interview and was unable to be contacted. A message was left on voicemail, however, surveyors received no call back. No RD notes were found in the clinical record, however, on [DATE] at 12:11 PM, the Administrator and Director of Nursing (DON) supplied one note they had received from the RD dated [DATE]. The RD note was reviewed and revealed continued weight loss and the following 4 recommendations, none of which were followed: 1. Consider benefit of appetite stimulant medication due to poor oral intake. 2. when poor oral intake less than 50% offer alternate meal options. 3. weekly weights for one month due to readmit. 4. RD to monitor for significant changes in weight poor oral intake or skin integrity and follow up as needed. Weekly Skin Review assessments were reviewed and were only completed on (5) weekly occasions during the Resident's 3.25 month stay equaling (13) weekly opportunities, and (8) missed weekly opportunities. The weekly skin checks were only completed on [DATE], [DATE], [DATE], [DATE], and [DATE]. No wounds were identified in any of the documents. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	All Nursing and physician progress notes, and a care plan meeting note from [DATE] were reviewed and revealed no identification of a wound on the Resident until [DATE], when the Registered Nurse Practitioner (NP) assessed the Resident. On [DATE] the NP documented on a Wound Assessment Report location sacrum, 14 centimeter (cm) length x width total measurement of the wound, 0.1 cm deep date acquired [DATE] in house, wound status new, stage/severity Full Thickness, 20% granulation, 80% slough, Erythema peri wound (red and inflamed), exposed tissue Epithelium, Dermis. Treatment daily and as needed cleanse with wound cleanser, hydrogel primary treatment, dressing bordered gauze. The report documented as an etiology skin failure at end of life. While this is a chronologically correct description, it is not a diagnosis of the causation of the skin failure, which was a pressure ulcer/skin failure. The Resident was experiencing no other skin failure/breakdown anywhere else on his body. This included his face and nose having undergone treatment for cancer, and no tissue there was failing nor open. The only skin failure for this Resident with a known high risk for skin breakdown, who suffered from incontinence of bowel and bladder was the pressure ulcer wound over a bony prominence. The Resident wore incontinence briefs and was found to be lacking adequate ADL care timely. Resident #117 was also not fed meals culminating in significant weight loss, nor given fluids adequately, culminating in dehydration and urinary tract infection with sepsis and hospitalization . He was afforded no preventive measures in place to relieve pressure while being bed ridden for 2 months per staff interview since his return from the hospital on [DATE]. Staff were interviewed on [DATE] and asked what interventions could be offered to a Resident to prevent pressure sores. The Director of Nursing (DON) provided a policy on Pressure Injury Prevention and Management that documented basic or routine care interventions which could include but were not limited to the following 4 items for prevention in one who was at risk for developing pressure sores. No other items were named specifically in the policy for prevention of pressure sores, and none of the 4 on the policy were followed; 1. Redistribute pressure (such as repositioning/protecting offloading) 2. Minimize exposure to moisture, and keep skin clean, especially of fecal contamination. 3. Provide appropriate pressure redistributing, support surfaces. 4. Maintain or improve nutrition and hydration status, where feasible. The DON was asked if Foley catheters were available to those who were bed ridden with incontinence to prevent pressure sores, and she stated yes. She was asked if supplements, fluids, diet changes, and moisture barrier creams, and positioning devices were available, and she stated yes. She was asked if she was aware that the mattress for Resident #117 was the same as the ones used for the ambulatory residents on the memory care unit, and she stated she was not aware of that. None of the above prevention strategies were afforded Resident #117 for prevention of the pressure sore indicating this ulcer was potentially avoidable. On [DATE] a redistribution air mattress was ordered for the Resident, however did not arrive until after his move to another unit on [DATE] (7 days after identification of the stage 3 pressure sore. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The professional nationally recognized experts in pressure ulcer staging, identification, and care are NUPAP. The National Pressure Injury Advisory Panel. In their reference guidance literature, it documents that this wound to be a stage 3 full thickness tissue loss at identification. On [DATE] a Weekly Non-pressure Wound Observation Tool document was completed by the LPN during wound rounds with the NP for the Resident and documented that the wound was first observed on [DATE], (even though there is no information nor documentation to support this) and the LPN documented that on [DATE] no inflammation was noted (in error) even though the NP documented there was Erythema (red and inflamed) by definition. The Wound Observation Tool note completed by the LPN went on to document that the Interdisciplinary Care Planning Team (IDT) and Responsible Party (RP) were notified at that time (on [DATE]). The IDT that was mentioned in the document was also documented in nursing progress notes and described the team as consisting only of the unit manager LPN and the new social worker which does not constitute an interdisciplinary team. The new Social worker was also found during survey not to be qualified for the position. The Wound Observation Tool document describes that the LPN writing the note was with the NP during the observation. The Care plan was reviewed and included focuses, goals and interventions for potential for pressure ulcer development created on [DATE] related to Dementia and bowel and bladder incontinence. A new care plan entry was created on [DATE] which identified the first actual impairment to skin integrity with interventions for the 3 following items; 1. Follow facility protocols for treatment of injury. 2. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands to avoid striking any sharp or hard surface. 3. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, and any other notable changes or observations. The care plan was not Resident specific and did not specify treatments, moisture barrier creams, nor devices, supplements, diet changes, nor any measures/interventions to be instituted to prevent new pressure sores, and to prevent this new pressure sore from worsening, as an interdisciplinary care plan team would be expected to produce. On [DATE] Review and copy of Physician's orders was conducted, and on [DATE] The Medication Administration Record (MAR) was copied, which is an exact copy of the physician orders. The MAR is used to document nursing signatures to show the orders are recorded as completed. Both revealed the 2 current orders for wounds; 1. Cleanse sacrum with wound cleanser, apply hydrogel and cover with dry dressing every day start date [DATE]. 2. Cleanse right buttock (MASD) moisture associated skin damage with wound cleanser and apply triad paste every day and evening shift start date [DATE], which was not identified in the NP assessment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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F 0686 Level of Harm - Actual harm Residents Affected - Few	It is unknown why the [DATE] orders were derived as skin assessment documents clearly denote no wounds for this Resident until [DATE], and the right buttock was never mentioned in any assessments, even by the NP on [DATE]. No documentation of wounds existed prior to [DATE], and the Resident's skin was documented as intact with no wounds up to [DATE]. No formal assessment was never completed and documented of wounds until [DATE]. This information indicates that there may have been further wounds that existed and were not documented prior to the identification of the full thickness sacral wound found on [DATE]. Only one supplement was ordered for the Resident, and it follows below; 1. Mighty shake 4 ounces at bedtime ordered [DATE]. The Might Shake was not given on the following nights, with no reason documented as to why it was withheld; October - [DATE], [DATE]. November - [DATE], [DATE], [DATE], [DATE]. December - [DATE], [DATE], [DATE]. Resident #117 experienced a potentially avoidable pressure ulcer injury which was not assessed nor identified until it became a full thickness wound with dead yellow slough tissue obscuring the base of the wound by 80%. The Resident was at risk for skin breakdown after being continuously bed ridden for months, was experiencing continued significant weight loss, and was hospitalized for fecal impaction with hemorrhage, and hospitalized for a urinary tract infection, dehydration, and severe sepsis while in the facility. No interventions were in place for a moisture barrier cream after incontinence, which was recommended in the NP note yet never ordered. The NP also recommended an air mattress which was ordered on [DATE], however, did not arrive until the Resident was moved a week after the identification of a stage 3 pressure sore. The pressure sore injury should have been identified during ADL care of the Resident, and no preventive interventions were ever care planned for this Resident until he exhibited a stage 3 pressure sore. On [DATE] at 11:15 a.m., the Administrator, Director of Nursing, and Corporate Nurse were notified that the survey team was considering a harm level deficiency. The facility staff was given the opportunity to provide any further information or explanation. They stated they had no further information to provide. On [DATE], and [DATE] during a meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns which could constitute harm for this Resident. Furthermore they were made aware that Residents were not being bathed and given hygiene timely, nor as often as needed, as this was the observation on days during the survey with multiple Residents being soiled and unkempt, in a dirty room with dirty linens and clothing. They were made aware that Resident #117 was not afforded preventive measures that were available such as; moisture barrier creams, Foley catheters, oral fluid increases, air mattress, protein and vitamin supplements, and alternate meal offerings. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE], prior to the survey exit the Director of Nursing informed surveyors that Resident #117 and his room mate had been moved back onto regular units last night ([DATE]). At the time of survey exit on [DATE] the facility Administrator, and Director of Nursing stated they had nothing further to provide. 40026 2. For Resident #379 the facility staff failed to ensure Resident had weekly skin assessments and interventions in place to prevent the development of pressure injury, resulting in the development of four (4) pressure ulcers. On [DATE] a review of the clinical record revealed that Resident #379 was admitted to the facility on [DATE] with diagnoses that included but was not limited to sepsis, metabolic encephalopathy, protein-calorie malnutrition, acute kidney failure, atherosclerotic heart disease, hypothyroidism, Alzheimer's disease, dementia, anxiety disorder hypertension, dysphagia, g-tube dependence, instability of gait and mobility and insomnia. Upon admission the Admission Screening form was completed. The admission screening form dated [DATE] section C states that the skin turgor is normal, skin temp is warm and there are no wounds or open areas documented on the form. A review of the clinical record revealed that the care plan for Resident #379 read as follows: FOCUS: [Resident name redacted] has DTI [Deep Tissue Injury] pressure ulcer to left hell [sic], left lateral ankle, right later ankle pressure or potential for pressure ulcer and potential for skin breakdown development r/t Dehydration, disease process, incontinence, Hx of ulcers, Immobility. Date Initiated: [DATE] Created on: [DATE]. GOAL: Pressure ulcer will show signs of healing and remain free from infection by/through review date. Date Initiated: [DATE] Target Date: [DATE]. INTERVENTIONS: Administer medications as ordered. Observe/document for side effects and effectiveness. Date Initiated: [DATE] Created on: [DATE]. Administer treatments as ordered and observe for effectiveness. [duplicate] Date Initiated: [DATE] Created on: [DATE] Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: [DATE] Created on: [DATE] If the resident refuses treatment, confer with the resident, IDT and family to determine why and try alternative methods to gain compliance. Document alternative methods. Date Initiated: [DATE] Created on: [DATE] (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Inform the resident/family/caregivers of any new area of skin breakdown Date Initiated: [DATE] Created on: [DATE]. On [DATE] a review of Policy entitled Pressure Injury Prevention and Management revealed the following excerpt: 3. Assessment of Pressure Injury Risk a. Licensed nurses will conduct a pressure injury risk assessment using the Braden Scale, on admission/readmission, weekly x four weeks, then quarterly or whenever the residents condition changes significantly. c. Licensed nurses will conduct a full body skin assessment weekly and after any newly identified pressure injury Findings will be documented in the medical record. 4. Interventions for Prevention and to Promote Healing c. Evidence based interventions for prevention will be implemented for all resident who are assessed at risk or who have a pressure injury present. Basic or routine care could include but are not limited to: i. Redistribute pressure (such as repositioning, protecting and or offloading heels, etc.) ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination. iii. Provide appropriate pressure-redistributing support surfaces iv Maintain or improve nutrition and hydration status where feasible. A review of the clinical record revealed the following: [DATE] - Weekly Skin assessment not filled out entire document left blank. [DATE] - Weekly skin assessment all questions left unanswered, and one comment was placed in the wound section Right heel - sdti [suspected deep tissue injury] right lateral ankle - sdti left heel - sdti left lateral ankle - sdti [DATE] - Weekly Skin Assessment all questions left unanswered and one comment in the wound section read: Left big toenail bleeding during morning hygiene. Weekly Wound Assessments: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	[DATE] - Wound #1 Location - Left heel SDTI (Suspected Deep Tissue Injury) 3a. SDTI 5a. Overall Impression -First observed 8a. Wound Measurements Length 7 cm Width 5.5 cm Depth 0.1 cm [DATE] Wound #2 1.Location - Left Lateral Ankle 3a. SDTI 5a. Overall Impression - First observed 8a. Length 2.0 cm Width 2.0 cm Depth 0.1 cm [DATE] - Wound #3 Right Lateral Ankle 3a. SDTI 5a. Overall Impression - First observed 8a. Length 3.0 cm Width 2.5 cm Depth 0.1 cm [DATE] - Wound #4 Right Lateral Foot (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3a. SDTI 5a. Overall Impression - First observed 8a. Length 3.5 cm Width 1.5 cm Depth 0.1 cm On [DATE] at approximately 1:00 p.m. an interview was conducted with the DON who was asked when interventions should be put in place for prevention of pressure ulcers, she stated that they should be done on admission. When asked if this was done in Resident #379's case she stated that it was not. When asked when the care plan should be updated after the development of a new pressure area, and she stated that the care plan should be updated immediately following a change in the condition of the Resident to include development of pressure areas treatment and any new interventions. When asked if that was done in this case, she stated it was not updated when the pressure areas were discovered on [DATE], and the care plan was not updated until a week later. When asked if the Resident received repositioning devices, booties, an air mattress or any specific turning and repositioning schedule to prevent or aid in healing of the pressure wounds, she stated, There is no evidence of these interventions in the chart. On [DATE] the during the end of day debreifing meeting, the Administrator was made aware of the findings and no further information was provided.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free from accidents, hazards receive adequate supervision and assistance devices to prevent accidents, resulting in harm for two (2) Residents (#78 & 56) in a survey sample of 74 Residents. 1. For Resident #78 the facility staff failed to implement fall precautions for a Resident known to be a high fall risk resulting in Resident #78 sustaining a fractured hip after a fall from her wheelchair, this is harm. On 12/11/24 a review of the clinical record revealed that Resident #78 was admitted to the facility on [DATE] with diagnoses that included but were not limited to cognitive communication deficit, dysphagia, muscle weakness, dementia, severe without behavioral disturbance, psychotic mood disturbance and anxiety, abnormalities of gait and mobility, hypertension, hx (history) of renal cancer, and hx of repeated falls. Resident #78 had a BIMS (Brief Interview of Mental Status) score of 13/15 on admission indicating mild cognitive impairment. On 2/13/24 (one month prior to falls) Resident #78 BIMS was assessed at 5/15 indicating severe cognitive impairment. A review of the clinical record revealed that Resident #78 had 6 falls from 3/23/24 through 11/24/24 (3/23/24, 3/30/24, 7/1/24, 8/2/24, 11/23/24 and 11/24/24). Each of those aforementioned falls had a Post Fall Review Sheet attached in the clinical record with the exception of the 3/23/24 fall. The progress notes for the fall on 3/23/24 read: 3/23/2024 4:53 p.m. - Note Text: Entered resident room at 4:12 pm noted resident laying on right-side head-on flood large amount of blood on floor surrounding head area. when spoke to resident she responded by saying help me, did not move resident due to large amount of blood, 911 called at 4:13pm and reported incident EMT response team arrived at 4:20pm, Place call to MD on call message left to return. received return call and they were made aware of the injury and okay to send to ER. Resident was assess [sic] by EMT and they transported resident to [Hospital name redacted] with Head Laceration. Call place to family member and spoke with family member. Call place to [Hospital name redacted] report given RN [Nurse name redacted]. Bed hole [sic] sent with paperwork. The clinical record revealed that Resident #78 returned to the facility on [DATE] the progress note read as follows: 3/25/24 4:16 p.m. - Note Text: At 2:58pm resident arrived from [Hospital name redacted] via stretcher. family member in room with resident. Resident back with diagnosis of hip fracture 1. Left valgus impacted femoral neck fracture. Alert and verbally responsive, skin warm and dry [sic], respiration even no distress noted. No complain [sic] or facial expression of pain or discomfort. Old dry wound to forehead no drainage or s/s of infection observed. Peripheral IV assess to right arm antecubital. Meds verified by NP. [Nurse Practitioner name redacted]. V/S 96.9, 99%,18,96/56,77. Fall precautions in place, bed in the lowest position, call light within reach. Will continue to monitor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #78's complete care plan revealed that on admission the Resident was identified as being a high fall risk as evidenced by the following entry on admission, dated 4/30/23: FOCUS: [Resident #78 name redacted] is High, risk for falls r/t Confusion, Gait/balance problems, Incontinence, Unaware of safety needs Date Initiated: 04/30/2023 Created on: 04/30/2023 GOAL: [Resident #78 name redacted] will be free of falls through the review date. Date Initiated: 03/05/2024 Revision on: 04/18/2024 Target Date: 10/09/2024 INTERVENTION: Anticipate and meet her needs. Date Initiated: 04/30/2023 Created on: 04/30/2023 Be sure call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 04/30/2023 Created on: 04/30/2023 Follow facility fall protocol. Date Initiated: 04/30/2023 Created on: 04/30/2023 Pt evaluate and treat as ordered or PRN. Date Initiated: 04/30/2023 Created on: 04/30/2023. The care plan update was not updated reviewed and revised after the fall with major injury on 3/23/24. The following revision to the care plan was made after the fall on 8/5/24. FOCUS: [Resident #78 name redacted] has had an actual fall with no injury, R/T Poor communication/comprehension Date Initiated: 08/05/2024 Created on: 08/05/2024 GOAL: [Resident #78 name redacted] will resume usual activities without further incident through the review date. Date Initiated: 08/05/2024 Revision on: 08/05/2024 INTERVENTIONS: Continue interventions on the at-risk plan. Low bed, Rt & Lt fall mats, repositioning every shift Date Initiated: 08/05/2024 Created on: 08/05/2024 Observe and report PRN to MD for s/sx: Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. Date Initiated: 08/05/2024 Created on: 08/05/2024 Neuro checks per protocol. Date Initiated: 08/05/2024 Created on: 08/05/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/18/24 an interview with LPN 1 (Unit Manager), who was asked what the expectation is for nursing staff after a fall occurs and she stated that Nurses are expected to assess the Resident for injuries, notify physician and family, follow any new orders from physician pertaining to the incident, and document the fall as well as the post fall follow up, and the care plan should be updated to add new interventions after a fall. When asked if this was done after each fall, she stated that it was not. On 12/18/24 a review of the facility FALL POLICY revealed the following excerpts: 9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a Post fall review and a Post fall follow up note in PCC [the electronic health record] c. Complete an incident report in PCC d. Notify physician and family. e. Review the resident's care plan and update as indicated f. Document all assessments and actions g. Obtain witness statements in the case of injury h. If there are signs of serious injury or there are concerns about the circumstances of the fall notify the Director of Nursing and or the Administrator. i. Begin neurologic assessment using Neurological Record assessment tool in PCC On 12/18/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 40711 2. The facility's staff failed to provide supervision and implement interventions to reduce environmental hazards for a resident who was burned after heating up her coffee in a microwave located in a communal dining room on Unit 2, resulting in harm. Resident #56 was originally admitted to the facility 08/22/19 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Unsteadiness on feet and Impulsiveness, Burn of first degree of left forearm, initial encounter. Burn of unspecified degree of single right finger (nail) except thumb, initial encounter. Unspecified dementia without behavioral disturbance. Unsteadiness on feet. Impulsiveness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/01/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #56 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities and Goals) the resident was coded as independent with eating, oral care, toileting hygiene, personal hygiene, bathing/showering self. Sub section: GG0120 coded resident as using a walker as a Mobility Device. The care plan focus dated 10/14/24 read that Resident #56 has actual impairment to skin integrity of the left third finger and right forearm burn r/t impaired safety awareness. The Goal was that resident will have no complications r/t burn of the right forearm and left third finger through the review date. The interventions: Encourage good nutrition and hydration in order to promote healthier skin, follow facility protocols for treatment of injury, identify/document potential causative factors and eliminate/resolve where possible and Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. During the initial rounds on 12/11/24 at approximately 10:27 AM., an interview was conducted with another resident, Resident #5 concerning warming her foods. Resident #5 mentioned We had a communal microwave in the break room. They took it away after a lady burned herself. Resident #5 also said that she didn't know the resident but after she was burned the microwave was removed and they could no longer warm their foods. A review of the Synopsis of the event: Date of incident: 6/03/24. Time: 6:00 PM. Location: Dining Area., Type of Injury: Burn to include redness, swelling and pain. Assessment: Redness, blistering, and swelling noted to left forearm, and right middle finger. Description of event: Resident was heating up coffee in a microwave in the unit 2 dining area. When attempting to pick coffee up, resident spilled hot coffee on her hand. According to the investigative document, Resident #56 was interviewed by staff at 10:00 AM., by then Unit 2 manager, now currently, the Infection Preventionist (IP) OSM #5. The resident stated the above mentioned had occurred. According to the staff interview, the resident was heard yelling out from the dining room. The June Treatment Administration Record (TAR). Right 3rd finger treatment. Clean area with durable wound cleanser (dwc), apply xeroform and cover with band aide everyday shift for wound care -Start Date- 06/06/2024. Discontinued Date-06/07/2024. Right Hand 3rd Digit. Cleanse with wound cleanser, apply bacitracin and cover with dry bandage every day shift for wound care -Start Date- 06/08/2024 0700 -Discontinued Date- 06/19/2024. Left Forearm. Apply Skin Prep and LOA every day and evening shift for Blister -Start Date- 06/07/2024 1500 -Discontinued Date- 06/12/2024. A review of the June 2024 TAR revealed daily wound care of the Right-Hand 3rd Digit. Cleanse with wound cleanser, apply bacitracin and cover with dry bandage every day shift for wound care -Start Date= 06/08/2024 0700. Discontinue Date =06/19/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Apply Skin Prep and LOA to Left Forearm every day and evening shift for Blister. Start Date= 06/07/2024 3:00 PM. discharge date =06/12/2024. A review of the Nurse Practitioner's Skin and Wound note on 06/05/2024 at 12:46 PM., read: Patient being evaluated for new left dorsal forearm burn and right middle finger burn secondary to coffee spill by the patient. Right middle finger with pink epithelial tissue and left dorsal forearm with intact blister. Recommend skin prep to forearm and bacitracin to right middle finger. WOUND ASSESSMENTS: Date wounds were acquired: 6/03/24 6/05/24- Wound #1 Location: right middle finger, Primary Etiology: Burn, Stage/Severity: Partial Thickness, Wound Status: New, Odor Post Cleansing: None, Size: 2.2 cm x 0.9 cm x 0.1 cm. Calculated area is 1.98 sq cm. Wound Base: 100% epithelial, Wound Edges: Attached, Peri wound: Intact, Exposed Tissues: Epithelium, Exudate: Scant amount of Serosanguineous, Wound Pain at Rest: 6. Wound: 2=6/04/24 Location: left forearm, Primary Etiology: Burn, Stage/Severity: Partial Thickness, Wound Status: New, Odor Post Cleansing: None, Size: 1.2 cm x 1.1 cm x 0.1 cm. Calculated area is 1.32 sq cm., Wound Base: 100% epithelial, Wound Edges: Attached, Peri wound: Intact, Exposed Tissues: Epithelium, Exudate: None amount of None, Wound Pain at Rest: 5. PLAN: Wound #1 right middle finger Burn Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Bacitracin ointment to base of the wound. 3. secure with Bordered gauze. 4. change BID, and PRN. PLAN: Wound #2 left forearm Burn. Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Skin Prep to base of the wound. 3. secure with Leave open to air. 4. change BID. PLAN: Wound #1=6/12/24 Location: right middle finger Burn, Partial Thickness, Improving without complications. Size: 1.0 cm x 0.20 cm x 0.10. 100% epithelial, wound edges attached, peri wound intact, scant exudate, serosanguinous, no odor. Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Bacitracin ointment to base of the wound. 3. secure with Bordered gauze. 4. change Daily and PRN. PLAN: Wound #2=6/12/24-24 Location: left forearm, Primary Etiology: Burn, Stage/Severity: Partial Thickness, Wound Status: Improving without complications: None, Size: 1.2 cm x 0.60 cm x 0.10 cm. Wound Base: 100% epithelial, Wound Edges: Attached, Peri wound: Intact, Exposed Tissues: Epithelium, Exudate: scant, serosanguineous, no odor. Treatment recommendations: Change dressing daily, Cleanse with wound Cleanser, apply bacitracin ointment use bordered gauze. PLAN: Wound #1=6/19/24 Location: right middle finger Burn. Wound Resolved. PLAN: Wound #2=6/19/24-24 Location: left forearm. Wound Resolved. (continued on next page)

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Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/12/24 at approximately 5:00 PM., during the end of day meeting. The Director of Nursing (DON), the Administrator and Corporate Staff #2., were asked if they had a Communal Microwave on Unit 2 and requested accident hazard reports on residents receiving burns. The DON said that she remembered an accident that took place months ago. The DON was asked if the microwave was still in the communal dining room. The DON said that the microwave had been removed, but she doesn't remember when the microwave was removed. On 12/13/24 at approximately 10:10 AM., the DON and Corporate Staff #1 informed surveyor of resident #56 receiving a coffee burn months ago. Documents of the incident were given to the survey staff. On 12/13/24 at approximately 3:55 PM., Resident not available to interview. Staff states resident was on Leave of Absence with activities. On 12/17/24 at approximately 11:15 AM., Resident not available to interview. Staff states resident was at an appointment. On 12/17/24 at approximately, 11:15 AM., an interview was conducted with Other Staff Member (OSM) #5. OSM #5 said that the room was for staff to heat up food, but the residents would use the microwave also. OSM #2 said that she took the microwave off the unit to keep everyone safe after the resident was burned. OSM #2 said they provided First aide to Resident #56. The forearm looked red and was swollen. Nurse didn't physically see the resident as she was warming up her coffee who used a walker for mobility on and off the unit. On 12/17/24 at approximately 3:25 PM., an interview was conducted with Certified Nursing Assistant (CNA) #11. CNA #11 said that she heard about the incident but didn't witness it. CNA #11 also mentioned that the incident occurred in the dining room on Unit 2. CNA #11 also said that initially a resident had the microwave in his room, but it was removed and put in the dining room. Licensed Practical Nurse (LPN) #7 wrapped her hand. On 12/17/24 at approximately 4:25 PM., an interview was conducted with Resident #56 concerning her incident. Resident #56 said that after she heated and removed her cup of coffee from the microwave, she spilled it on her hand and arm as she was using her walker. On 12/19/24 at approximately 5:55 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided prior to survey exit.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed to prevent a significant weight loss and dehydration for one (1) Resident (Residents #117) in a survey sample of 74 Residents. The findings included: For Resident #117, the facility staff did not provide meals consistently, and did not provide hydration consistently, resulting in significant weight loss and dehydration. Resident #117 was originally admitted to the facility on [DATE], and was hospitalized 10 days later on [DATE] for a colonic hemorrhage caused by a Stercoral ulcer (impacted hard stool at the anus and distal rectum) which pierced the bowel wall, after having had no bowel movements. The ulcer/perforation of the bowel wall resulted in blood loss requiring 2 blood transfusions according to hospital records. The Resident was again sent out to the hospital on [DATE] through [DATE] for a severe urinary tract infection causing sepsis and septic shock, and acute kidney injury which was reversed successfully in the hospital with IV (intravenous) fluids for dehydration and IV antibiotics. Resident #117 had a medical diagnosis history including; Congestive heart failure with diuretic use, unspecified dementia without behaviors, hypertension, depression, anxiety, dysphagia, gastro-esophageal reflux disease, and cardiac disease. Resident #117's most recent Minimum Data Set (MDS) assessment was a Significant change assessment with an assessment reference date of [DATE]. Resident #117 had a Brief Interview of Mental Status score of 99 indicating severe cognitive impairment. He was dependant on staff for eating, bathing and personal hygiene. He was coded to have no skin impairment, and at risk for skin impairment. He was coded with no weight loss (which was incorrect), a weight of 123 pounds, no swallowing difficulty, and having a mechanically altered diet. The only previous MDS assessment to the [DATE] MDS was dated [DATE], and was the Resident's admission assessment. This MDS had not been signed as completed until [DATE], and submitted late. The document revealed the Resident's weight at that time to be 139 pounds. This indicated a greater than 10% weight loss in the previous 2 months. It is notable to mention that the Resident was admitted with a weight of 145.3 pounds on [DATE]. This revealed a significant weight loss of 22.3 pounds since admission, equaling a greater weight loss than 15% in the 3 month period from admission to the current survey which was well documented in the clinical record. Before hospitalization and after hospitalization the Resident's diet remained the same. Regular diet, Dysphagia pureed texture, thin consistency. On [DATE] mighty shakes 4 ounces was ordered at bedtime for a supplement. No other diet changes nor supplements were ever ordered during the Resident's stay. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the entire survey Resident #117 was never observed during the day shift out of bed, and asked the surveyors often for something to drink stating Please, Please bring me some water I'm so thirsty. The Residents lips were noted to be cracked and dry, and his eyes were sunken. His skin was flaking and dry and when the skin on his hand was examined it tented when pulled gently in an upward fashion and stayed that way. His mucus membranes were sticky and when he spoke his lips would stick together with thick saliva briefly. He constantly complained my butt hurts, my butt hurts. Staff were made aware that the Resident was thirsty, and complaining of butt pain. Staff stated they would have the NP look at him. On [DATE] A Certified Nursing Assistant (CNA) was found in the hallway after Resident #117 was found begging for water. The CNA brought in 120 milliliters of tea for the Resident, and was again told he asked for water. She stated oh he just wants to drink, not eat. The CNA was asked if she was aware that the caffeine in tea was a diuretic and could further dehydrate the Resident. She did not respond. On [DATE] the Kitchen manager was interviewed and stated that they did not keep track of percentages of meals and fluids consumed, and stated that the nursing staff were responsible for that. She was asked if she had decaffeinated tea on hand, and she stated she had decaf coffee but not tea. On [DATE] A CNA was interviewed and stated, he (Resident #117) went out to the hospital with altered mental status, low blood pressure, dehydration and a UTI (urinary tract infection), and when he came back he went on hospice. He's been in bed now since then. The Resident had actually returned on [DATE], and was not placed on hospice until [DATE] (one month later). The CNA was asked for his hospice notes, and she went to the LPN (Licensed Practical Nurse) unit manager with the surveyor accompanying her and asked for the notes. The LPN stated I will look for them, and later stated I don't have any. The entire clinical record was reviewed and no hospice notes were in the clinical record. Staff were then asked if hard copy notes could be located in a binder, and they stated they had no such binder. There was an observed notice taped to the Resident's closet door from the new social worker addressed to the hospice staff. The document instructed that the Resident's hospice supplies had been found in the general supply closet in the facility with normal inventory. The document instructed hospice staff to inform the nurses on the unit when hospice supplies were brought in for the Resident. It appeared that the facility staff and hospice staff were not communicating. On [DATE] from 11:30 AM until 1:00 PM a second surveyor was observing lunch service on the memory care secured unit until the meal was finished. Resident #117 was never fed, and his tray was removed from his room. The tray was placed back on the tray cart to return to the kitchen for disposal, untouched. The CNA was asked why he was not fed, and she replied oh he's hospice he don't want it. The Resident received no food, and no fluids from 9:00 AM breakfast to 5:00 PM dinner (8 hours). No water was in any Resident room on the secured unit during the entire survey. Resident #117's clinical record was reviewed. Weight documents all completed by chair scale revealed the following; [DATE] - 145.3 pounds on admission. [DATE] - 143.0 pounds out to hospital on [DATE] with bleeding, returned [DATE]. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] - 139.0 pounds [DATE] - 139.0 pounds [DATE] - 123.0 pounds [DATE] - 122.6 pounds No further weights were being recorded as staff stated well, he's hospice now, so no need really. The Resident was not placed on hospice until [DATE], (2 weeks later with no weights completed) and remained a Full Code CPR status. The Registered Dietician (RD) was called via cellular phone for interview and was unable to be contacted. A message was left on voicemail, however, surveyors received no call back. No RD notes were found in the clinical record, however, on [DATE] at 12:11 PM, the Administrator and Director of Nursing (DON) supplied the only note they had received from the RD dated [DATE] (8 days after returning from the hospital with sepsis and dehydration). The RD note was reviewed and revealed continued weight loss and the following 4 recommendations, none of which were followed: 1. Consider benefit of appetite stimulant medication due to poor oral intake. 2. when poor oral intake less than 50% offer alternate meal options. 3. weekly weights for one month due to readmit. 4. RD to monitor for significant changes in weight poor oral intake or skin integrity and follow up as needed. Staff were interviewed on [DATE] and asked what interventions could be offered to a Resident to prevent significant weight loss. The Director of Nursing (DON) provided two policies on Nutritional Management, and Weight Monitoring that documented the following; 1. Nutritional Management. Nutritional Status includes both nutrition and hydration status. The document describes a systematic approach to optimize a Resident's nutritional status. Staff are to identify risk factors, evaluate and analyze assessment information, develop and consistently implement approaches, and monitor the effectiveness of interventions and to revise interventions as necessary which would be reflected in the Resident's plan of care. The document goes on to describe that a comprehensive assessment will be completed by the Registered Dietician (RD) within 72 hours of a change in condition to include persistent hunger, poor intake, or continued weight loss, or evidence of fluid loss. One intervention included diet liberalization, and feeding assistance. 2. Weight Monitoring. Significant unintended changes in weight (loss or gain) .may indicate a nutritional problem. A comprehensive nutritional assessment, The Nutritional Data Collection Tool will be completed and that information would identify risk which would then drive the care planning process development to include; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Identified causes of impaired nutritional status, reflect the Resident's personal goals and preferences, identify resident specific interventions, time frame and parameters for monitoring, be updated as needed during Resident's condition changes, interventions are ineffective, or new problems are identified, and be conducted as per professional standards. Residents with weight loss monitor weights weekly. Documentation will include notification of physician, if significant weight loss is identified the RD should be consulted to assist the interdisciplinary (IDT) care plan team with interventions who could initiate the care planning process, as well as the nursing department may initiate the care planning process. The IDT communicates care instructions to staff. On [DATE] the NP documented on a Wound Assessment Report location sacrum, 14 centimeter (cm) length x width total measurement of the wound, 0.1 cm deep date acquired [DATE] in house, wound status new, stage/severity Full Thickness, 20% granulation, 80% slough, Erythema peri wound (red and inflamed), exposed tissue Epithelium, Dermis. Treatment daily and as needed cleanse with wound cleanser, hydrogel primary treatment, dressing bordered gauze. The DON was asked if Foley catheters to keep skin dry and for intake and output assessments were available, and she stated yes. She was asked if formal protein supplements, fluids, diet changes, and moisture barrier creams, and positioning devices were available for Resident's with known significant weight loss and wounds and she stated yes. She was asked if she was aware that the mattress for Resident #117 was the same as the ones used for the ambulatory residents on the memory care unit, and she stated she was not aware of that. None of the above prevention strategies were afforded Resident #117 for prevention of further significant weight loss and the pressure sore indicating this ulcer was potentially avoidable. On [DATE] a redistribution air mattress was ordered for the Resident, however did not arrive until after his move to another unit on [DATE]. On [DATE] Review and copy of Physician's orders revealed only 1 order for weight management; 1. Mighty shake 4 ounces at bedtime was ordered by the physician on [DATE] after the Resident returned from the hospital after experiencing dehydration and sepsis. Mighty Shakes nutrition facts included; Only 220 calories per each 4 ounces which equals approximately 2 tablespoons of peanut butter which would contain 8 grams of protein whereas the mighty shake only had 6 grams. The Might Shake was not given on the following nights, with no reason documented as to why it was withheld; October - [DATE], [DATE]. November - [DATE], [DATE], [DATE], [DATE]. December - [DATE], [DATE], [DATE]. The Care plan was reviewed and included focuses, goals and interventions for malnutrition Risk related to history of rectal bleed constipation created on [DATE] with a goal to be free of significant weight changes. A new care plan revision entry was created on [DATE], however, none of the interventions were changed, and none were added. The care plan identified only the following 5 interventions; 1. Administer medications as ordered, observe for side effects and effectiveness alert MD (doctor) as needed. 2. Provide, serve diet as ordered. Monitor intake and record every meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. RD to evaluate and make diet change recommendations as needed. 4. Receives a mechanical soft pureed diet, related to diagnosis. 5. weight per facility protocol/MD order. The care plan was not Resident specific and did not specify feeding needs, fluid provision, supplements, diet changes, alternate diet changes, nor RD interventions/recommendations, and was not followed with regard to weights. It did not specify any measures/interventions to be instituted to prevent dehydration which the Resident had been hospitalized previously for. No treatments were specified in the care plan for the care of a pressure sore after it developed and was identified at a stage 3 further complicating significant weight loss and a history of dehydration. It is also notable to mention that the care plan was not derived by an interdisciplinary team and the only 2 individuals who were present for the most recent care plan update was the LPN (Licensed Practical Nurse) unit manager, and the Social Worker who was found to not have been vetted properly, and had insufficient qualifications for the Role. Resident #117 experienced a potentially avoidable pressure ulcer injury which was not identified until it became a full thickness wound with dead yellow slough tissue obscuring the base of the wound by 80%. The Resident was at risk for skin breakdown after being continuously bed ridden for months, was experiencing continued significant weight loss, and was hospitalized for fecal impaction with hemorrhage, and hospitalized for a urinary tract infection, dehydration, and severe sepsis. On [DATE] at 11:15 a.m., the Administrator, Director of Nursing, and Corporate Nurse were notified that the facility staff failed to prevent significant weight loss and dehydration, and further had not intervened during the known weight loss. The facility staff was given the opportunity to provide any further information or explanation. They stated they had no further information to provide. On [DATE], and [DATE] during a meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns for this Resident. On [DATE], prior to the survey exit the Director of Nursing informed surveyors that Resident #117 had been moved back onto a regular unit last night ([DATE]). At the time of survey exit on [DATE] the facility Administrator, and Director of Nursing stated they had nothing further to provide.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 34306 Based on a resident interview, staff interviews, and clinical record review, the facility staff failed to manage pain for one (1) of 74 residents (Resident #280), in the survey sample which resulted in harm. The findings included: Resident #280 was originally admitted to the facility 12/3/24 after an acute care hospital stay. The resident's current diagnoses included a TIA, migraines, chronic pain of the back and neck, fibromyalgia, and Raynaud's phenomena. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) 12/10/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #280's cognitive abilities for daily decision making were moderately impaired. On 12/13/24 at approximately 12:55 PM an interview was conducted with Resident #280. The resident stated she arrived at the facility on 12/3/24 after 5:00 PM and she was experiencing significant neck and back pain at the time of her arrival. The resident stated she informed the nurses of her pain and her desire to be medicated before it became severe, but it was 2-3 hours before she received the pain medication, Hydromorphone 2 mg (Scheduled II narcotic). The resident stated she did not receive her routine Morphine (Schedued II narcotic) the night of admission or at all the next day 12/4/24. She stated on 12/5/24 she began receiving a liquid Morphine, not the tablet she received in the hospital or what she took at home. Resident #280 stated she gave up hope of ever getting her pain under control while in the facility, until the liquid Morphine was started on 12/5/24. The resident also stated by the time she received the liquid Morphine she was experiencing such excruiating pain that she was unable to lie down or sit up without wanting to scream. The resident also stated she could not participate in her care or eat. The resident further stated the first few doses of the liquid Morphine did not have the same effect as the tablets but she was grateful to finally start getting routine pain medication. Resident #280 reiterated that no one informed her why she was not receiving the Morphine tablets or told her to request the Hydromorphone when needed. The resident stated the nurses allowed her pain to become debilitating by only administering the Hydromorphone once when the scheduled Morphine was not available. Resident #280 was discharged from the acute care hospital to the rehabilitation facility on Morphine SR 15 milligram(mg) tablet - take one tablet by mouth every 12 hours, Gabapentin 300 mg - take two tablets by mouth three times each day, and Hydromorphone 2 mg, 1-2 tablets by mouth every three hours as needed for pain, maximum daily dose 16 tablets. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The physician order summary revealed the following pain medications, Gabapentin Capsule 300 MG - Give 1 capsule by mouth three times a day for pain (This is half of what she was discharged on) start on 12/4/24, Morphine SR 15 milligram(mg) tablet - take one tablet by mouth every 12 hours (this was discontinued on 12/4/24), Morphine Sulfate (Concentrate) Solution 20 MG/ML - Give 10 mg by mouth three times a day for pain was ordered to start on 12/5/24, and Hydromorphone tablet 2 mg - Give 1 tablet by mouth every 4 hours as needed for Pain give 1-2 tabs every 3 hours for pain, start on 12/3/24. The person-centered care plan had a problem dated 12/12/24 which stated at risk for alteration in comfort related to pain, Raynaud's syndrome, asthma with SOB while lying flat, GERD, HTN, Hypothyroidism, HF, PVD, Depression, osteoporosis, spinal stenosis, and B&B incontinence. The goals included will alert staff to need for pain medication through next review date, Will have pain/discomfort recognized and controlled by next review date, and Will verbalize relief from discomfort through next review date, 03/12/2025. The interventions included Medicate as ordered, obtain resident rating of the pain scale face/verbal descriptor and document, and offer repositioning, pillows, to get out of bed or to return to bed to increase comfort. A review of the Medication Administration Record revealed on 12/3/24 the resident received no pain medication even after complaining of pain of 5 out of 10 upon arriving to the facility. On12/4/24, resident #280 received Hydromorphone tablet 2 mg at 8:41 PM for pain rated as 8 out of 10. The Hydromorphone tablet 2 mg was not administered again during the resident's stay at the facility although it was available for administration as needed. The resident only received one-half of the dose of Gabapentin (300 mg three times daily for pain management) the acute care hospital discharged her to receive, and the Morphine SR was discontinued on 12/4/24 at 8:04 PM because it was on backorder from the pharmacy and Morphine Concentrate was ordered on 12/4/24 at 4:54 PM to start on 12/5/24. On 12/19/24 at approximately 11:34 AM an interview was conducted with the Manager for Unit 4 regarding Resident #280 pain management. The Manager stated We could have done a better job managing her pain. On 12/19/24 at approximately 6:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, the Owner and three Corporate Nurse Consultants. They voiced no concerns regarding the above findings. Opioids have been regarded for millennia as among the most effective drugs for the treatment of pain. Their use in the management of acute severe pain and chronic pain related to advanced medical illness is considered the standard of care in most of the world (https://pmc.ncbi.nlm.nih.gov/articles/PMC2711509/). Hydromorphone belongs to the opioid class of medications and is utilized to effectively manage and treat moderate-to-severe acute pain and severe chronic pain in patients. The drug exerts its analgesic effects by interacting with the mu-opioid receptors (https://pubmed.ncbi.nlm.nih.gov/29261877/). FDA-approved usage of morphine sulfate includes moderate to severe pain that may be acute or chronic. Most commonly used in pain management, morphine provides major relief to patients afflicted with pain (https://pubmed.ncbi.nlm.nih.gov/30252371/). (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Gabapentin is an anticonvulsive medication that is beneficial in managing certain types of neural pain and psychiatric disorders(https://www.ncbi.nlm.nih.gov/books/NBK493228/). Gabapentin at doses of 1800 mg to 3600 mg daily (1200 mg to 3600 mg gabapentin encarbil) can provide good levels of pain relief to some people with postherpetic neuralgia and peripheral diabetic neuropathy (https://pubmed.ncbi.nlm.nih.gov/28597471/).

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 34306 Based on a resident interview, staff interview, and clinical record review, the facility staff failed to have ongoing records of communication between the facility and the dialysis center for one (1) of 74 residents (Resident 13), in the survey sample. The findings included: Resident #13 was originally admitted to the facility 6/25/24. The current diagnoses included end stage renal disease requiring dialysis. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/2/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #13's cognitive abilities for daily decision making were intact An interview was conducted with the Resident #13 on 12/10/24 at 3:55 PM. Resident #13 stated she receives dialysis services outside the facility on a Monday, Wednesday and Friday schedule. The resident stated she was waiting for the staff to add a low air loss mattress to her bed because she was experiencing back pain. The resident stated the back pain started when the dialysis transport personnel dropped her on Friday 12/6/24, when they were transferring her from the dialysis chair to the stretcher for her return to the facility. The resident stated she reported the fall to the nurse when she arrived in the facility and the facility transferred her to the hospital for an evaluation of her back. A review of the resident dialysis communication book revealed no communications notes from the dialysis center or the facility. The person-centered care plan dated 6/27/24 had a problem which stated (name of the resident) needs hemodialysis related to renal failure. The goal read (name of the resident) will have no signs or symptoms of complications from dialysis through the review date, 1/1/25. The interventions failed to include ongoing communication, coordination and collaboration between the nursing home and the dialysis center. An interview was conducted with the Unit 4 Manager on 12/13/24 at approximately 4:30 PM. The Unit 4 Manager stated there were no communication notes in the book therefore she would contact medical records to determine if they were there waiting to be uploaded in the medical record. The medical records clerk stated she did not have any dialysis communication notes for Resident #13 therefore, the Unit 4 Manager telephoned the dialysis center to obtain the communication notes. The Unit 4 Manager stated on dialysis days they complete a dialysis note and send it with the resident to dialysis, but they were not consistently receiving the forms back from the dialysis center. She stated now that she was aware of the problem she would contact the dialysis center Manager to establish ongoing records of communication between the facility and the dialysis center. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/24 at approximately 6:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, the Owner and three Corporate Nurse Consultants. They voiced no concerns regarding the above findings.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on observation, interview and clinical record review the facility staff failed to ensure medications were acquired and available to meet the needs of one (1) of 74 residents in the survey sample, Resident #327. The findings included: For Resident # 327, the facility staff failed to ensure several medications were available for administration as ordered by the physician. Resident # 327 was a [AGE] year old admitted to the facility on [DATE], with diagnoses that included but were not limited to: Asthma, emphysema, Pulmonary Fibrosis, Seizure disorder, Chronic anxiety and depression, Hypothyroidism and Gastroesophageal reflux disease, historyof Pulmonary Embolism, orthostatic hypotension and chronic hypoxic respiratory failure-on oxygen at 4 liters per minute via nasal cannula, Congestive Heart Failure. Cerebral Vascular Accident. The most recent MDS (Minimum Data Set) assessment was coded as an Admission assessment with an ARD (Assessment Reference Date) of 8/1/2023. The BIMS (brief interview for mental status) assessment was coded as 15 out of possible 15, indicating no cognitive impairment. The assessment also coded Resident # 327 as requiring assistance with activities of daily living; and continent of bowel and bladder. Review of the clinical record was conducted on 12/10/2024 to 12/19/2024. Review of the Progress Notes and August 2023 Medication Administration Record (MAR) revealed documentation of several medications being unavailable several times including but not limited to: Effective Date: 08/01/2023 23:56 Type: eMar - Medication Administration Note Note Text: Topiramate Tablet 100 MG (milligrams) Give 1 tablet by mouth three times a day for Seizure three times per day on order. Review revealed that 4 doses of Topiramate were not available on: 8/9/2023 at 8 a.m. 8/14/2023 at 8 a.m. 8/19/2023 at midnight 8/19/2023 at 8 a.m. Effective Date: 08/02/2023 21:36 Type: eMar - Medication Administration Note (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Note Text : Adderall XR Capsule Extended Release 24 Hour 15 MG Give 1 capsule by mouth two times a day for ADHD (Attention Deficient Hyperactivity Disorder) (scheduled at 9 a.m. and 9 p.m.) On order Review revealed that 3 doses of Adderall were not available on: 8/19/2023 at 9 a.m. 8/19/2023 at 9 p.m. 8/21/2023 at 9 a.m. The medication, Adderrall, was not listed in the Cubex contents. Note Text : Lidocaine HCl (PF) Injection Solution 1 % Inject 3.5 ml intramuscularly one time a day for UTI for 2 Days awaiting from rx (Pharmacy) The medication, Lidocaine, was prescribed for 2 days. Review of the MAR revealed only one dose was given on 8/7/2023. There was no documentation of the second dose being given as ordered. Note Text: Savella Oral Tablet 50 milligrams Give 1 tablet by mouth two times a day for depression not available- ordered 8/2/2023 at 9 am. The medication, Savella, was not started until 8/4/2023 at 9 a.m. The medication was not listed in the Cubex Stat box contents. On 12/10/2024 at 3:05 p.m., an interview was conducted with LPN(Licensed Practical Nurse) # 3 who stated the medications come in a blister pack for each resident. The blister pack should have the medications for each scheduled dose. LPN # 3 stated if the medication was not available, the nurse was expected to check the Cubex (in house Stat box) for an available supply of the medication and to notify the Pharmacy that the medication was not available. The nurse would order the medication from the Pharmacy so it would be available for the next scheduled dose. The nurse should notify the physician that the medication was not available for administration as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/2024 at 10:20 a.m., an interview was conducted with the Director of Nursing who stated medications should be available for administration as ordered by the physician. She stated the nurses should call the Pharmacy to inform them that the medication was not available in the medication cart, order the medication, check the Cubex and notify the physician if the medication was not available to be administered. She stated the Pharmacy delivers twice a day at the facility. She also stated the expectation was for the Pharmacy to send medications on the next delivery after notification that a medication was not available as ordered. On 12/11/2024 at 11:00 a.m., an interview was conducted with the Regional Nurse Consultant (Corporate # 1) who stated medications should be available for administration as ordered by the physician. Corporate # 1 stated the Pharmacy should have ensured the medication was available for administration. She also stated the nurses should have checked the Cubex (in house Stat box) for an available supply of the medication. The Regional Nurse Consultant (Corporate # 1) explained that the Pharmacy would have sent a blister pack with the entire course of medication for the month. The nurses would have had access to the medications for each time of scheduled administration. She stated medications should be available for administration. During the end of day debriefing on 12/18/2024, the Facility Administrator, Regional Nurse Consultant and and Director of Nursing were informed of the findings. No further information was provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 31199 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure pharmacy recommendations were obtained and acted upon for five Residents (Residents #117, #226, #51, #33 and #78), in the survey sample of 74 Residents. The findings included: 1. For Resident #117, the pharmacist recommendations were either not obtained, or not acted upon, and none were in the clinical record in 2 of the preceding 3 months of survey (September, and October 2024). Resident #117's clinical record was reviewed and for the last 3 months prior to survey (September through November), as December had not yet been completed, The Registered Pharmacist (RPH) Monthly Medication Regimen Reviews (MMR) were reviewed. Resident #117 was receiving anticoagulants, blood pressure medication, psychotropic medication, anti seizure medication, diuretics, pain medication, heart medication, was on a fluid restriction, and had a history of kidney disease, congestive heart failure, bleeding, and dehydration. On 12-16-24 the Director of Nursing (DON) was interviewed and asked when the MMR's were conducted and how they were conducted. She stated that the RPH reviewed a percentage of the Resident's medications every month. When asked what that percentage was, she stated I will have to check, I am not sure how many they do every month. She was asked if irregularities occurred how the staff would be made aware of that, and again she stated I'm not sure, I don't get that, I will have to find out. On 12-16-24 the DON and Administrator returned with the Monthly Reviews and revealed that not all Residents were being reviewed monthly. The reviews also revealed that the physician had not been notified of those residents with recommendations for changes, which would have required a documented explanation by the physician of what their decision was in regard to the RPH recommendations for each resident listed. The DON and Corporate RN consultant stated that the recommendations had not been printed from the system where the RHP had documented them and so were not made available to the physician to act upon timely. They stated that the procedure had some cracks in it and that the DON would now be responsible to track this for 100% of the Residents monthly and that she would make sure the physician (MD) received these recommendations and acted upon them. The MMR reviews were as follows; September 2024 - Resident #117 - Not evaluated by the RPH. October 2024 - Resident #117 - Recommendation for psychoactive medication Geodon. Not acted on by MD. November 2024 - Resident #117 - Resident reviewed with no new recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy was reviewed and revealed that the MRR's would be completed at least monthly and placed in the Resident's clinical chart. They would be available in an easily retrievable format to nurses, physician's, and the care planning team after completion for review. The recommendations and findings will be documented and acted upon by the nursing care center and/or physician. On 12-18-24 at 4:00 PM during a meeting with the Administrator and DON they were informed of the missing MRR evaluations, documentation, and MD responses to recommendations made by the RPH. They stated they had nothing further to provide. 2. For Resident #226, the pharmacist recommendations were not acted upon, and none were in the clinical record in 2 of the preceding 3 months of survey (September, and November 2024). Resident #226 was receiving anticoagulants, blood pressure medication, muscle relaxants, opiate pain medication, dialysis medication, was on a renal dialysis diet, had a history of kidney disease, and was actively being treated with hemodialysis. On 12-16-24 the Director of Nursing (DON) was interviewed and asked when the MMR's were conducted and how they were conducted. She stated that the RPH reviewed a percentage of the Resident's medications every month. When asked what that percentage was, she stated I will have to check, I am not sure how many they do every month. She was asked if irregularities occurred how the staff would be made aware of that, and again she stated I'm not sure, I don't get that, I will have to find out. On 12-16-24 the DON and Administrator returned with the Monthly Reviews and revealed that not all Residents were being reviewed monthly. The reviews also revealed that the physician had not been notified of those residents with recommendations for changes, which would have required a documented explanation by the physician of what their decision was in regard to the RPH recommendations for each resident listed. The DON and Corporate RN consultant stated that the recommendations had not been printed from the system where the RHP had documented them and so were not made available to the physician to act upon timely. They stated that the procedure had some cracks in it and that the DON would now be responsible to track this for 100% of the Residents monthly and that she would make sure the physician (MD) received these recommendations and acted upon them. The MMR reviews were as follows; September 2024 - Resident #226 - Recommendation for Diabetes diagnosis with no treatment, and Baclofen muscle relaxant, Not acted on by MD. October 2024 - Resident #226 - Resident reviewed with no new recommendations. November 2024 - Resident #226 - Recommendation for Norco opiate for pain, Not acted on by MD. The facility policy was reviewed and revealed that the MRR's would be completed at least monthly and placed in the Resident's clinical chart. They would be available in an easily retrievable format to nurses, physician's, and the care planning team after completion for review. The recommendations and findings will be documented and acted upon by the nursing care center and/or physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12-18-24 at 4:00 PM during a meeting with the Administrator and DON they were informed of the missing MRR evaluations, documentation, and MD responses to recommendations made by the RPH. They stated they had nothing further to provide. 40026 3. For Resident # 51 the facility staff failed to ensure drug regimen review was completed monthly. On 12/16/24 during the clinical record review it was noted that Resident #51 did not have drug regimen reviews in the clinical record. On the morning of 12/16/24 an interview was conducted with the DON who stated that she was not sure of which Residents the pharmacist reviewed each month. She stated that she had a book with the reviews and any recommendations in her office. Resident #51's past years pharmacy reviews and recommendations were requested at that time. On 12 /17/24 the DON submitted the pharmacy reviews for Resident #51 and the months of February, May, June, and November of 2024 were missing. When asked if there were any more, she stated that was all that she had. On 12/17/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 4. For Resident #33 the facility staff failed to ensure drug regimen review was completed monthly. On 12/16/24 during the clinical record review it was noted that Resident #33 did not have drug regimen reviews in the clinical record. On the morning of 12/16/24 an interview was conducted with the DON who stated that she was not sure of which Residents the pharmacist reviewed each month. She stated that she had a book with the reviews and any recommendations in her office. Resident #33's past years pharmacy reviews and recommendations were requested at that time. On 12 /17/24 the DON submitted the pharmacy reviews for Resident #33 and the months of, August and September 2024 were missing. When asked if there were any more, she stated that was all that she had. On 12/17/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 5. For Resident # 78 the facility staff failed to ensure drug regimen review was completed monthly. On 12/16/24 during the clinical record review it was noted that Resident #78 did not have drug regimen reviews in the clinical record. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the morning of 12/16/24 an interview was conducted with the DON who stated that she was not sure of which Residents the pharmacist reviewed each month. She stated that she had a book with the reviews and any recommendations in her office. Resident #78's past years pharmacy reviews and recommendations were requested at that time. On 12 /17/24 the DON submitted the pharmacy reviews for Resident #78 and the months of September and October of 2024 were missing. When asked if there were any more, she stated that was all that she had. On 12/17/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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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** 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure Residents are free from significant medication errors for three (3) Residents (378, 109, and 327) in a survey sample of 74 Residents. The findings included: 1. For Resident # 378 the facility staff failed to ensure Vancomycin (an anti-biotic used to treat infection) was administered as prescribed by physician, delaying treatment by 4 days for C-Diff (Clostridium difficile a bacteria that causes watery diarrhea, abdominal pain and cramping, fever, nausea, and dehydration). On 12/12/24 a review of the clinical record revealed that Resident #378's admission order for Vancomycin read: 2/15/24 Vancomycin HCl Oral Capsule 125 MG (Vancomycin HCl) Give 5 ml via PEG-Tube one time a day for C. Diff for 6 Days -Start Date- 02/16/2024 1200 The following progress notes were entered regarding the Vancomycin administration or lack thereof: 2/16/24 1:36 p.m. - Vancomycin HCl Oral Capsule 125 MG Give 5 ml via PEG-Tube one time a day for C. Diff for 6 Days AWITING [sic] Pharmacy, NP notified. 2/16/24 1:42 p.m. - ON HOLD UNTIL COMES FROM PHARMACY, NP NOTIFIED 2/18/24 1:09 p.m. - Note Text: Vancomycin HCl Oral Capsule 125 MG Give 5 ml via PEG-Tube one time a day for C. Diff for 7 Days. Pharmacy needs clarification. Left a message with on call if corrected by 1530 it can be sent on the next run today. On 2/19/24 the following Physician note was entered to clarify the Vancomycin order: Chief Complaint / Nature of Presenting Problem: New Admission 2/15/2024F/u and monitoring C-Diff and left BKA. Medication List: Vancomycin HCl, Vancomycin HCl Oral Suspension 50 MG/ML, Give 2.5 ml by mouth one time a day for c-diff for 7 Days, 50MG/ML, ACTIVE, 2/19/2024 to 2/26/2024. A review of the MAR (Medication Administration Record) revealed that the Vancomycin was started on 2/19/24 at 12:00 p.m. This resulted in a delay in treatment and 4 days of missed medications. On 12/18/24 at 11:00 a.m. an interview was conducted with LPN #3 who was asked what the nurses do if a medication is unavailable, LPN #3 stated they notify the physician and get an order to hold it until it becomes available. When asked if this is facility policy to obtain a hold order, she stated that it was what she was told to do. When asked if they had a backup pharmacy or a stat box, she stated that they do have stat boxes but that sometimes the med or the dose needed was not in the stat box. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 an interview was conducted with the DON who was asked if there is a backup pharmacy, and she stated that there was. When asked if it is acceptable to make a Resident wait 4 days for an antibiotic, she stated that it was not. On 2/19/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 49917 2. Resident #109 did not receive the physician ordered scheduled doses of Insulin. Resident #109 was originally admitted to the facility 1/4/24. The resident's diagnoses included chronic obstructive pulmonary disease, type 2 diabetes mellitus without complications, essential hypertension, chronic kidney disease, and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/23/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #109's cognitive abilities for daily decision making were intact. On 12/10/24 at 2:15 PM an interview was conducted with Resident #109. Resident #109 stated, I did not receive scheduled doses of my Insulin on a Sunday in November. I was not sure why and could not get a clear answer from the staff. The Physician's Order Summary (POS) for November 2024 read: Insulin Aspart FlexPen 100 Unit/ML Solution pen-injector Inject 20 unit subcutaneously with meals related to Type 2 Diabetes Mellitus without complications with a start date of 11/8/2024 and Insulin Glargine-yfgn 100 Unit/ML Solution pen injector Inject 55 unit subcutaneously at bedtime for DM Administer Emergency Glucagon for hypoglycemia<60 blood glucose notify provider with a start date of 11/1/2024. A review of the Medication Administration Record (MAR) revealed that Resident #109 missed 1 dose of Insulin Aspart FlexPen 100 Unit/ML Solution pen-injector Inject 20 unit subcutaneously with meals related to Type 2 Diabetes Mellitus without complications on the following date: 11/10/24 and missed 1 dose of Insulin Glargine-yfgn 100 Unit/ML Solution pen injector Inject 55 unit subcutaneously at bedtime for DM on the following date: 11/10/24. Insulin aspart is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood) in adults and children. It is also used to treat people with type 2 diabetes (a condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood who need insulin to control their diabetes. https://medlineplus.gov/druginfo/meds/a605013.html). Insulin glargine products are used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). Insulin glargine products are also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes. https://medlineplus.gov/druginfo/meds/a600027.html (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 2:43 PM an interview was conducted with the Licensed Practical Nurse (LPN) #2. LPN #2 stated that the medications were available for Resident #109, and she could not explain why the resident was not administered these medications on 11/10/24. On 12/19/24 at approximately 6:25 p.m., a final interview was conducted with the Regional [NAME] President of Operations, Administrator, Regional Nursing Consultant, Regional MDS Consultant, Director of Nursing, Assistant Director of Nursing, and Owner. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information. 34894 3. For Resident # 327, the facility staff failed to ensure that intravenous antibiotics were available for administration and administered as ordered by the physician. Resident # 327 was a [AGE] year old admitted to the facility on [DATE], with diagnoses that included but were not limited to: Asthma, emphysema, Pulmonary Fibrosis, Seizure disorder, Chronic anxiety and depression, Hypothyroidism and Gastroesophageal reflux disease, historyof Pulmonary Embolism, orthostatic hypotension and chronic hypoxic respiratory failure-on oxygen at 4 liters per minute via nasal cannula, Congestive Heart Failure. Cerebral Vascular Accident. The most recent MDS (Minimum Data Set) assessment was coded as an Admission assessment with an ARD (Assessment Reference Date) of 8/1/2023. The BIMS (brief interview for mental status) assessment was coded as 15 out of possible 15, indicating no cognitive impairment. The assessment also coded Resident # 327 as requiring assistance with activities of daily living; and continent of bowel and bladder. Review of the clinical record was conducted on 12/10/2024 to 12/19/2024. Review of the Progress Notes on pages 329-336 of 339 revealed documentation of an encounter on 8/2/2023 for a history and physical with a problem that listed tx (treatment) with IV (Intravenous fluids) and Rocephin. The note documented a diagnosis of sepsis secondary to urinary tract infection and treatment with IV fluids and antibiotics. Further review of the Progress Notes revealed documentation of an encounter by the physician on 08/03/2023 that was listed as a new evaluation involving the chief complaint of Follow-up regarding cough. The note also stated History Of Present Illness: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[AGE] year-old female seen for follow-up for complaints of cough. On arrival patient was lying in the bed she complains of cough congestion generalized fatigue and weakness. Discussed with nursing staff with [sic]obtain further overview medication lab and chart reviewed patient anticipated to receive antibiotic course of Rocephin however a slight delay in delivery. Discussed with nursing staff to ensure medication arrives notify provider of any complications we will further delay in antibiotic course the verbalized understanding. Discussed with patient reporting persistent cough or congestion will recommend further x-rays should verbalized understanding. Further evaluation conducted Review of the Progress Notes revealed Rocephin was not administered until the evening of 8/4/2023. the note written on 8/5/2023 stated this resident is on IV (intravenous) Rocephin X 3 (times 3.) This resident received her first dose and tolerated it well. The note also stated when passing meds, this writer observed the PIV (peripheral intravenous) to her (L) hand had come out and the resident stated that she did not want to put another one because it hurt her hand. The Medication Administration Record did not show documentation of administration of Rocephin until 8/5/2023 and again on 8/6/2023. Review of the Cubex Stat box contents list revealed on page 1 of 6 that the medication, Rocephin 1000 milligrams vial -two vials was available for use. Rocephin IV change to IM Effective Date: 08/05/2023 20:17 Type: eMar - Medication Administration Note Note Text: Ceftriaxone Sodium Solution Reconstituted 1 GM (gram) Use 1 gram intravenously every 24 hours for UTI (urinary tract infection)for 3 Days order changed to IM (intramuscularly) On 12/10/2024 at 3:05 p.m., an interview was conducted with LPN(Licensed Practical Nurse) # 3 who stated the medications come in a blister pack for each resident. The blister pack should have the medications for each scheduled dose. LPN # 3 stated if the medication was not available, the nurse was expected to check the Cubex (in house Stat box) for an available supply of the medication and to notify the Pharmacy that the medication was not available. The nurse would order the medication from the Pharmacy so it would be available for the next scheduled dose. The nurse should notify the physician that the medication was not available for administration as ordered. On 12/11/2024 at 10:20 a.m., an interview was conducted with the Director of Nursing who stated medications should be available for administration as ordered by the physician. She stated the nurses should call the Pharmacy to inform them that the medication was not available in the medication cart, order the medication, check the Cubex and notify the physician if the medication was not available to be administered. She stated the Pharmacy delivers twice a day at the facility. She also stated the expectation was for the Pharmacy to send medications on the next delivery after notification that a medication was not available as ordered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/2024 at 11 a.m., an interview was conducted with the Regional Nurse Consultant (Corporate # 1) who stated medications should be available for administration as ordered by the physician. Corporate # 1 stated the Pharmacy should have ensured the medication was available for administration. She also stated the nurses should have checked the Cubex (in house Stat box) for an available supply of the medication. She stated medications should be available for administration and administered as ordered. During the end of day debriefing on 12/18/2024, the Facility Administrator, Regional Nurse Consultant and and Director of Nursing were informed of the findings that the antibiotic was ordered on 8/2/2023 but not started until the evening on 8/4/2023. The staff had access to the medication in the Cubes in house supply. No further information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to label with expiration date and store medications appropriately for 3 Residents (Resident #8, #74 and #103) and for the facility stock multi use vial medications, in a survey sample of 74 residents, and the facility failed to ensure that narcotic medications no longer in use by residents were properly locked away, accounted for and disposed of in a timely manner. The findings included: 1. For Resident #8, the facility had failed to correctly label / store 2 bottles of Ativan (Lorazepam an anti-anxiety medication). On [DATE] at approximately 3 p.m. while inspecting the medication room it was discovered that 2 bottles of liquid Ativan prescribed for Resident 8, had been opened and used however neither bottle had an open date on them. The bottles were open and available for use and clearly labeled to discard after 90 days. LPN #3 was asked how would you know if the bottle was expired. LPN #3 stated you would not know because no one put an opened-on date on the bottle or the box. When asked if this medication is available for administration, she stated that it was. When asked what the facility policy was for medications requiring disposal within a certain timeframe she stated, We are to label the bottle when we open it so that we know when it is time to dispose of it. A review of the facility policy entitled Medication Administration revealed the following excerpt: 12. Identify the expiration date if expired notify the nurse manager. 2. For Resident #74 the facility staff failed to correctly store 2 bottles of liquid Ativan and one bottle of liquid Morphine (a narcotic pain medication). On [DATE] at approximately 3 p.m. while inspecting the medication room it was discovered that a bottle of liquid Morphine 100 mg/ml prescribed for Resident #74, was opened without a date. There were 2 bottles of liquid Ativan (Lorazepam) prescribed to Resident #74 one bottle had no opened date, the second bottle had been opened on [DATE]. These medications clearly were labeled to be discarded after 90 days. On [DATE] during the end of day meeting the Administrator was made aware of the findings and no further information was provided. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #3 was asked how would you know if the bottle was expired. LPN #3 stated you would not know because no one put an opened-on date on the bottle or the box. When asked if this medication is available for administration, she stated that it was. When asked what the facility policy was for medications requiring disposal within a certain timeframe she stated, We are to label the bottle when we open it so that we know when it is time to dispose of it. A review of the facility policy entitled Medication Administration revealed the following excerpt: 12. Identify the expiration date if expired notify the nurse manager. On [DATE] during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 3. For Resident #103 the facility staff failed to correctly store a bottle of Augmentin 400 mg/5 ml (an antibiotic) prescribed for Resident #103. On [DATE] at approximately 3 p.m. while inspecting the medication room it was discovered that a bottle of liquid Augmentin 400 mg/5ml prescribed for Resident #103 was open and available for use when it should have been completed on [DATE] and disposed of at that time. The label clearly stated to dispose of after 7 days. LPN #3 was asked how to tell if the medication was expired LPN #3 pointed out the label that stated to discard after 7 days. When asked if this medication is available for administration, she stated that it was. When asked what the facility policy was for medications requiring disposal within a certain timeframe she stated, We are to label the bottle when we open it so that we know when it is time to dispose of it. A review of the facility policy entitled Medication Administration revealed the following excerpt: 12. Identify the expiration date if expired notify the nurse manager. On [DATE] during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 4. The facility staff failed to correctly label / store 2 house stock multi use vials of Tubersol (Mantoux test solution for PPD). On [DATE] at approximately 3 p.m. while inspecting the medication room it was discovered that 2 house stock vials of Tubersol were incorrectly labeled / stored, open and available for use. When asked if this medication is available for administration, she stated that it was. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When asked what the facility policy was for medications requiring disposal within a certain timeframe she stated, We are to label the bottle when we open it so that we know when it is time to dispose of it. When asked how long a multi-use vial was good for and she stated 30 days. LPN #3 was asked how would you know if the bottle was expired. LPN #3 stated you would not know because no one put an opened-on date on the bottle or the box. A review of the policy entitled Storage of Medication revealed the following excerpt: 6. d. Date label of any multiuse vial is first accessed (needle punctured), the vial should be dated and discarded within 28 days unless the manufacturers specify a different date (shorter or longer) date for that opened vial. On [DATE] during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 5. The facility staff failed to ensure that narcotic medications no longer in use by residents were properly locked away, accounted for and disposed of in a timely manner. On the afternoon of [DATE] during an interview with the Unit Manager (LPN 2) Surveyors accompanied the LPN to her office to obtain some documents. The Unit Manager's door was unlocked, and surveyors and DON along with the Unit Manager walked in the office. The surveyors noticed that a large number of medications were left in an unlocked cart (open to view, no doors or enclosures on the cart, typically used for supply or mail distribution). The Unit Manager was asked what the medications were, and she stated that those were medications that needed to be destroyed or sent back to pharmacy. When asked if any of them were controlled substances she stated that they were not. The DON was asked what the proper procedure is for storage of narcotic medications, and she stated they should be behind 2 locks, usually the cart and the lock box or narcotic box on the cart. When asked if it was proper procedure to hold any medications in an unlocked office, she stated that it was not acceptable practice for any medications to be unsecured. The Surveyors looked at the overflowing bin of medications and saw Zolpidem (Ambien -a controlled substance used to aid in sleep) on the top of the bin. At that point the entire cart was taken to the conference room and with the DON and Administrator as witnesses, the contents were viewed. The cart was found to have the following controlled substances: 1 bottle Dilaudid 1mg/ml - No count sheet - 30 ml bottle dispensed - 23 ml left (signed off destroyed after surveyors counted on [DATE]). 1 card of Oxycodone ,d+[DATE] mg - No count sheet 7 tablets (signed off destroyed after surveyors counted on [DATE]). 1 Card of Pregabalin 75 mg - No count sheet 34 tablets -(signed off destroyed after surveyors counted on [DATE]). 1 bottle of Morphine 100 ml/ 5 ml. - No count sheet 2 ml left in 30 ml bottle (signed off destroyed after surveyors counted on [DATE]). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 bottle of Morphine 100 ml/ 5 ml. No count sheet 4 ml left in 30 ml bottle (signed off destroyed after surveyors counted on [DATE]). 1 bottle of Ativan 2mg /ml - Label altered to change the time from every 4 hours to every 8 hours and from PRN to routine. also, Narcotic sheet stated 24.75 ml, but 12.5 ml was in bottle (signed off destroyed after surveyors counted on [DATE]). 1 bottle of Ativan 2mg /ml - Narcotic count sheet shows 25 ml however 20 ml in bottle (signed off destroyed after surveyors counted on [DATE]). 1 bottle of Morphine 100 ml/ 5 ml - Narcotic count sheet shows 20 ml in bottle however only 2.0 ml in bottle (signed off destroyed after surveyors counted on [DATE]). 1 card of Hydrocodone ,d+[DATE] - Narcotic sheet says 50 tabs (Count correct signed off destroyed after surveyors counted on [DATE]). 1 Card of 30 Gabapentin 300 mg Narcotic sheet says 30 (Count correct signed off destroyed after surveyors counted on [DATE]). 1 Card hydrocodone ,d+[DATE] mg Narcotic sheet says 8 dispensed, 5 left -(Count correct signed off destroyed after surveyors counted on [DATE]). Zolpidem (Ambien) Narcotic sheet says 30 dispensed- 13 remaining on card -(Count correct signed off destroyed after surveyors counted on [DATE]). 1 Card of 30 Gabapentin 300 mg Narcotic sheet says 10 dispensed 2 remaining on card -(Count correct signed off destroyed after surveyors counted on [DATE]). Policy for Storage of Medications page 2 read: 6. Mechanism to minimize loss / diversion: a. Maintain records for receipt and disposition of all controlled substances. b. Records should provide sufficient detail for accurate reconciliation c. All discrepancies that cannot be resolved must be reported immedicably as follows: i. Notify the DON, charge nurse, or designee and pharmacy. ii. Complete an incident report detailing the discrepancy, steps taken to resolve it and the names of all licensed staff working when the discrepancy was noted. iii. The DON, charge nurse, or designee must also report any loss of controlled substances where theft is suspected to the appropriate authorities such as local law enforcement, Drug Enforcement Agency, State Board of Nursing, State Board of Pharmacy and possible the State Licensure Board for Nursing Home Administration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on observations and staff interviews, the facility staff failed to ensure resources necessary to provide for the needs of the residents who resided on the Memory unit were available. The findings included: On 12/10 through 12/13/24 observations were made from the conference room of the windows of residents who resided on the Memory Unit. Most windows were with broken window blinds which were unsightly and allowed residents and staff to be viewed. 12/12/24 and 12/13/24 observations were made of supplies (soap, paper towels, window coverings, damaged and missing tile or molding) to create a clean and homelike environment for all of the residents who resided on the unit. On 12/12/24 at 11:21 AM observations were made of multiple resident room floors (62, 64, 65, 66, 68, 69 and 71). The floors were discolored, with spills, dirt/debris, and some had molding pulling away from the walls. Multiple rooms (62, 65,66, 68, and 71) were with no blinds or window coverings or severely damaged window blinds. Several resident occupied rooms which faced the activity room allowed persons in the activity room to directly see in the resident's room. Also, on 12/12/24 residents who resided in rooms (62, 64, 65, 66, 68, 69 and 71) had no access to soap and towels at their sink. Strong odors of urine were prominent upon entering the unit, curtains in room [ROOM NUMBER] was observed hanging by zip ties instead of on a curtain rod. Severely warped sinks were observed in rooms (62, 64, and 65). In room [ROOM NUMBER] a receptacle box was pulling away from the wall at the head of the bed and the heating unit receptacle box was damaged. An interview was conducted with the Administrator on 12/13/24 at approximately 11:40 AM. The Administrator stated the administrative staff performed facility rounds routinely and presented the findings to the administrative team during their meeting. On 12/13/24 at approximately 2:50 P.M., a final interview was conducted with the Administrator, Director of Nursing, and three Corporate Nurse Consultants. The above information was conveyed to the present administrative staff, they all looked at each other but voiced no comments regarding the above findings.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility failed to employ a full time professional necessary to carry out the provisions of a licensed or certified Social worker in a 220 bed facility impacting resident care to all residents including 1 Resident (Resident #226) in a survey sample of 74 Residents. The findings included: For Resident #226, who refused a transfer to the locked memory care unit (for Residents with dementia and behaviors), the facility staff failed to honor the Resident's request. The staff moved him against his will, and did not afford him the services of a Social worker to plan care and discharge, per his wishes. He was involuntarily secluded. Resident #226 was admitted to the facility on [DATE] with diagnoses including: End stage renal disease with hemodialysis, history of stroke, anemia, chronic congestive heart failure, hypertension, and diabetes type 2. The Resident did not have a diagnosis of dementia and was his own responsible party and by facility agreement cognitively intact and able to make his own decisions. On 9-26-24 at 4:42 PM the Resident was moved to the memory care locked unit and the Resident's son was notified according to the room change notification document in the clinical record, however, the document stated that the Resident's brother agreed to the room change even though these individuals were only emergency contacts and the Resident refused and was his own responsible party. The reason given for the move, was elopement risk. The Resident had never eloped and on the one occasion that he went outside to sit in the sun after dialysis he did not leave, even though he could have walked away, he simply sat there until staff came to take him back to his room. When asked about this incident the Resident stated there is no reason that I can't sit outside for awhile and get some fresh air. I am not a prisoner. During an initial interview on 12-10-24, at 11:40 AM, Resident #226 was found to be alert and oriented to person, place, time, and situation. He stated that he had requested to stay in his current room after learning that the facility planned to move him rather than discharge him home. Resident #226 stated he was told his son and grandson were not able or willing to care for him in the home that the three of them had formerly shared. The Resident insisted on planning a discharge back to the community, or an assisted Living Facility as soon as possible, however, he stated no one listened, no one came to talk to me about it, and nothing ever happened even though I kept telling them. During this interview, Resident #226 verbalized that he is a dialysis patient and that he received dialysis there in the facility. (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	He further stated he hates the memory care unit because everyone is crazy in here, they wander into my room and take things, my room mate yells and crys all night for something to drink, I don't even get food every meal, the room is nasty and falling apart, and I can't even get a shower in here because the showers are so nasty dirty. He went on to say I like to walk around, it makes the time go faster, if I don't walk now I won't be able to leave, but locked in here I have no where to walk, I don't even have a TV to watch and I love TV, being in here will make you crazy with nothing to do. The Residents had no television, no clock, no telephone, no radio and the room had no personal items in it nor on the walls. Resident #226 had no shoes, no coat, 2 pairs of pants, and 2 shirts (the Resident was wearing one of each). When asked about his clothing he stated I had more, but they have been stolen. It is notable to mention that no activities were noted to be conducted in the secured unit from 12-10-24 until 12-18-24. The staff were asked why no activities were being conducted for the residents and they replied that we only have one activity person for the whole facility. Facility CNA (Certified nursing Assistant) and LPN (Licensed Practical Nurse) staff on the memory care unit and other units were interviewed, and stated the reason that Resident #226 had been placed on the memory unit was wandering and behaviors When asked what his behaviors were, they were only able to say he went outside and sat in his wheel chair one time after dialysis, and further stated he would wander up and down the halls and that will get you put in here for sure. The surveyor asked why he walked, and there was no response. The Social worker was interviewed on 12-10-24 and revealed that she had just been hired on 11-19-24. The former Social worker resigned on 6-28-24, and there had been no social worker in the facility from 6-28-24 until 11-19-24. She stated she would be putting in a progress note for Resident #226 on this same day, and she stated that she didn't really know much about him. On 12-11-24 the social work note was reviewed and revealed a progress note that documented the Resident as long term care during a care planning meeting, and nothing about discharge planning or his desire to be discharged . On 12-12-24 the Social worker's license and curriculum vitae were requested for verification and vetting as part of the employee records review for competency of staff. It was noted that the required course work and degree required by state and federal regulation for this employee was not sufficient for the role. The Director of Nursing and Administrator were asked for a policy or procedural guidance for moving a Resident onto the memory care locked unit. Both stated that they did not have one, and could not describe a pathway to the decision for moving a resident into the secure unit. On 12-11-24, through 12-19-24 a clinical record review was conducted. There was no evidence in the clinical record that the physician had been called and notified of the Resident's move, nor was a request made for assessment and told that the Resident wished to discharge. (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12-5-24 a PHQ-9 (the only one during his stay) evaluation for depression was conducted and gave a score of 3 which equaled minimal or not at all suffering from depression. The Resident was not ordered to have any psychoactive medications, nor did he have any diagnoses to support the use of them. On 12-12-24, during a meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the lack of Social Work services for 5.5 months which continued through survey, and that the Resident had requested to stay in his room, and to be planned for discharge. The discharge request was ignored. Further they were notified that no Social Worker was providing care during the Resident's stay which compounded the incident further, which culminated in the withholding of a resident's rights, and involuntary seclusion. On 12-19-24, prior to the survey exit the Director of Nursing informed surveyors that Resident #226 and his room mate had been moved back onto regular units last night (12-18-24). At the time of survey exit on 12-19-24 the facility Administrator, and Director of Nursing stated they had nothing further to provide.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 49917 Based on staff interviews, the facility staff failed to obtain agreements for dental services and audiology services. The findings included: On 12/18/24 at 1:20 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that the facility does not have written agreements for dental services and audiology services. The ADON also stated that if a resident requires dental services, the facility will make an appointment with a dentist the resident requests or recommends. On 12/19/24 at approximately 6:25 p.m., a final interview was conducted with the Regional [NAME] President of Operations, Administrator, Regional Nursing Consultant, Regional MDS Consultant, Director of Nursing, Assistant Director of Nursing, and Owner. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain accurate and readily accessible medical records for one (1) resident (Resident # 327) in a sample size of 74 residents. The findings included: For Resident # 327, the Social Worker did not document social services notes in the clinical record regarding details of a grievance that was filed on [DATE]. Resident # 327 was a [AGE] year old admitted to the facility on [DATE], with diagnoses that included but were not limited to: Asthma, emphysema, Pulmonary Fibrosis, Seizure disorder, Chronic anxiety and depression, Hypothyroidism and Gastroesophageal reflux disease, history of Pulmonary Embolism, orthostatic hypotension and chronic hypoxic respiratory failure-on oxygen at 4 liters per minute via nasal cannula, Congestive Heart Failure. Cerebral Vascular Accident. The most recent MDS (Minimum Data Set) assessment was coded as an Admission assessment with an ARD (Assessment Reference Date) of [DATE]. The BIMS (brief interview for mental status) assessment was coded as 15 out of possible 15, indicating no cognitive impairment. The assessment also coded Resident # 327 as requiring assistance with activities of daily living; and frequently incontinent of bowel and always incontinent of bladder. The resident was readmitted to the facility on [DATE] and expired in the facility on [DATE]. Review of the clinical record was conducted on [DATE] to [DATE]. For Resident # 327, the Social Worker did not document Social Services notes in the clinical record regarding details of a grievance that was filed on [DATE]. The note specifically stated the resident requested to be transferred to another facility and that a grievance had been completed. The note stated information was faxed to two facilities per the resident's request. There was no follow up documentation noted in the clinical record. The facility Administrator was asked to provide copies of grievances for [DATE]. The Administrator stated she did not know if she could find any grievances for that time period. She stated she was hired in March of 2024 and had no knowledge about a grievance for Resident # 327. She stated she recognized the resident's name due to another admission to the facility in June of 2024 until [DATE]. The clinical record was reviewed and revealed no social worker notes were written regarding documentation of a grievance completed on [DATE]. Further review of the Progress Notes revealed documentation by the nursing staff on [DATE] that Resident # 327 requested a room change. There were no details regarding a reason for the request. Nor was there any documentation of any follow up. (continued on next page)

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Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at approximately 11:40 AM, an interview with the Social Worker (Administration # 4) was conducted. When asked about the social services process for grievances, the Social Worker stated all residents have the right to file grievances and that they should be documented. She stated the residents and their responsible parties were informed of the grievance policies upon admission. When asked if she was familiar with Resident #327, she stated, Yes. The Social Worker stated she reviewed the clinical record and saw the note about a grievance that was filed on [DATE]. The Social Worker stated she did not remember what the grievance was about. She stated she checked the files in her office and could not find anything regarding the grievance. The Social Worker stated she typically would complete the Grievance form and give it to the Administrator for review and signature. She stated the Administrator would sign off and return the form. The Social Worker stated she did not see any records of the grievance and did not know what happened to it. She stated she remembered assisting Resident # 327 with securing utilities at her home prior to discharge in [DATE] based on her notes but did not remember anything else. When asked about the process for documenting Social Services information, she stated she normally would document issues in the electronic health record but would document grievances on paper to be kept it in her office. When asked if the information in the grievance was considered part of the clinical record, she stated, Yes. When asked why it was important to put social services notes in the hard chart as part of the clinical record, the Social Worker stated, It would allow staff members to follow up on the issues or grievance. A copy of social services grievance policy was requested. Review of the facility documentation revealed grievances for [DATE]. However, none were listed for Resident # 327. On [DATE] during the end of day debriefing, the Facility Administrator and Director of Nursing were informed of the findings. The Administrator and Director of Nursing stated they had no knowledge of the grievance filed on [DATE] but that there should have been documentation. No further information was provided.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on Observation, staff interview, clinical record review, and facility document review the facility staff failed to provide services for two Residents receiving hospice care (Resident #117, and #78) in a survey sample of 74 Residents. The findings included; 1. For Resident #117, The facility staff failed to provide the following federally required areas for a Resident receiving hospice care; Provision of MDS assessments timely, and accurate. Provision of timely ADL care. Provision of a comprehensive care plan for services. Provision of medication regimen reviews. Provision of social work. Provision of a hospice communication process. Provision of nutritional support. Resident #117 was originally admitted to the facility on [DATE], and was hospitalized 10 days later on [DATE] for a colonic hemorrhage caused by a Stercoral ulcer (impacted hard stool at the anus and distal rectum) which pierced the bowel wall, after having had no bowel movements. The ulcer/perforation of the bowel wall resulted in blood loss requiring 2 blood transfusions according to hospital records. The Resident was again sent out to the hospital on [DATE] through [DATE] for a severe urinary tract infection causing sepsis and septic shock, and acute kidney injury which was reversed successfully in the hospital with IV (intravenous) fluids for dehydration and IV antibiotics. Resident #117 had a medical diagnosis history including; Congestive heart failure with diuretic use, unspecified dementia without behaviors, hypertension, depression, anxiety, dysphagia, gastro-esophageal reflux disease, and cardiac disease. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #117's most recent Minimum Data Set (MDS) assessment was a Significant change assessment with an assessment reference date of [DATE]. Resident #117 had a Brief Interview of Mental Status score of 99 indicating severe cognitive impairment. He was dependant on staff for eating, bathing and personal hygiene. He was coded to have no skin impairment, and at risk for skin impairment. He was coded with no weight loss (which was incorrect), a weight of 123 pounds, no swallowing difficulty, and having a mechanically altered diet. The document denotes hospice care, however, the question of life expectancy being less than 6 months was documented as no. The only previous MDS assessment to the [DATE] MDS was dated [DATE], and was the Resident's admission assessment. This MDS had not been signed as completed until [DATE], and submitted late. The document revealed the Resident's weight at that time to be 139 pounds. This indicated a greater than 10% weight loss in the previous 2 months. It is notable to mention that the Resident was admitted with a weight of 145.3 pounds on [DATE]. This revealed a significant weight loss of 22.3 pounds since admission, equaling a greater weight loss than 15% in the 3 month period from admission to the current survey which was well documented in the clinical record. Before hospitalization and after hospitalization the Resident's diet remained the same. Regular diet, Dysphagia pureed texture, thin consistency. On [DATE] mighty shakes 4 ounces was ordered at bedtime for a supplement. No other diet changes nor supplements were ever ordered during the Resident's stay. The Resident was observed during initial tour of the facility on [DATE] immediately following a shower room observation with Resident #117's room mate. The room tour included but was not limited to the following being observed; A urine soaked bathroom, a pervasive smell of urine and feces in the room and on the entire unit. The floor of the room was sticky and made a sucking sound as one walked across it, and the base board was peeling and drooping over in places. The floor was crusted with crumbs, brown debris, and black particles. The bed divider curtain had brown stains and smeared feces on it. Resident #117 was in bed covered with only a bed sheet with no blanket and wore no clothing nor gown, and only an incontinence brief under the bed sheet. The fitted bed sheet under the Resident had a yellow halo around the Resident which appeared to be dried urine with a strong odor. The Residents incontinence brief was obviously soaked with urine and wrinkled down at the waist with the heaviness of the liquid it contained. The Residents hair was matted to his head, greasy, dandruff lay in his bed and on his pillow, and body odor/sweat could be clearly smelled. During the entire survey Resident #117 was never observed during the day shift out of bed, and asked the surveyors often for something to drink stating Please, Please bring me some water I'm so thirsty. The Residents lips were noted to be cracked and dry, and his eyes were sunken. His skin was flaking and dry and when the skin on his hand was examined it tented when pulled gently in an upward fashion and stayed that way. His mucus membranes were sticky and when he spoke his lips would stick together with thick saliva briefly. He constantly complained my butt hurts, my butt hurts. Staff were made aware that the Resident was thirsty, and complaining of butt pain. Staff stated they would have the NP look at him. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] the Resident was assessed by the Registered Nurse Practitioner (NP) and found to have a stage 3 sacral pressure sore. Each day of survey the Resident was visited and observed to be in bed lying on his back or right side facing the window. No support devices and repositioning was ever observed. The Residents had no television, no clock, no telephone, no radio and the room had no personal items in it nor on the walls. Each room on the unit was then inspected by all surveyors and found to be in the same condition as Resident #117's room. There were no televisions in any room, and no water to drink in any room. Staff on the memory care unit were interviewed and asked why Resident #117 was not clean, they stated well, he refuses a lot, and (name) Resident #117 is hospice now and doesn't like to be moved much. Staff were taken to the Residents' room and #117 was asked if he would like a shower or bath, and he simply shook his head yes. ADL (activities of daily living) care records were reviewed for Resident #117 and revealed that the Resident was totally dependant on one staff member. The document indicated that a bath was given every morning, however, the Resident was observed every day during survey and found to be dirty and unkempt with flaking skin, dandruff, greasy hair, and in a soiled bed with soiled linens. At times the Resident was found wearing only an incontinence brief, and at other times wearing a white stained T-shirt and also an incontinence brief. The Resident was never seen out of bed during daytime hours for the entire survey. On [DATE] A Certified Nursing Assistant (CNA) was found in the hallway after Resident #117 was found begging for water. The CNA brought in 120 milliliters of tea for the Resident, and was again told he asked for water. She stated oh he just wants to drink, not eat. The CNA was asked if she was aware that the caffeine in tea was a diuretic and could further dehydrate the Resident. She did not respond. On [DATE] the Kitchen manager was interviewed and stated that they did not keep track of percentages of meals and fluids consumed, and stated that the nursing staff were responsible for that. She was asked if she had decaffeinated tea on hand, and she stated she had decaf coffee but not tea. On [DATE] A CNA was interviewed and stated, he (Resident #117) went out to the hospital with altered mental status, low blood pressure, dehydration and a UTI (urinary tract infection), and when he came back he went on hospice. He's been in bed now since then. The Resident had actually returned on [DATE], and was not placed on hospice until [DATE] (one month later). The CNA was asked for his hospice notes, and she went to the LPN (Licensed Practical Nurse) unit manager with the surveyor accompanying her and asked for the notes. The LPN stated I will look for them, and later stated I don't have any. The entire clinical record was reviewed and no hospice notes were in the clinical record. Staff were then asked if hard copy notes could be located in a binder, and they stated they had no such binder. There was an observed notice taped to the Resident's closet door from the new social worker addressed to the hospice staff. The document instructed that the Resident's hospice supplies had been found in the general supply closet in the facility with normal inventory. The document instructed hospice staff to inform the nurses on the unit when hospice supplies were brought in for the Resident. It appeared that the facility staff and hospice staff were not communicating. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] from 11:30 AM until 1:00 PM a second surveyor was observing lunch service on the memory care secured unit until the meal was finished. Resident #117 was never fed, and his tray was removed from his room. The tray was placed back on the tray cart to return to the kitchen for disposal, untouched. The CNA was asked why he was not fed, and she replied oh he's hospice he don't want it. The Resident received no food, and no fluids from 9:00 AM breakfast to 5:00 PM dinner (8 hours). No water was in any Resident room on the secured unit during the entire survey. Resident #117's clinical record was reviewed. Weight documents all completed by chair scale revealed the following; [DATE] - 145.3 pounds on admission. [DATE] - 143.0 pounds out to hospital on [DATE] with bleeding, returned [DATE]. [DATE] - 139.0 pounds [DATE] - 139.0 pounds [DATE] - 123.0 pounds [DATE] - 122.6 pounds No further weights were being recorded as staff stated well, he's hospice now, so no need really. The Resident was not placed on hospice until [DATE], (2 weeks later with no weights completed) and remained a Full Code CPR status. The Registered Dietician (RD) was called via cellular phone for interview and was unable to be contacted. A message was left on voicemail, however, surveyors received no call back. No RD notes were found in the clinical record, however, on [DATE] at 12:11 PM, the Administrator and Director of Nursing (DON) supplied the only note they had received from the RD dated [DATE] (8 days after returning from the hospital with sepsis and dehydration). The RD note was reviewed and revealed continued weight loss and the following 4 recommendations, none of which were followed: 1. Consider benefit of appetite stimulant medication due to poor oral intake. 2. when poor oral intake less than 50% offer alternate meal options. 3. weekly weights for one month due to readmit. 4. RD to monitor for significant changes in weight poor oral intake or skin integrity and follow up as needed. Staff were interviewed on [DATE] and asked what interventions could be offered to a Resident to prevent significant weight loss. The Director of Nursing (DON) provided two policies on Nutritional Management, and Weight Monitoring that documented the following; (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Nutritional Management. Nutritional Status includes both nutrition and hydration status. The document describes a systematic approach to optimize a Resident's nutritional status. Staff are to identify risk factors, evaluate and analyze assessment information, develop and consistently implement approaches, and monitor the effectiveness of interventions and to revise interventions as necessary which would be reflected in the Resident's plan of care. The document goes on to describe that a comprehensive assessment will be completed by the Registered Dietician (RD) within 72 hours of a change in condition to include persistent hunger, poor intake, or continued weight loss, or evidence of fluid loss. One intervention included diet liberalization, and feeding assistance. 2. Weight Monitoring. Significant unintended changes in weight (loss or gain) .may indicate a nutritional problem. A comprehensive nutritional assessment, The Nutritional Data Collection Tool will be completed and that information would identify risk which would then drive the care planning process development to include; Identified causes of impaired nutritional status, reflect the Resident's personal goals and preferences, identify resident specific interventions, time frame and parameters for monitoring, be updated as needed during Resident's condition changes, interventions are ineffective, or new problems are identified, and be conducted as per professional standards. Residents with weight loss monitor weights weekly. Documentation will include notification of physician, if significant weight loss is identified the RD should be consulted to assist the interdisciplinary (IDT) care plan team with interventions who could initiate the care planning process, as well as the nursing department may initiate the care planning process. The IDT communicates care instructions to staff. On [DATE] the NP documented on a Wound Assessment Report location sacrum, 14 centimeter (cm) length x width total measurement of the wound, 0.1 cm deep date acquired [DATE] in house, wound status new, stage/severity Full Thickness, 20% granulation, 80% slough, Erythema peri wound (red and inflamed), exposed tissue Epithelium, Dermis. Treatment daily and as needed cleanse with wound cleanser, hydrogel primary treatment, dressing bordered gauze. The DON was asked if Foley catheters to keep skin dry and for intake and output assessments were available, and she stated yes. She was asked if formal protein supplements, fluids, diet changes, and moisture barrier creams, and positioning devices were available for Resident's with known significant weight loss and wounds and she stated yes. She was asked if she was aware that the mattress for Resident #117 was the same as the ones used for the ambulatory residents on the memory care unit, and she stated she was not aware of that. None of the above prevention strategies were afforded Resident #117 for prevention of further significant weight loss and the pressure sore indicating this ulcer was potentially avoidable. On [DATE] a redistribution air mattress was ordered for the Resident, however did not arrive until after his move to another unit on [DATE]. On [DATE] Review and copy of Physician's orders revealed only 1 order for weight management; 1. Mighty shake 4 ounces at bedtime was ordered by the physician on [DATE] after the Resident returned from the hospital after experiencing dehydration and sepsis. Mighty Shakes nutrition facts included; Only 220 calories per each 4 ounces which equals approximately 2 tablespoons of peanut butter which would contain 8 grams of protein whereas the mighty shake only had 6 grams. The Might Shake was not given on the following nights, with no reason documented as to why it was withheld; October - [DATE], [DATE]. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	November - [DATE], [DATE], [DATE], [DATE]. December - [DATE], [DATE], [DATE]. For Resident #117, the pharmacist recommendations were either not obtained, or not acted upon, and none were in the clinical record in 2 of the preceding 3 months of survey (September, and [DATE]). Resident #117's clinical record was reviewed and for the last 3 months prior to survey (September through November), as December had not yet been completed, The Registered Pharmacist (RPH) Monthly Medication Regimen Reviews (MMR) were reviewed. Resident #117 was receiving anticoagulants, blood pressure medication, psychotropic medication, anti seizure medication, diuretics, pain medication, heart medication, was on a fluid restriction, and had a history of kidney disease, congestive heart failure, bleeding, and dehydration. On [DATE] the Director of Nursing (DON) was interviewed and asked when the MMR's were conducted and how they were conducted. She stated that the RPH reviewed a percentage of the Resident's medications every month. When asked what that percentage was, she stated I will have to check, I am not sure how many they do every month. She was asked if irregularities occurred how the staff would be made aware of that, and again she stated I'm not sure, I don't get that, I will have to find out. On [DATE] the DON and Administrator returned with the Monthly Reviews and revealed that not all Residents were being reviewed monthly. The reviews also revealed that the physician had not been notified of those residents with recommendations for changes, which would have required a documented explanation by the physician of what their decision was in regard to the RPH recommendations for each resident listed. The DON and Corporate RN consultant stated that the recommendations had not been printed from the system where the RHP had documented them and so were not made available to the physician to act upon timely. They stated that the procedure had some cracks in it and that the DON would now be responsible to track this for 100% of the Residents monthly and that she would make sure the physician (MD) received these recommendations and acted upon them. The MMR reviews were as follows; [DATE] - Resident #117 - Not evaluated by the RPH. [DATE] - Resident #117 - Recommendation for psychoactive medication Geodon. Not acted on by MD. [DATE] - Resident #117 - Resident reviewed with no new recommendations. The Care plan was reviewed and included focuses, goals and interventions for the following 4 areas (1. weight loss, 2. Pressure sores, 3. Hospice, 4. ADL care); 1. (Weight loss), Malnutrition Risk related to history of rectal bleed constipation created on [DATE] with a goal to be free of significant weight changes through review date of [DATE]. A new care plan revision entry was created on [DATE], however, none of the interventions were ever changed, and none were added even after significant weight loss continued and a supplement was ordered on [DATE]. The care plan identified only the following (5) interventions, and never identified significant weight loss, only intake documentation and diet type were followed; (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1). Administer medications as ordered, observe for side effects and effectiveness alert MD (doctor) as needed. (2). Provide, serve diet as ordered. Monitor intake and record every meal. (3). RD to evaluate and make diet change recommendations as needed. (4). Receives a mechanical soft pureed diet, related to diagnosis. (5). weight per facility protocol/MD order. 2. (Pressure sores), The Resident has actual impairment to skin integrity created on [DATE] with a goal to have no complications related to skin impairment through the review date of [DATE]. The Care plan was reviewed and included focuses, goals and interventions for potential for pressure ulcer development created on [DATE] related to Dementia and bowel and bladder incontinence. A new care plan entry was created on [DATE] which identified the first actual impairment to skin integrity with interventions for the (3) following items; No treatments were ever specified. (1). Follow facility protocols for treatment of injury. (2). Use caution during transfers and bed mobility to prevent striking arms, legs, and hands to avoid striking any sharp or hard surface. (3). Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, and any other notable changes or observations. 3. Hospice, (Resident name) is receiving hospice services from (name of company) and phone number, created on [DATE] with a goal of (Resident name) needs will be met through the next review period [DATE]. Interventions were for the following (2) items. No specific care was specified to be given by the hospice agency, nor by the facility to direct staff in the care required to be performed by each participant, and no collaboration/communication was ever documented between the 2 care givers. (1). Collaborate with all disciplines, family, Hospice to meet (Resident name) needs. (2). (Resident name) will be made comfortable. 4. ADL Care, Has bladder incontinence related to dementia, unsteady gait, diuretic use created on [DATE], with a goal of The Resident will remain free of skin breakdown due to incontinence through the review date [DATE]. Interventions were for the following (4) items. The Resident was also incontinent of bowel, fluids were not encouraged leading to dehydration, bowel impaction, and hospitalization . The Resident was non-ambulatory, and only diagnostic testing ordered by a physician could be conducted to diagnose the causes of incontinence in the #(4) intervention. (1). Clean peri-area with each incontinence episode. (2). Encourage fluids during the day to promote prompted voiding responses. (3). Ensure the Resident has unobstructed path to the bathroom. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(4). Observe/report as needed any possible causes of incontinence, bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects. The care plan was not Resident specific and did not specify feeding needs, supplements, diet changes, alternate diet changes, nor RD interventions. It did not specify any measures/interventions to be instituted to prevent a pressure sore from forming/worsening, like treatments, positioning devices and moisture barrier creams, or support devices. No treatments were specified for the care of a pressure sore after it developed and was identified at a stage 3. Hospice services were never care planned, and ADL care was never care planned for bathing, feeding, hygiene, and toileting as an interdisciplinary care plan team would be expected to produce. It is also notable to mention that the care plan was not derived by an interdisciplinary team and the only 2 individuals who were present for the most recent care plan update was the LPN (Licensed Practical Nurse) unit manager, and the Social Worker who was found to not have been vetted properly, and had insufficient qualifications for the Role. On [DATE] at 11:15 a.m., the Administrator, Director of Nursing, and Corporate Nurse were notified that the care planning for Resident #117 was insufficient to inform and drive care, was not interdisciplinary, and was not comprehensive per diagnosis and need of the Resident. The facility Administrator and staff were further notified that no hospice care plan was derived for this Resident to indicate what services would be provided by the facility and or by the hospice company for the long list of needs for this Resident, nor was communication between hospice and facility staff occurring. The facility staff was given the opportunity to provide any further information or explanation. They stated they had no further information to provide. On [DATE], prior to the survey exit the Director of Nursing informed surveyors that Resident #117 had been moved from the secure unit back onto a regular unit last night ([DATE]). At the time of survey exit on [DATE] the facility Administrator, and Director of Nursing stated they had nothing further to provide. 40026 2. For Resident #78 the facility staff failed to include the Hospice Nurses notes and the Hospice CNA notes in the clinical record. On [DATE] a review of the clinical record revealed that Resident #78 was admitted to the facility on [DATE] with diagnoses that included but were not limited to cognitive communication deficit, dysphagia, muscle weakness, dementia, severe without behavioral disturbance, psychotic mood disturbance and anxiety, abnormalities of gait and mobility, hypertension, hx (history) of renal cancer, and hx of repeated falls. Resident #78 had a BIMS (Brief Interview of Mental Status) score of ,d+[DATE] on admission indicating mild cognitive impairment. On [DATE] (one month prior to falls) Resident #78 BIMS was assessed at ,d+[DATE] indicating severe cognitive impairment. Resident #78 was admitted to Hospice on [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10 a.m. Resident #78 was observed in bed dressed in hospital gown and had an odor of urine. When CNA 3 was asked about her bathing she stated, She will be getting a bath from hospice today. On [DATE] at 12 p.m. a review of the clinical record revealed that there were no weekly visit notes from Hospice in the clinical record. On [DATE] at approximately p.m. an interview was conducted with the DON who was asked how the Hospice nurses communicate with the facility about the care they provide, and she stated they speak with the nurses on the floor. When asked if they document in the Resident chart, she stated that they did not have access to the Resident chart, but they documented on Hospice charts and were scanned into the Resident chart at the facility. When the DON was asked to show this documentation in the electronic health record, she also could not find it. When asked how the physicians and nurses at the facility would know what care was provided if they did not have access to the notes, she stated that she was unaware they did not have access to the notes and that they had not been scanned in the chart. When asked if it was important to have that information, she stated that it was. On the morning of [DATE] a review of the clinical record revealed that the facility had scanned in over 30 documents related to Hospice care provided to Resident #78. On [DATE] during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility failed to maintain a qualified Social Worker in a 220 bed facility resulting in a Substandard Level of Care impacting resident care to all residents including 1 Resident (Resident #226) in a survey sample of 74 Residents. The findings included: For Resident #226, who refused a transfer to the locked memory care unit (for Residents with dementia and behaviors), the facility staff failed to honor the Resident's request. The staff moved him against his will, and did not afford him the services of a Social worker to plan care and discharge, per his wishes. Resident #226 was admitted to the facility on [DATE] with diagnoses including: End stage renal disease with hemodialysis, history of stroke, anemia, chronic congestive heart failure, hypertension, and diabetes type 2. The Resident did not have a diagnosis of dementia and was his own responsible party and by facility agreement cognitively intact and able to make his own decisions. On 9-26-24 at 4:42 PM the Resident was moved to the memory care locked unit and the Resident's son was notified according to the room change notification document in the clinical record, however, the document stated that the Resident's brother agreed to the room change even though these individuals were emergency contacts and the Resident refused and was his own responsible party. The reason given for the move, was elopement risk. The Resident had never eloped and on the one occasion that he went outside to sit in the sun after dialysis he did not leave, even though he could have walked away, he simply sat there until staff came to take him back to his room. When asked about this incident the Resident stated there is no reason that I can't sit outside for awhile and get some fresh air. I am not a prisoner. During an initial interview on 12-10-24, at 11:40 AM, Resident #226 was found to be alert and oriented to person, place, time, and situation. He stated that he had requested to stay in his current room after learning that the facility planned to move him rather than discharge him home. Resident #226 stated he was told his son and grandson were not able or willing to care for him in the home that the three of them had formerly shared. The Resident insisted on planning a discharge back to the community, or an assisted Living Facility as soon as possible, however, he stated no one listened, no one came to talk to me about it, and nothing ever happened even though I kept telling them. During this interview, Resident #226 verbalized that he is a dialysis patient and that he received dialysis there in the facility. (continued on next page)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	He further stated he hates the memory care unit because everyone is crazy in here, they wander into my room and take things, my room mate yells and crys all night for something to drink, I don't even get food every meal, the room is nasty and falling apart, and I can't even get a shower in here because the showers are so nasty dirty. He went on to say I like to walk around, it makes the time go faster, if I don't walk now I won't be able to leave, but locked in here I have no where to walk, I don't even have a TV to watch and I love TV, being in here will make you crazy with nothing to do. The Residents had no television, no clock, no telephone, no radio and the room had no personal items in it nor on the walls. Resident #226 had no shoes, no coat, 2 pairs of pants, and 2 shirts (the Resident was wearing one of each). When asked about his clothing he stated I had more, but they have been stolen. It is notable to mention that no activities were noted to be conducted in the secured unit from 12-10-24 until 12-18-24. The staff were asked why no activities were being conducted for the residents and they replied that we only have one activity person for the whole facility. Facility CNA (Certified nursing Assistant) and LPN (Licensed Practical Nurse) staff on the memory care unit and other units were interviewed, and stated the reason that Resident #226 had been placed on the memory unit was wandering and behaviors When asked what his behaviors were, they were only able to say he went outside and sat in his wheel chair one time after dialysis, and further stated he would wander up and down the halls and that will get you put in here for sure. The surveyor asked why he walked, and there was no response. The Social worker was interviewed on 12-10-24 and revealed that she had just been hired on 11-19-24. The former Social worker resigned on 6-28-24, and there had been no social worker in the facility from 6-28-24 until 11-19-24. She stated she would be putting in a progress note for Resident #226 on this same day, and she stated that she didn't really know much about him. On 12-11-24 the social work note was reviewed and revealed a progress note that documented the Resident as long term care during a care planning meeting, and nothing about discharge planning or his desire to be discharged . On 12-12-24 the Social worker's license and curriculum vitae were requested for verification and vetting as part of the employee records review for competency of staff. It was noted that the required course work and degree required by state and federal regulation for this employee was not sufficient for the role. The Director of Nursing and Administrator were asked for a policy or procedural guidance for moving a Resident onto the memory care locked unit. Both stated that they did not have one, and could not describe a pathway to the decision for moving a resident into the secure unit. On 12-11-24, through 12-19-24 a clinical record review was conducted. There was no evidence in the clinical record that the physician had been called and notified of the Resident's move, nor was a request made for assessment and told that the Resident wished to discharge. (continued on next page)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12-5-24 a PHQ-9 (the only one during his stay) evaluation for depression was conducted and gave a score of 3 which equaled minimal or not at all suffering from depression. The Resident was not ordered to have any psychoactive medications, nor did he have any diagnoses to support the use of them. On 12-12-24, during a meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the lack of Social Work services for 5.5 months which continued through survey, and that the Resident had requested to stay in his room, and to be planned for discharge. The discharge request was ignored. Further they were notified that no Social Worker was providing care during the Resident's stay which compounded the incident further, which culminated in the withholding of a resident's rights, and involuntary seclusion. On 12-19-24, prior to the survey exit the Director of Nursing informed surveyors that Resident #226 and his room mate had been moved back onto regular units last night (12-18-24). At the time of survey exit on 12-19-24 the facility Administrator, and Director of Nursing stated they had nothing further to provide.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility staff failed to implement an infection prevention and control program to include environmental concerns for 4 of 4 nursing units to include the entire locked memory care unit and the direct care of four Residents (Resident #226, #117, #105, and #87) in a survey sample of 74 Residents. The findings included: 1. For Resident #226, the entire memory care unit was dirty, in disrepair, had bodily fluids on surfaces, and there were no paper towels nor soap to wash staff hands in any resident room. 2. For Resident #117, the entire memory care unit was dirty, in disrepair, had bodily fluids on surfaces, and there were no paper towels nor soap to wash staff hands in any resident room. 1. Resident #226 was admitted to the facility on [DATE] with diagnoses including: End stage renal disease with hemodialysis, history of stroke, anemia, chronic congestive heart failure, hypertension, and diabetes type 2. The Resident did not have a diagnosis of dementia and was his own responsible party and by facility agreement cognitively intact and able to make his own decisions. The Resident had a room mate, Resident #117. 2. Resident #117 was admitted to the facility on [DATE] with diagnoses including: Dementia without behavioral disturbance, hypertension, major recurrent depression. dysphagia, chronic kidney disease, cardiac disease, malignant cancer of nasal cavity, and congestive heart failure. The Resident had a room mate, Resident #226. During an initial interview on 12-10-24, at 11:40 AM, Resident #226 was found to be alert and oriented to person, place, time, and situation. He stated that he had requested to stay in his current room after learning that the facility planned to move him rather than discharge him home. During this interview, Resident #226 verbalized that he is a dialysis patient and that he received dialysis there in the facility. He further stated he hates the memory care unit because everyone is crazy in here, they wander into my room and take things, my room mate yells and cries all night for something to drink, I don't even get food every meal, the room is nasty and falling apart, and I can't even get a shower in here because the showers are so nasty dirty. He went on to say I like to walk around, it makes the time go faster, if I don't walk now I won't be able to leave, but locked in here I have no where to walk, I don't even have a TV to watch and I love TV, being in here will make you crazy with nothing to do. The surveyor and Resident then immediately walked to the shower room for an initial observation and found it to be dirty, mildewed/moldy, foul smelling, had a strong odor of urine and feces, trash and debris littered the floor, used brown stained wet linens were on the floor, a white crusted substance was on the floor and walls, used soap and shampoo bottles were crusted on the shelves and hand rails in the shower, and the room was being used as a storage area as well for boxes of supplies and durable medical equipment. The Resident asked would you want to take a shower in here? (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Immediately following the shower room observation the Resident's room was examined. The Resident's room was shared with a second Resident. The room tour included but was not limited to the following being observed; broken vinyl window blinds, no curtains, a urine soaked bathroom, a pervasive smell of urine and feces in the room and on the entire unit. The free standing broken armoire closets in the rooms were swollen and splitting, with rotten splinters and chunks of disintegrating wood and wood particles all over the Residents few items in the closet, and in the rooms. The sink vinyl laminate countertop area was water damaged and swollen and separated revealing particle board disintegration with the sink partially separated from the wall in a downward unstable dropped position, and wood dust everywhere. Under the sink a cabinet door was ajar as it would not close because of the downward sloping sink, and the inside compartment was an open hole with what appeared to be a black concrete floor. Inside was found mildew, mold, trash, a pair of urine stained white tennis shoes, and 2 shirts that were stuck together with an unknown substance, all thrown in onto the floor. The floor of the room was sticky and made a sucking sound as one walked across it, and the base board was peeling and drooping over in places. The floor was crusted with crumbs, brown debris, and black particles. The bed divider curtain had brown stains and smeared feces on it. The PTAC (air conditioning wall unit) was not secured and had fallen forward into the room approximately 12 inches revealing light around it and cold air coming into the room from the outside of the building. The front cover of the unit was also missing and the sharp metal grill was exposed. The Resident's room mate's bed (#117) was pushed against the PTAC holding it in place so it would not completely fall out of the hole in the outside facing wall. The Residents had no television, no clock, no telephone, no radio and the room had no personal items in it nor on the walls. Resident #226 had no shoes, no coat, 2 pairs of pants, and 2 shirts (the Resident was wearing one of each). When asked about his clothing he stated I had more, but they have been stolen. Each room on the unit was then inspected by all surveyors and found to be in the same condition as Resident #226's room. There were no televisions in any room, and no water to drink in any room. There was also noted in the hallway the air conditioning main vent in the ceiling and air return on the wall were so dusty that they had the appearance of brown fur coating them. The walls were marked and smeared and had paint scraped off in places. There was no soap nor paper towels in the Resident rooms for hand washing of staff or Residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12-13-24 the Director of Maintenance and Director of Environmental Services (house keeping) were interviewed and agreed that staffing for the 2 departments had been tight. Environmental services had 13 total employees. That number was responsible for house keeping, laundry and floor machine technicians. This number culminated in daily staffing dispersal of 3 staff in laundry, and 1 floor tech, which left 1 housekeeper on each of the 4 nursing units, and 1 housekeeper in common areas such as dining rooms on each unit, the main kitchen, activities, offices, therapy, bathrooms, conference rooms, the dialysis center, and main hallways/entrances. The added 4 staff positions would be trade outs for the other staff members days off during a seven day schedule. With 123 resident rooms total each of the nursing units housed approximately 20 to 35 Resident rooms for one house keeper to clean each day in an 8 hour shift allowing for 16 minutes to clean each room. Two of the 3 dryers in the laundry had been broken since June 2024, so linens and privacy curtains and resident personal laundry was not being washed and returned timely even though the staff was washing and drying around the clock. The only working dryer was being operated 24 hours per day. The dirty linen storage on the units was backed up as a result, and creating some of the pervasive urine and feces odors in the facility. Linens, bedding, and privacy curtains were not being changed as often as necessary due to the inability to have enough on hand to change them out more frequently. The maintenance Director stated they were starting to get some priorities taken care of in the facility now as staffing had improved just recently, and he began painting the memory unit and new cabinets began to be installed on 12-13-24. On 12-12-24, and 12-13-24 during a meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns and that the entire memory care unit was not safe, clean and comfortable. On 12-19-24, prior to the survey exit the Director of Nursing informed surveyors that Resident #226 and his room mate had been moved back onto regular units last night (12-18-24). At the time of survey exit on 12-19-24 the facility Administrator, and Director of Nursing stated they had nothing further to provide. 34306 3. The facility's staff failed to have soap and towels available for use in Resident #105's room. Resident #105 was originally admitted to the facility 10/27/23 and he was readmitted [DATE] after an acute care hospital stay. The current diagnoses included a major neurocognitive disorder with Lewy Bodies dementia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/17/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 4 out of a possible 15. This indicated Resident #105's cognitive abilities for daily decision making were severely impaired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident #105's person-centered care plan dated 1024/24 failed to reveal an intervention not to have soap or a towel at the sink for use. On 12/11/24 at approximately 12:10 PM Resident #105 was observed in his room as the lunch meal was being served. At the sink it was identified there was no means of washing the resident's or staff's hands for there was no soap or towels for use. The room across the hall was also observed without soap or towels for use. The staff did not perform hand hygiene for Resident #105 before serving the lunch meal. On 12/13/24 at 12:45 PM, an observation was also made of Resident #105 prior to serving of the lunch meal and after the meal. Again, there were no soap or towels available to be used and the resident had no hand hygiene before or after lunch. On 12/13/24 at 12:55 PM an interview was conducted with Licensed Practical Nurse (LPN) #8. LPN #8 stated Resident #105 does not communicate in English and is unable to wash his own hands therefore the staff provides hygienic services to the resident. On 12/13/24 at approximately 2:50 P.M., a final interview was conducted with the Administrator, Director of Nursing, and three Corporate Nurse Consultants. The above information was conveyed to the administrative staff, they all looked at each other but voiced no comments/concerns regarding the above findings. 40711 4. The facility staff failed to ensure her hands were washed with soap and dried with paper towels before providing Activity of Daily Living (ADL) care for a dependent care Resident. Resident #87 was originally admitted to the facility 03/06/23 and readmitted [DATE] after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Difficulty in walking, not elsewhere classified. The Minimum Data Set (MDS) assessment with discharge assessment reference date (ARD) of 10/20/24 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for short term memory problems as well as severely impaired for daily decision making. In sectionGG(Functional Abilities Goals) the resident was coded as dependent oral hygiene, toileting hygiene, showering/bathing, personal hygiene, requiring set-up eating. The care plan dated 9/20/24 read that Resident #87 has an ADL self-care performance deficit r/t Activity Intolerance, Aggressive Behavior, Confusion, Dementia, Impaired balance and Stroke. The goal was resident will maintain current level of function in ADLs through the review date 10/29/2024. The interventions are the following: Resident requires limited to extensive assistance by 1 staff with bathing/showering and Provide sponge bath when a full bath or shower cannot be tolerated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/19/24 at approximately 11:00 AM., a Full bed bath observation was conducted on Resident #87 with Certified Nursing Assistant (CNA) #14 was observed washing her hands with water and with dripping wet hands she placed them inside of her gloves and began to provide a full bed bath to Resident #87. License Practical Nurse (LPN) #8 was also present. An observation was made of the resident's room, no soap dispenser or paper towels were seen. On 12/19/24 at approximately 11:40 AM., an interview was conducted with CNA #14 concerning Resident #87. CNA #14 said that she was not able to use soap because the rooms don't have soap or paper towels in them. CNA #14 also said that she needs soap and paper towels to wash her hands and the resident hands. About Handwashing: Many diseases and conditions are spread by not washing hands with soap and clean, running water. If soap and water are not readily available, use a hand sanitizer with at least 60% alcohol to clean your hands. Follow these five steps every time. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds. Rinse your hands well under clean, running water. Dry your hands using a clean towel or an air dryer. https://www.cdc.gov/clean-hands/about/index.html On 12/19/24 at approximately 5:55 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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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. 49917 Based on clinical record review and staff interviews, the facility staff failed to administer the influenza vaccine for 1 of 5 residents reviewed for immunization (Resident #34), in a survey sample of 74 Residents. The findings included: Resident #34 was originally admitted to the facility 4/1/16. The current diagnoses included; Alzheimer's Disease with early onset, hyperlipidemia, depression, dysphagia, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/8/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 00 out of a possible 15. This indicated Resident #34's cognitive abilities for daily decision making were severely impaired. The facility's policy on Influenza Vaccination with a revision date of 10/15/2024 was reviewed. The policy stated influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. A review of Resident #34's medical record revealed that the Responsible Party for Resident #34 consented by signature for the influenza vaccine to be administered on the Vaccine Consent Form dated 9/24/24. On 12/17/24 at 11:40 AM the Infection Preventionist (IP) stated that regarding the influenza immunization, Resident #34 has not received this immunization. The IP also stated that this was an oversight, and the consent documentation for the influenza immunization was signed by the responsible party in September of 2024 and this immunization should have been administered by now. On 12/19/24 at approximately 6:25 p.m., a final interview was conducted with the Regional [NAME] President of Operations, Administrator, Regional Nursing Consultant, Regional MDS Consultant, Director of Nursing, Assistant Director of Nursing, and Owner. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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	495150	A. Building B. Wing	12/19/2024

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Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 49917 Based on clinical record review and staff interviews, the facility staff failed to administer the Covid-19 vaccine for 1 of 5 residents reviewed for immunization (Resident #34), in a survey sample of 74 Residents. The findings included: Resident #34 was originally admitted to the facility 4/1/16. The current diagnoses included; Alzheimer's Disease with early onset, hyperlipidemia, depression, dysphagia, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/8/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 00 out of a possible 15. This indicated Resident #34's cognitive abilities for daily decision making were severely impaired. The facility's policy and procedures on Influenza, Pneumococcal and Covid-19 Disease Prevention with a date of May 2022 was reviewed. The policy and procedures stated the resident's medical record includes: Documentation that the resident either received the influenza, pneumococcal and Covid-19 immunization or did not receive it due to medical contraindications or refusal. A review of Resident #34's medical record revealed that the Responsible Party for Resident #34 consented by signature for the Covid-19 vaccine to be administered on the Vaccine Consent Form dated 10/28/24. On 12/17/24 at 11:40 AM the Infection Preventionist (IP) stated that regarding the Covid-19 immunization, Resident #34 has not received this immunization. The IP also stated that this was an oversight, and the consent documentation for the Covid-19 immunization was signed by the responsible party in October of 2024 and this immunization should have been administered by now. On 12/19/24 at approximately 6:25 p.m., a final interview was conducted with the Regional [NAME] President of Operations, Administrator, Regional Nursing Consultant, Regional MDS Consultant, Director of Nursing, Assistant Director of Nursing, and Owner. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure functional, and sanitary environment for the residents, staff and the public. The findings included: For the facility, the facility staff failed to ensure all 3 dryers were operational to ensure Residents had clean personal laundry as well as staff having adequate linens to care for the Resident population. On 12/11/2024 at 3pm a Resident Council meeting was held and in the meeting several Residents mentioned the delay in getting laundry back in a timely manner and the shortage of linens was also mentioned. Excerpts from the Resident council minutes revealed the following: On 8/14/24, 9/26/24, and 10/24/24 - Resident council minutes reflected complaints of needing more linens, (towels, sheets), long turnaround time for getting laundry back from housekeeping, and personal items missing from laundry, as well as unclean bathrooms and shower rooms. On 12/11/24 - Linen carts were observed low of linens such as washcloths and towels as well as sheets. On 12/12/24 at approximately 1:30 p.m. an interview was conducted with Other Employee #7 who was asked about staff cutting towels up to use as wash cloths, he stated that it was not something done or sanctioned by the housekeeping dept. it was the nursing staff who were doing it. When asked why they would do this he stated that there was a shortage of linen due to the dryers being broken. When asked about the dryers and how long they had been broken he stated that they have 3 dryers and 2 have been broken for a couple of months. When asked how they have managed with only 1 dryer he stated that it has not been easy they have been using it all day long. When asked if he was concerned about the possibility of damage to the one remaining dryer due to constant use, and he stated that he was. On 12/13/24 the Administrator was asked to supply the work orders for the dryers. The work orders revealed the following: 5/28/24 - Repair company fixed dryer - Replaced contactor and put covers back in place. Customer provided contactor and connector. All dryers were operational. 6/13/24 - Repair company fixed two of three dryers and made the following recommendation: Found bad connection of power to motor on upper contactor. Cleaned up for temporary fix. Need contactor and wire harness for permanent repair. Recommend replacing all 3 dryers due to age and poor condition. 7/1/24 - Found contact connectors and wire connectors loose/ broken replaced parts listed. Two of three dryers were operational. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/5/24 - Replaced parts listed. for two of the three dryers. No further repair orders were presented. On 12/19/24 the Administrator was made aware of the findings. The Administrator provided a requisition dated 12/10/24 to purchase one new dryer.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 49916 Based on staff interview and facility documentation the facility failed to maintain a training program for all new and existing staff based on the facility's assessment. The findings included: The facility failed to maintain a training program for all new and existing staff. Review of the Staff Education, SNF Clinic and Healthcare Academy training transcripts revealed that not all facility staff had completed all the required training. On 12/19/24 at approximately 6:30 PM, a final interview was conducted with the Administrator, Director of Nursing and the Staff Development Coordinator. They were made aware of the concerns. No additional information was provided.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 49916 Based on staff interview, and facility documentation, the facility failed to ensure that all direct care staff complete mandatory Effective Communication training. The findings included: The facility failed to ensure that all direct care staff complete mandatory Effective Communication training. Review of the Staff Education, SNF Clinic and Healthcare Academy training transcripts revealed that not all direct care staff has documented completion of mandatory Effective Communication training. On 12/18/2024 at approximately 2:40 p.m., an interview was conducted with the Staff Development Coordinator (SDC) who was asked about, direct care staff having completed mandatory Effective Communication training, she stated that training and education is recorded by SNF Clinic and Healthcare Academy, and that files are correct and up to date. On 12/19/24 at approximately 6:30 PM, during the end of day meeting the Administrator, Director of Nursing and Staff Development Coordinator were made aware of the concerns. No further information was provided.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 49916 Based on staff interview, and facility documentation, the facility failed to ensure that all staff members are educated in the rights of the residents and responsibilities of the facility. The findings included: The facility failed to ensure that staff members are educated in the rights of the residents and responsibilities of the facility. Review of the Staff Education, SNF Clinic and Healthcare Academy training transcripts, it was revealed that not all staff reviewed had completed the Resident Rights Training. On 12/18/24 at approximately 2:40 p.m., an interview was conducted with the Staff Development Coordinator (SDC) who was asked about, staff Residents Rights mandatory training, she stated that training and education, is recorded by SNF Clinic and Healthcare Academy and that the files are correct and up to date. On 12/19/24 at approximately 6:30 PM, during the end of day meeting the Administrator, Director of Nursing and Staff Development Coordinator were made aware of the concerns. No further information was provided.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 49916 Based on staff interview and facility documents the facility staff failed to ensure that all staff members were educated regarding the Quality Assurance and Performance Improvement The findings included: Review of the Staff Education, SNF Clinic and Healthcare Academy training transcripts revealed that not all facility staff had completed all the required training for Quality Assurance and Performance Improvement. On 12/19/24 at approximately 6:30 PM, a final interview was conducted with Administrator, Director of Nursing and the Staff Development Coordinator, they were made aware of the concerns. No additional information was provided.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 49916 Based on review of facility documents and staff interview the facility staff failed to ensure that all staff members were educated on Compliance and Ethics. The findings included: Review of the Staff Education, SNF Clinic and Healthcare Academy training transcripts revealed that not all facility staff had completed all the required training for Compliance and Ethics. On 12/19/24 at approximately 6:30 PM, a final interview was conducted with Administrator, Director of Nursing and the Staff Development Coordinator, they were made aware of the concerns. No additional information was provided.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49916 Based on review of facility documents and staff interview the facility staff failed to ensure that all Certified Nurse's Aides (CNA) completed the mandatory twelve (12) hours of education each year. The findings included: Review of the Staff Education, SNF Clinic and Healthcare Academy training transcripts revealed that not all CNAs had completed the mandatory twelve (12) hours of education each year which addressed each CNA's areas of weakness as determined in nurse aides' performance reviews the facility assessment and the special needs of residents as determined by the facility staff. On 12/17/24 at 12:00 PM, an interview was conducted with the Staff Development Coordinator (SDC) regarding CNAs mandatory training. The SDC stated that training and education for most CNAs have been completed, but states that some of the transcripts were lost when the facility switched from Healthcare Academy to SNF Clinic for training transcripts, but that there was an ongoing plan for all CNAs to become compliant with mandatory training. On 12/19/24 at approximately 6:30 PM, a final interview was conducted with Administrator, Director of Nursing and the Staff Development Coordinator, they were made aware of the concerns. No additional information was provided.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 49916 Based on staff interview, and facility documentation, the facility failed to ensure that all staff members had completed mandatory Behavioral Health Training. The findings included: The facility failed to ensure that all staff members had completed the mandatory Behavioral Health Training. Review of the Staff Education, SNF Clinic and Healthcare Academy training transcripts revealed that all staff had not completed the mandatory Behavioral Health Training. On 12/18/24 at 2:40 p.m. an interview was conducted with the Staff Development Coordinator (SDC) who was asked about staff training regarding, the mandatory Behavioral Health Training. She stated that the training and education is recorded by SNF Clinic and Healthcare Academy and that the files are correct up to date. On 12/19/24 at approximately 6:30 PM, during the end of day meeting the Administrator, Director of Nursing and Staff Development Coordinator were made aware of the concerns. No further information was provided.