STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Portsmouth	3610 Winchester Dr Portsmouth, VA 23707

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, facility document review, and policy review, the facility failed to honor the food choices for 11 of 98 facility residents (Resident (R) R5, R15, R94, R93, R103, R120, R84, R63, R49, R8, and R22). This failure had the potential to lead to dissatisfaction with meals, malnutrition or weight loss, or feelings of helplessness among resident whose preferences were not honored.Findings include:1. Review of R5's Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses including diabetes, anemia, and malnutrition. Review of R5's the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/08/26 and located under the Resident Assessment Instrument (RAI) tab of the EMR revealed a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition.2. Review of R15's Face Sheet, located under the Face Sheet tab of the EMR revealed he was admitted to the facility on [DATE] with diagnoses including obesity and cirrhosis of the liver.Review of R15's Quarterly MDS with an ARD of 02/06/26 and located under the RAI tab of the EMR revealed a score of 15 out of 15 on the BIMS, indicating intact cognition.3. Review of R94's Face Sheet, located under the Face Sheet tab of the EMR revealed she was admitted to the facility on [DATE] with diagnoses including diabetes, dysphagia, reflux, depression, and malnutrition.Review of R94's admission MDS with an ARD of 01/22/26 and located under the RAI tab of the EMR revealed a score of 15 out of 15 on the BIMS, indicating intact cognition.4. Review of R93's Face Sheet, located under the Face Sheet tab of the EMR revealed he was admitted to the facility on [DATE] with diagnoses including diabetes, gastrointestinal hemorrhage, obesity, anxiety, and depression.Review of R93's Annual MDS with an ARD of 11/25/25 and located under the RAI tab of the EMR revealed a score of 15 out of 15 on the BIMS, indicating intact cognition.5. Review of R103's Face Sheet, located under the Face Sheet tab of the EMR revealed he was admitted to the facility on [DATE] with diagnoses including diabetes, obesity, anxiety, and malnutrition.Review of R103's admission MDS with an ARD of 12/02/25 and located under the RAI tab of the EMR revealed a score of 15 out of 15 on the BIMS, indicating intact cognition.6. Review of R120's Face Sheet, located under the Face Sheet tab of the EMR revealed she was admitted to the facility on [DATE] with diagnoses including diabetes, anemia, end stage renal disease, anorexia, and malnutrition.Review of R120's Quarterly MDS with an ARD of 01/30/26 and located under the RAI tab of the EMR revealed a score of 11 out of 15 on the BIMS, indicating moderately impaired cognition.7. Review of R84's Face Sheet, located under the Face Sheet tab of the EMR revealed he was admitted to the facility on [DATE] with diagnoses including anemia and peptic ulcer.Review of R84's Quarterly MDS with an ARD of 01/16/26 and located under the RAI tab of the EMR revealed a score of eight out of 15 on the BIMS, indicating moderately impaired cognition.8. Review of R63's Face Sheet, located under the Face Sheet tab of the EMR, revealed she was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, reflux, obesity, and malnutrition. Review of R63's Quarterly MDS with an ARD of 12/29/25 and located under the RAI tab of the EMR revealed a score of 15 out of 15 on the BIMS, indicating intact cognition.9. Review of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R49's Face Sheet, located under the Face Sheet tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including anemia, depression, obesity, and anxiety.Review of R49's Quarterly MDS with an ARD of 01/29/26 and located under the RAI tab of the EMR revealed a score of 15 out of 15 on the BIMS, indicating intact cognition.10. Review of R8's Face Sheet, located under the Face Sheet tab of the EMR, revealed she was admitted to the facility on [DATE] with diagnoses including chronic kidney disease and cirrhosis of the liver.Review of R8's Quarterly MDS with an ARD of 01/17/26 and located under the RAI tab of the EMR revealed a score of 15 out of 15 on the BIMS, indicating intact cognition.11. Review of R22's Face Sheet, located under the Face Sheet tab of the EMR, revealed she was admitted to the facility on [DATE] with diagnoses including dysphagia, depression, and malnutrition.Review of R22's Quarterly MDS with an ARD of 01/27/26 and located under the RAI tab of the EMR revealed a score of six out of 15 on the BIMS, indicating moderately impaired cognition.12. Resident CouncilReview of the [NAME] Resident/Family Council Agenda Minutes provided on paper by the Regional [NAME] President (VP) of Operations and dated 11/16/25 revealed R5, R15, and R94 attended the meeting. The minutes documented, Residents put alternate order for lunch [and] dinner but dietary sends what they want. The resolution was, Has alternate dietary sheets [and] put in mailbox. Paper, no longer verbal.During a resident group interview on 02/26/26 at 1:12 PM with R5, R15, R94, R93, R103, R120, R84, R63, and R49, all residents agreed they did not receive the foods they ordered on the alternate order sheet at times. R15 explained residents had to have their alternate order forms completed by 10:00 AM for lunch and by 1:00 PM for supper. R93 stated Even when the forms go in on time, you don't get what you ordered, they just give you what they want to give you. All residents in the group agreed this was true and stated there was a lack of communication in the kitchen. R93 added the kitchen often ran out of menu items and served something else in place of the items without letting you know. All residents in the group agreed. R93 stated if you did not receive the food you ordered, you had to wait until everyone else was served to receive what you wanted and often times the kitchen would be out of that item. R5, R15, and R94 stated these concerns had come up in the Resident Council meetings but things had not improved. During an interview on 02/27/26 at 3:06 PM, the Dietary Regional Manager stated that when the Resident Council brought upmentioned concerns regarding receiving alternates as ordered at meals, the dietary department initiated use of the alternate order sheets rather than a verbal ordering system. The DRM stated there was no formal education done with staff or residents at this time, but the Dietary Manager (DM) had verbally educated the kitchen staff and showed them the new forms. The DRM stated there was no documented follow up to this concern to ensure the new form had made improvements. 13. Meal ServiceDuring an interview on 02/27/26 at 11:27 AM, the DRM stated residents' preferences were recorded on the alternate order forms, which were in a pile on the counter next to the tray line. The DRM stated residents' preferences were only recorded on the order forms, the tray card was not updated and listed the regular menu meal for all residents with their applicable texture and portion size.During an observation of the lunch service in the kitchen on 02/27/26 beginning at 11:27 AM, the following were noted:Observation of the 02/27/26 lunch Alternate Order Forms at 11:34 AM on the countertop in the kitchen revealed:A. R93 ordered two hamburgers, the veggie of the day (Capri mixed vegetables), and a side salad.B. R8 ordered a grilled chicken sandwich, the veggie of the day, and a side salad.C. R22 ordered a chicken pot pie.Observation of meal service beginning at 11:43 AM at the tray line revealed:A. R93 was served two hamburgers and a side salad. He did not receive the veggie of the day as ordered.B. R8 was served a grilled chicken sandwich and French fries. She did not receive the veggie of the day or the side salad as ordered.C. R22 was served herb baked chicken legs, yellow rice, Capri mixed vegetables, and dinner roll. She did not receive a chicken pot pie as ordered.D. At 12:19 PM, [NAME] (C) 1 had run out of the Capri mixed vegetables and began serving green peas to residents who had ordered the regular meal. During an interview on 02/27/26 at 12:39 PM, C1 stated he had run out of the Capri mixed vegetables and served green peas instead. During a concurrent interview on 02/27/26 at 12:43 PM, (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the DM stated it was unusual for food to run out of mid-service, and those changes would not necessarily be announced to residents. However, if menu substitutions were made before meal service began, she would update the menu to notify the residents. The DRM stated education was needed on portion forecasting and menu preparation to ensure adequate amounts of food are available to all residents who order it. The DM stated alternate order forms were filled out by residents or staff and dropped off in the mailbox. They were due around 10:30 AM for lunch and 1:30 PM for supper. The DM stated the kitchen staff should be using and following the alternate order forms during tray service. The DM added the alternate order forms were kept on the counter near the tray line, but orders were not added to tray tickets. During an interview on 02/27/26 at 1:03 PM, R93 stated he did not receive the Capri mixed vegetables on his lunch tray as ordered and he had to request a dish of vegetables from the kitchen. R93 stated, I shouldn't have to ask for them. If I ordered them, they should be on the plate.During an interview on 02/27/26 at 1:15 PM, R8 stated she received fries with her chicken sandwich today instead of the Capri mixed vegetables and side salad she had ordered. She stated she did not eat the fries and wanted vegetables with the meal but never received them. R8 stated it frequently occurred where she did not receive her order as requested. She added, What's the point of having a paper if they don't do it. During an interview on 02/27/26 at 2:21 PM, R22 stated she did not receive a chicken pot pie at lunch today as she ordered; she received the regular meal of baked chicken, rice, vegetables, and a roll. R22 stated she ate what she was served and did not request it be replaced with the pot pie. R22 stated this happened frequently.Review of the facility's policy titled, Menu Planning Policy dated 03/28/25 revealed, Based on a facility's reasonable efforts, menus will reflect the religious, cultural, and ethnic needs of the resident population, as well as individual resident and resident groups.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and facility policy review, the facility failed to implement their abuse policy, and protect three out of 38 sampled residents, (Resident (R123) R112 and R111) from a resident-to-resident encounter. Encounters involved R123 & R122; R112 and R26, and R111 and R121. R123 expressed fear to staff and did not feel safe after R122 threatened R123 with physical violence. This resulted in the potential for mental harm for R123 and had the potential to affect other residents. Findings include: 1. Review of R122's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated no cognitive impairment. R122 was discharged on 07/25/25 and did not return. Review of R122's Care Plan, dated 05/01/25 and located in the residents' EMR under the Care Plan tab, revealed R122 was care planned for a history of physical and verbal behaviors. Interventions in place dated 0528/25 were for a psychiatric evaluation and treat as needed; monitor for changes in behaviors, and care provided by two staff members. 2. Review of R123's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted on [DATE] with diagnosis of cerebral infarction and muscle weakness. Review of R123's 5-day Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/20/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated no cognitive impairment. Review of R123's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated no cognitive impairment. R123 was discharged [DATE]. Incident:Review of R122's Nurse's Note dated 05/24/25 at 10:10 PM and located in the EMR under the Notes'' tab written by Licensed Practical Nurse (LPN) 5 revealed, Resident R122 was observed cursing and yelling at R123 in his room, (R123) saying that he continues to urinate on the toilet seat. R122 threatened R123 with physical harm and continued to tell him that he was from Russia. R122 had to be redirected by staff multiple times before he walked away from R123. R122 walked into his room and slammed the door behind him. Monitoring behavior will continue. Review of R123's Nurse's Note dated 05/24/25 at 10:22 PM and located in the EMR under the Notes'' tab written by LPN5 revealed, R123 stated that while he was lying in bed watching television, R122 approached his bedroom door and begin yelling and cursing at him. Resident R122 was observed cursing and yelling at resident R123, saying that R123 continue to urinate on the toilet seat. R123 stated that R122 threatened him with physical harm and continued to tell him that he was from Russia. Nursing staff redirected R122 back to his room multiple times before he would even walk away from R123's door. R123 was asked if he felt safe and he stated that he was starting to feel uncomfortable because no one should be coming to his door yelling and cursing at him. During an interview on 02/26/26 at 11:05 AM LPN5 stated R122 kept saying R123 was urinating on (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the toilet seat in their shared bathroom, but she did not think R123 was physically able to get up on the toilet. R122 had to be redirected multiple times away from R123's room. R122 kept telling R123 I will come in that room and put my hands on you; he was from Russia and knew people that would take care of R123. LPN1 said R123 was absolutely scared of R122. She asked R123 if he felt safe, and he replied no. She asked him if he wanted a room change, but he replied no. She stated she did not report the incident to a supervisor that night because she said, It was the 3-11 shift and there was nobody to report to. She stated she did report it the next morning, but she could not remember who. She thought she mentioned it to the Administrator and informed her that R123 was fearful. She stated she did not feel like any actions were taken to properly address these types of situations. She said R122 had told her, He could do whatever he wanted and get away with it. During an interview on 02/26/2026 at 5:06 PM, the Administrator stated she did not remember getting a call on 05/24/25 around 10 PM when the incident occurred. She stated she would have expected the incident to be reported immediately to a supervisor, and it was not appropriate to just redirect R122 back into his room. The Administrator was unable to answer if staff did enough to ensure the safety of R123 and the other residents in the facility. 2. R112 and R26A. Review of R112's Face Sheet located under the Face Sheet tab of the EMR revealed he was admitted to the facility on [DATE] with diagnoses of Charcot's joint of the right ankle and foot [a severe, progressive condition causing rapid destruction of joints and bones] and end stage renal disease. R112 was discharged from the facility on 04/18/25 and did not return. Review of R112's admission MDS with an ARD of 03/18/25 and located under the RAI tab of the EMR revealed a score of 15 out of 15 on the BIMS, indicating intact cognition. R112 did not exhibit mood or behavioral symptoms. B. Review of R26's Face Sheet, located under the Face Sheet tab of the EMR revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, schizoaffective disorder, depression, insomnia, gout, malnutrition, anxiety, and restlessness/agitation. Review of R26's Quarterly MDS with an ARD of 03/27/25 and located under the RAI tab of the EMR revealed she was unable to complete the BIMS as she was rarely/never able to make herself understood. She had impaired short- and long-term memory and moderately impaired cognition. She did not exhibit any mood or behavioral symptoms. She was dependent on staff for assistance with activities of daily living but was independently mobile in her wheelchair. Review of R26's Significant Change of Condition MDS with an ARD of 12/14/25 and located under the RAI tab of the EMR revealed a score of one out of 15 on the BIMS, indicating severely impaired cognition. She exhibited moderate symptoms of depression. The MDS indicated R26 did not exhibit any behavioral symptoms. Review of R26's Care Plan located under the RAI tab of the EMR with a start date of 07/22/24 and revision date of 02/18/26 revealed R26 exhibited increased agitation at times as evidenced by hitting/kicking at staff and an episode of kicking a resident on 04/16/25. The approaches included, Divert resident's behavior . Seat resident where constant/near constant observation is possible . Allow distance in seating other residents around resident . Remove resident from group activities when behavior is unacceptable . Provide structured rest periods . Simplify ADLs . Assign staff people to assist with direct care . Prepare and organize supplies before caring for resident. Avoid delays and interruptions in care . When resident becomes physically abusive, keep distance between resident and others (e.g., staff, other residents, visitors) . When resident becomes physically abusive, STOP and try task later. Do not force to do task . When resident becomes physically abusive, move to a quiet, calm environment . Provide consistent staff as much as possible . Maintain a calm, slow, understandable approach with the resident . psychosocial therapy . Provide (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care, activities, and a daily schedule that resembles the resident's prior lifestyle . If resident has delusions/hallucinations, do not try to reason with or confront resident. Offer reassurance . [and] Avoid over-stimulation (e.g., noise, crowding, other physically aggressive residents). C. Review of a facility's Facility Reported Incident (FRI) form dated 04/16/25 and provided on paper by the Regional [NAME] President of Operations (RVPO) revealed an allegation of resident-to-resident abuse by R26 to R112 was reported to the SA. The form documented R112 alleged was kicked on the external fixator (a surgical method using metal plates, screws, rods, or pins to stabilize and align fractured bones from inside the body) on his right leg by R26 while in the hallway. Review of the facility's untitled follow-up report to the SA, dated 04/22/25 and provided on paper by the RVPO, revealed R112 was being escorted in a wheelchair by a transportation aide (TA) from an outside company through the hallway upon return from a dialysis appointment. R26 was in the middle of the hallway and would not move when asked by the TA. R112 alleged R26 kicked her leg out and made contact with his injured leg with an external fixator in place. Staff removed R26 from the hallway and R112 was assessed with no noted injuries and was sent to the emergency room per his request for evaluation of the external fixator. R26 was unable to recall the incident or explain the situation due to dementia. A witness statement from the TA at the time of the investigation revealed R26's foot came in contact with R112's leg/external fixator. There were no other witnesses to the actual resident-to-resident contact, though additional staff had witnessed the two residents in the hall and R26's leg being raised in a kicking motion. The report documented, After completion of interviews, it was established that resident to resident contact occurred. During a telephone interview on 02/26/26 at 5:06 PM, the Administrator stated the incident of resident-to-resident abuse was substantiated through investigation. During an interview on 02/26/26 at 5:36 PM, LPN1 stated he was behind the nurses' station desk when R112 was being wheeled down the hall by the TA in a wheelchair. R26 was in the hallway, and the TA confronted her to get through because he was not familiar with her, and she reacted by raising her leg, which was a typical reaction for her that facility staff were aware of. LPN1 stated he did not witness R26's foot come in contact with R112, he only saw her leg go up. LPN1 stated he assessed R112's external fixator and lower extremity but found no injury or displacement. LPN1 stated R112 requested to go to the emergency room for evaluation, though there was no clinical reason he needed to go. 3. R111 and R121A. Review of R111's Face Sheet located under the Face Sheet tab of the EMR revealed he was admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder, depression, and muscle weakness. Review of R111's admission MDS, with an ARD of 07/03/25 and located under the RAI tab of the EMR revealed a score of 15 out of 15 on the BIMS, indicating intact cognition. He did not exhibit any mood or behavioral symptoms. Review of R111's Quarterly MDS, with an ARD of 01/03/26 and located under the RAI tab of the EMR, revealed a score of 12 out of 15 on the BIMS, indicating moderately impaired cognition. He exhibited mild mood symptoms and no behavioral symptoms. Review of R111's Nursing note written on 08/31/25 at 3:25 AM by LPN2 and located under the Progress Notes tab of the EMR revealed, Resident in bed awake watching TV. Roommate grabbed his bed remote and hit him on his left arm and left leg several times. Resident immediately removed from room at this time. B. Review of R121's Face Sheet, located under the Face Sheet tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including history of stroke, malnutrition, encephalopathy, and diabetes. He was discharged from the facility on 08/31/25 and did not return. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure allegations of resident-to-resident abuse involving four of six residents (Resident (R) 111, R121, R122, and R123) reviewed for abuse were reported to the State Agency (SA) within required time frames. The failure had the potential to allow potential abuse without recognition or regulatory follow-up to prevent recurrence.Findings include: 1. Review of R111's Face Sheet, located under the Face Sheet tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder, depression, and muscle weakness. Review of R111's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/03/25 and located under the RAI (Resident Assessment Instrument) tab of the EMR, revealed a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. He did not exhibit any mood or behavioral symptoms. Review of R111's Nursing Note written on 08/31/25 at 3:25 AM by Licensed Practical Nurse (LPN) 2 and located under the Progress Notes tab of the EMR revealed, Resident in bed awake watching TV. Roommate grabbed his bed remote and hit him on his left arm and left leg several times. Resident immediately removed from room at this time. Review of R121's Face Sheet, located under the Face Sheet tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including history of stroke, malnutrition, encephalopathy, and diabetes. He was discharged from the facility on 08/31/25 and did not return. Review of a facility's Facility Reported Incident form, dated 08/31/25 and provided on paper by the Regional [NAME] President of Operations (RVPO), revealed the above allegation of resident-to-resident abuse by R121 to R111 was reported to the SA. An attached fax Tx [Transmission] Result Report revealed the initial report of the allegation was made to the SA on 08/31/25 at 10:15 AM, over seven hours after the allegation was first documented. During an interview on 02/26/26 at 12:01 PM, LPN2 stated the incident happened around 3:00 AM on 08/31/25 and she had reported it to the on-call physician and Administration right away. During a telephone interview on 02/26/26 at 5:06 PM, the Administrator stated her understanding of reporting timelines was to report any allegation of abuse that causes severe bodily injury within two hours and any other allegation within 24 hours. The Administrator was not aware of the regulatory requirement and facility policy to report any allegations of abuse or events that cause serious bodily injury within two hours. The Administrator stated she could not remember the details of this incident but stated she had probably sent in the initial report when she arrived at work later that morning since it happened around 3:00 AM. 2. Review of R122's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated no cognitive impairment. R122 was discharged on 07/25/25 and did not return. Review of R122's Care Plan, dated 05/01/25 and located in the residents' EMR under the Care Plan (continued on next page)

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	495194	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Portsmouth	3610 Winchester Dr Portsmouth, VA 23707

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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 - Some	tab, revealed R122 was care planned for a history of physical and verbal behaviors. Interventions in place dated 05/28/25 were for a psychiatric evaluation and treat as needed; monitor for changes in behaviors, and care provided by two staff members. 3. Review of R123's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted on [DATE] with diagnosis of cerebral infarction and muscle weakness. Review of R123's 5-day Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/20/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated no cognitive impairment. Review of R123's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated no cognitive impairment. R123 discharged [DATE] Review of R122's Nurse's Note dated 05/24/25 at 10:10 PM and located in the EMR under the Notes'' tab written by Licensed Practical Nurse (LPN) 5 revealed, Resident R122 was observed cursing and yelling at resident in room [ROOM NUMBER]-1 (R123) saying that he continues to urinate on the toilet seat. R122 threatened resident in room [ROOM NUMBER]-1 with physical harm and continued to tell him that he was from Russia. R122 had to be redirected by staff multiple times before he walked away from resident in room [ROOM NUMBER]-1. R122 walked into his room and slammed the door behind him. Monitoring behavior will continue. Review of R123's Nurse's Note dated 05/24/25 at 10:22 PM and located in the EMR under the Notes'' tab written by LPN 5 revealed, R123 stated that while he was lying in bed watching television, R122 approached his bedroom door and begin yelling and cursing at him. R122 was observed cursing and yelling at R123, saying that R123 continue to urinate on the toilet seat. R123 stated that R122 threatened him with physical harm and continued to tell him that he was from Russia. Nursing staff redirected R122 multiple times before he would even walk away from R123 door. R123 was asked if he felt safe and he stated that he was starting to feel uncomfortable because no one should be coming to his door yelling and cursing at him. Review of the Facility Reported Incident dated 05/26/25 revealed the incident occurred on 05/24/26 but was not reported until 05/26/25 at 4:09 PM. During an interview on 02/26/26 at 11:05 AM, LPN5 stated she did not report the incident between R122 and R123 to a supervisor that night because she said it was the 3-11 shift and there was nobody to report to. She stated she did report it the next morning, but she could not remember who. She thought she mentioned it to the Administrator and informed her that R123 was fearful. She stated she did not feel like any actions were taken to properly address these types of situations. She said R122 had told her, He could do whatever he wanted and get away with it. During an interview on 02/26/2026 at 5:06 PM, the Administrator stated she did not remember getting a call on 05/24/25 around 10 PM when the incident occurred. She stated she would have expected the incident be reported immediately to a supervisor, and it was not appropriate to just redirect R122 back into his room. The Administrator was unable to answer why the allegation was not reported to the state survey agency until two days later on 05/26/25 at 4:09 PM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Virginia Resident Abuse Policy, dated 01/16/26, revealed, All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing (DON), and to the applicable State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the [SA] immediately, but not later than 2 hours after the allegation is made.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, facility document review, and policy review, the facility failed to ensure staff followed the menus for mechanical soft and puree diets for 14 residents who received these diet textures (five residents on puree diets and nine residents on mechanical soft diets) out of a census of 98. This failure placed those residents at risk of malnutrition, weight loss, or dissatisfaction with meals.Findings include:Review of an untitled, undated handwritten document, provided on paper by the Director of Nursing (DON), revealed the facility had nine residents who received a mechanical soft diet and five residents who received a puree diet.Review of the facility's Diet Guide Sheet for lunch on 02/27/26, provided on paper by the Dietary Regional Manager (DRM), revealed the regular texture meal was herb roasted chicken, yellow rice, Capri mixed vegetables, and a dinner roll. For a mechanical soft texture, the menu was ground herb roasted chicken, Capri mixed vegetables, buttered noodles, and a dinner roll. For a puree texture, the menu was pureed herb roasted chicken, pureed Capri mixed vegetables, cream of rice, and pureed bread.During an observation of the lunch service in the kitchen on 02/27/26 beginning at 11:27 AM, the DRM asked the [NAME] (C1) what he was serving instead of rice for the mechanical soft diet, and he responded, mashed potatoes. The DRM stated it should be buttered noodles. The DRM then asked C1 what sides were being served for a pureed diet. C1 responded he had made mashed potatoes. The DRM stated he should be serving cream of rice but stated it was a substitute of equal nutritive value, so it was ok. Throughout meal service, C1 served residents on a mechanical soft diet mashed potatoes instead of the buttered noodles and served residents on a puree diet mashed potatoes instead of cream of rice that was called for on the menu. Additionally, there was no pureed bread on the tray line or served to the residents on a pureed diet. During an interview on 02/27/26 at 12:39 PM, C1 stated he served mashed potatoes instead of noodles for the mechanical soft diet and instead of cream of rice for the puree diet. C1 stated there was no reason he used mashed potatoes but stated, I just know they can eat it. C1 confirmed he had not prepared or served pureed bread and stated he had forgotten. C1 stated he did not look at the menu to determine what to serve for mechanical soft and pureed diets. During a concurrent interview on 02/27/26 at 12:43 PM, the Dietary Manager (DM) stated she did not think C1 looked at the menu to determine the correct foods to serve and the DRM stated C1 needed more training on following menus. The DM stated she had recently done an in-service training on following menus; however, C1 had not attended. The DM stated C1 should have pureed bread and served it with the puree meal.Review of the facility's policy titled, Menu Substitutions Policy, dated 03/28/25, revealed, Regular and therapeutic menus will be written to provide a variety of foods served on different days of the week, adjusted for seasonal changes, and in adequate amounts at each meal to satisfy recommended daily allowances . Regular and therapeutic menus will be written by the facility's food and nutrition professional(s) in accordance with the facility's approved diet manual . A registered dietitian nutritionist (RDN) or designee will approve all menus . A computerized nutritional analysis is used to evaluate nutritional adequacy in menu planning. The menus have been evaluated for Dietary Reference Intake (DRI) based on the Recommended Dietary Allowances (RDA), Estimated Average Requirements (EAR), Adequate Intakes (AI), and Acceptable Macronutrient Distribution Ranges (AMDR).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to follow infection control guidelines during the medication administration observation by touching pills prior to being administered to two of four residents (Resident (R)84 and R119) and failed to don appropriate personal protective equipment for two of four residents in transmission-based precautions (R50 and R63) out of 38 total sampled residents. These failures had the potential to expose R84, R119, R50, and R63 to infections in an already vulnerable population.Findings include: 1. During the medication administration observation on 02/26/26 at 7:54 AM, Licensed Practical Nurse (LPN) 3 was observed preparing Aspirin 81 milligrams (mg) to administer to R119. LPN3 poured the pills into the lid of the Aspirin bottle. While doing so, LPN3 was observed placing her bare index finger on the extra tablet of Aspirin so as not to pour this tablet into the medication cup. LPN3 then proceeded to put this tablet of Aspirin back in the Aspirin bottle. 2. During another observation on 02/26/26 at 8:06 AM, LPN3 was observed preparing Tylenol 325 mg two tablets to administer to R84. As LPN3 was pouring the Tylenol tablets in the lid of the bottle, three tablets of this medication were noted to be in the lid of the bottle. LPN3 then proceeded to place her bare index finger on the extra Tylenol so as not to pour this tablet into the medication cup. LPN3 then poured the extra tablet back into the bottle of Tylenol. LPN3 performed this procedure when attempting to put one tablet of Aspirin 81 mg chewable into the lid of the bottle. Again, as the nurse poured the Aspirin into the resident's medication cup, LPN3 placed her bare index finger on the tablet and then returned this tablet into the remaining bottle of Aspirin tablets. During an interview on 02/26/26 at 11:15 AM, LPN3 stated, I didn't realize that I put my finger on the pills so I wouldn't get the wrong number of tablets in the resident's medication cup. When I did that, I should have worn gloves so that I would not be touching the pills with my bare fingers. During an interview on 02/27/26 at 3:33 PM, the Director of Nursing (DON) stated, The nurse should never touch the pills with her bare hands. If she was going to touch the pills, she should have worn gloves so this would not be a problem. Review of the pharmacy's policy titled, General Dose Preparation and Medication Administration, dated 11/15/24 indicated, . Appropriate hand hygiene should be performed before and after direct resident contact. Medications should not come in contact with any surface except for the medication cup. 3. Review of R63's Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with a diagnosis of malignant breast cancer. Review of R63's EMR under the Orders tab revealed a physician's order dated 09/15/25 for Neutropenic Precautions at all times. Review of R63's Care Plan located under the Resident Assessment Instrument (RAI) tab of the EMR revealed, Neutropenic Precautions. The approaches included, Precautions per protocol, monitor for compliance. During an observation on 02/24/26 at 12:05 PM outside of R63's room, a sign on the door indicated, Neutropenic Precautions and directed anyone entering the room to perform hand hygiene, don a gown, gloves, and mask before entering the room, and doff the Personal Protective Equipment (PPE) before exiting the room. The door also held a supply of PPE needed for room entry. Certified Nursing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistant (CNA) 5 entered R63's room to deliver and set up her lunch tray while only wearing a mask and no additional PPE. During an interview on 02/24/26 at 12:05 PM, CNA5 stated she only donned a mask because she was just serving R63's food and was not coming in close contact with the resident. CNA5 stated she would don a gown and gloves if she was entering the room to provide care. During an observation on 02/25/26 at 5:48 PM, CNA6 entered R63's room with only a mask on and no additional PPE to deliver and set up her dinner tray. During an interview on 02/25/26 at 5:50 PM, CNA6 stated he should have donned a gown and gloves in addition to his mask before entering the room and stated he had forgotten. During an interview on 02/27/26 at 4:23 PM, the DON stated for neutropenic precautions, the staff should clean their hands and apply gloves, mask, and gown prior to entering a room, no matter the situation. The DON stated PPE should be donned for every room entry. Review of the facility's undated Neutropenic Precautions signage, provided on paper by the DON revealed, Put on gloves before entering and remove before leaving room. Put on a gown before entering and remove before leaving room. Put on mask before entering room if you have a respiratory infection . 4. Review of R50's Face Sheet, located under the Face Sheet tab of the EMR, revealed he was admitted to the facility on [DATE]. Review of R50's EMR under the Diagnostic Order Review tab revealed a C. Difficile (c-diff) test result reported 02/21/26. Review of R50's EMR under the Orders tab revealed a physician's order dated 02/21/26 for Contact Precautions related to a diagnosis of c-diff. Review of R50's Care Plan located under the RAI tab of the EMR and dated 02/24/25 revealed, Resident has need for isolation related to c-diff. The approaches included, Have adequate PPE available for staff and visitors.The resident is on Transmission-Based Precautions (Contact, Droplet, or Airborne) - not just standard precautions. The Care Plan had not been updated to specify contact precautions. During an observation on 02/24/26 at 12:28 PM outside R50's room, signage on the door indicated Contact Precautions and directed anyone entering the room to perform hand hygiene, don a gown and gloves before entering the room, and doff the PPE before exiting the room. The door also held a supply of PPE needed for room entry. CNA7 entered R50's room to check on the resident and did not don any PPE prior to entrance. During an interview on 02/24/26 at 12:28 PM, CNA7 stated staff were supposed to wear gloves, a mask, and a gown when providing care to R50 but only a mask if not providing direct resident care. CNA7 stated she did not don any PPE because she was just rushing in to check on the resident due to a report he had not received his lunch tray. During an observation on 02/25/26 at 5:48 PM, CNA6 entered the room wearing only a mask and no additional PPE. He delivered R50's meal tray, moved the bedside table, then was reminded by another staff member to don a gown and gloves, which he began to do. During an interview on 02/25/26 at 5:50 PM, CNA6 he had forgotten to don a gown and gloves prior to room entrance but was reminded and would be putting them on. During an interview on 02/27/26 at 4:23 PM, the DON stated for contact precautions, the staff should clean their hands and apply gloves (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and gown prior to entering a room, no matter the situation. The DON stated PPE should be donned for every room entry. Review of the facility's undated Contact Precautions signage, provided on paper by the DON, revealed, Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to provide written information on how to formulate an Advance Directive for one of five residents (Resident (R)30) reviewed for Advance Directives out of a total of 38 sampled residents. This failure has the potential for R30 not to be able to make her desires known if she was unable to speak for herself.Findings include:Review of R30's Face Sheet, located under the Resident tab in the electronic medical record (EMR) indicated R30 admitted to the facility on [DATE] with the diagnoses including chronic obstructive pulmonary disease (COPD) and congested heart failure (CHF). R30 was also documented as being a Full Code.Review of R30's admission Minimum Data Set (MDS), located under the Resident Assessment Instrument (RAI) tab in the EMR with an Assessment Reference Date (ARD) of 01/29/26 indicated R30 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R30 had moderately impaired cognition. During an interview on 02/26/26 at 11:00AM, R30 was asked if her heart stopped or she stopped breathing what would she want the staff to do for her. R30 stated, I want everything to be done for me.During an interview on 02/27/26 at 12:14 PM, the Social Services Director (SSD) stated, There is a path meeting within three days of admission, and we go over the Advance Directive and code status with the resident and/or family member. This is done at the bedside.During an interview on 02/27/26 at 1:00 PM, Registered Nurse (RN) 2 stated, When we do an admission, we will ask if they have an Advance Directive and what they would like the code status to be. But I don't give the residents any information on Advance Directives.During an interview on 02/27/26 at 4:30 PM, the Admissions Director (ADMD) stated, We will ask if the resident has an Advance Directive when they are admitted to the facility but that is all that I do. I don't give them anything about this.Review of R30's admission Packet, provided by the ADMD, and dated 01/29/26 indicated, . A written summary of the FACILITY Advance Directive policy. (App [Appendix] C) I _____ have __X____ have not executed an Advance Directive .Review of the facility's policy titled, Advanced Care Planning Meeting Protocol, dated 08/27/25 indicated, . Information (ex. Living Wills, Medical [NAME] of Attorney including the resident's right to form an Advance Directive and the right to refuse medical/surgical treatment is provided to the resident and family by the facility on admission.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to implement their abuse policy and thoroughly investigate an allegation of resident-to-resident abuse for two of five residents (Resident (R) 122, R123) reviewed for abuse out of 38 sample residents. This had the potential to affect residents in the facility who were at risk for abuse. Findings include:1. Review of R122's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated no cognitive impairment. R122 discharged on 07/25/25. Review of R122's Care Plan, dated 05/01/25 and located in the residents' EMR under the Care Plan tab, revealed R122 was care planned for a history of physical and verbal behaviors. Interventions in place dated 05/28/25 were for a psychiatric evaluation and treat as needed; monitor for changes in behaviors, and care provided by two staff members. 2. Review of R123's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted on [DATE] with diagnosis of cerebral infarction and muscle weakness. Review of R123's 5-day Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/20/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated no cognitive impairment. R123 discharged [DATE]. Review of R123's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated no cognitive impairment. R123 discharged [DATE]. Review of R122's Nurse's Note dated 05/24/25 at 10:10 PM and located in the EMR under the Notes'' tab written by Licensed Practical Nurse (LPN) 5 revealed, Resident R122 was observed cursing and yelling at resident in room [ROOM NUMBER]-1 (R123) saying that he continues to urinate on the toilet seat. R122 threatened resident in room [ROOM NUMBER]-1 with physical harm and continued to tell him that he was from Russia. R122 had to be redirected by staff multiple times before he walked away from resident in room [ROOM NUMBER]-1. R122 walked into his room and slammed the door behind him. Monitoring behavior will continue.Review of R123's Nurse's Note dated 05/24/25 at 10:22 PM and located in the EMR under the Notes'' tab written by LPN5 revealed, R123 stated that while he was lying in bed watching television, R122 approached his bedroom door and begin yelling and cursing at him. R122 was observed cursing and yelling at R123, saying that R123continue to urinate on the toilet seat. R123stated that R122 threatened him with physical harm and continued to tell him that he was from Russia. Nursing staff redirected R122 multiple times before he would even walk away from R123 door. R123 was asked if he felt safe and he stated that he was starting to feel uncomfortable because no one should be coming to his door yelling and cursing at him.Review of the Facility's Five Day Follow Up dated 06/01/25 revealed the findings did not indicate the date the incident occurred. The incident occurred on 05/24/25 and only R122, R123 and LPN1 were interviewed. R122 was interviewed on 05/26/25 and R123 was interviewed on 05/28/25. Other residents were interviewed and asked four basic questions, Has staff, a resident, or anyone else here mistreated you?, Did you tell staff about the mistreatment?, Have you seen any resident here being mistreated?, and if yes, did you tell anyone the mistreatment? None of the residents interviewed were asked about the incident that occurred on 05/24/25 or their observations and interactions with R122. During an interview on 02/26/26 at 11:05 AM LPN5 stated she did not report the incident between R122 and R123 to a supervisor that night because she said, It was the 3-11 shift and there was nobody to report to. She stated she did report it the next morning, but she could not remember who. She thought she mentioned it to the Administrator and informed her that R123 was fearful. She said she was Not interviewed about what happened or asked to write a statement about it. During an interview on 02/26/2026 at 5:06 PM, the Administrator stated they would interview all staff working on the unit at the time an incident occurred and other residents. She was unsure why no other staff besides LPN5 was interviewed. Review of the facilities policy titled Virginia Abuse Policy dated 01/05/26 revealed the facility staff must immediately begin an investigation.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure a written transfer notice that contained all required information and the bed hold notice was provided for one of seven residents (Resident (R) 74) and/or their responsible party (RP) reviewed for hospital transfer out of 38 sampled residents. This failure had the potential to result in the resident and their RP not having the knowledge of where and why a resident was transferred, the bed holds policy, and/or how to appeal the transfer, if desired.Findings include:Review of R74's Face Sheet, located under the Resident tab in the electronic medical record (EMR) indicated R74 was readmitted to the facility on [DATE] with the diagnosis of transient cerebral ischemic attack (TIA).Review of R74's quarterly Minimum Data Set (MDS), located under the Resident Assessment Instrument (RAI) tab in the EMR, with an Assessment Reference Date (ARD) of 09/24/25 indicated R74 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R74 had moderately impaired cognition. Review of R74's Nursing Progress Note, located under the Resident tab in the EMR and dated 11/09/25 at 7:02 PM indicated, Went in to take residents evening vitals, he was alert but unable to speak when his name was called. Vitals and blood sugar were within normal limits; hand grips were weak bilateral. Notified NP [nurse practitioner] and informed them [sic] that resident will be sent out for further evaluation .Review of R74's EMR did not indicate documentation of the facility providing a written transfer and bed hold policy to the resident and RP when R74 was transferred to the hospital on [DATE].During an interview on 02/27/26 at 11:57 AM, the Social Services Director (SSD) stated, The process is for the nurses to fill out the information for the transfer notice and bed hold policy. After that I am not aware of what happens with the information.During an interview on 02/27/26 at 1:00 PM, Registered Nurse (RN)2 stated, We fill out the information on the transfer notice and bed hold policy, then after they are completed, the forms are placed in the envelope that is given to the EMTs [Emergency Medical Transports] and is taken to the hospital with the resident. RN2 stated they were not sure how the transfer notice and bed hold policy was provided to the RP. During an interview on 02/27/26 at 6:30 PM, the Regional [NAME] President of Operations (RVPO) stated, The Social Worker is to call the resident's representative and/or the resident as a follow up after the resident is transferred to the hospital to go over this information with them.Review of the facility's policy titled, Discharge Planning Policy, and dated 02/03/26 indicated, Transfers and discharges will meet regulatory requirements. The facility will take steps to ensure that the transfer or discharge is documented in the resident's medical record and necessary information is communicated to the receiving healthcare institution or provider .

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	495194	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Portsmouth	3610 Winchester Dr Portsmouth, VA 23707

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the status for two of 38 sampled residents (Resident (R) 34 and R76). Specifically, the MDS did not accurately assess presence of pressure ulcers for R34 and the use of oxygen for R76. These failures placed the residents at risk for unmet care needs related to pressure ulcers for R34 and oxygen for R76.Findings include: 1. Review of R34's Face Sheet, located under the Face Sheet tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses including stroke, malnutrition, gout, muscle weakness, seizures, and diabetes. Review of R34's admission MDS with an Assessment Reference Date (ARD) of 01/29/26 and located under the RAI (Resident Assessment Instrument) tab of the EMR revealed a score of 10 out of 15 on the Brief Interview for Mental Status (BIMS) indicating moderately impaired cognition. The MDS documented R34 had one unstageable pressure ulcer. Review of R34's Care Plan dated 01/26/26 and located under the RAI tab of the EMR revealed, Wound Focus: PU [pressure ulcers] to sacrum left heel. Review of R34's Admission/readmission Observation dated 01/23/26 and located under the Observations tab of the EMR, revealed R34 had pressure ulcers to her sacrum and left heel upon admission to the facility. Review of R34's EMR under the Wound Care tab revealed Wound Observation dated 01/24/26, revealed two wounds: a stage IV pressure ulcer to the sacrum and an unstageable pressure ulcer to the left heel, both of which were present on admission. Review of subsequent Wound Observation, dated 01/31/26, revealed both the stage IV sacrum and unstageable heel pressure ulcers were still present. During an interview on 02/27/26 at 2:35 PM, the MDS Coordinator (MDSC) stated she was unsure why R34's MDS only reflected one pressure ulcer and not two, adding that section had been completed by the Infection Preventionist (IP). During an interview on 02/27/26 at 3:13 PM, the IP stated R34 had two pressure ulcers with which she was admitted . The IP stated both pressure ulcers should have been reflected on the MDS and this was a discrepancy that needed to be corrected. 2. Review of R76's admission Record, located in the Profile tab of the EMR revealed admission to the facility on [DATE] and with diagnoses of chronic obstructive pulmonary disease (COPD). Review of R76's quarterly MDS under the MDS tab of the EMR, with an ARD of 01/26/26, revealed the BIMS, revealed a score of 12 out of 15 which indicated no cognitive impairment. The resident was not coded as receiving oxygen therapy. Review of R76's Care Plan, located under the Care Plan tab of the EMR, dated 02/12/25, revealed The resident required the use of oxygen due to a diagnosis of COPD. The Resident was at risk for altered respiratory status. Intervention in place was to administer oxygen per physician orders. Review of R76's Physician Orders located under the Orders, tab in the EMR, dated 10/17/25, revealed oxygen at 2 LPM (liters per minute) via (by way of) nasal cannula continuously. Review of the Medication Administration Record (MAR) located under the Records tab in the EMR, dated January and February 2026, revealed on 02/26/2024, LPN did not document R76's oxygen at 3 LPM continuously. Further review noted nothing had been documented on the MAR about R76's oxygen administration. Review of R76's Nurse's Note dated 01/20/26 and located in the EMR under the Notes" tab written by the Nurse Practitioner (NP) revealed, R76, [AGE] years old female, is seen (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	today per nursing request for reports of poor appetite times the last 1-2 days. She reports she is drinking fluids but has been refusing meals. Her scopolamine patch was discontinued 3 days ago due to complaint of dry mouth. Patient is seen sitting up in bed awake and cooperative, CNA (Certified Nurse Assistant) is offering ADL (Activities of Daily Living) care at this time. Patient reports not feeling well but is nonspecific, appears slightly dyspneic on exam. Has oxygen in place via nasal cannula 3 L with oxygen saturations of 98%. CNA reports patient has been coughing. ROS is challenging due to her dementia.During an interview on 02/27/2026 at 3:10 PM, the MDS Coordinator confirmed she did not indicate that R76 was on oxygen when she completed the 01/26/26 MDS assessment. She stated she looked at the MAR and there was no indication that R76 received oxygen therapy. She stated she made an observation of R76 in her room, and she did not have an oxygen concentrator or nasal cannula. The MDS Coordinator did not have any documentation of that observation. During an interview on 02/27/26 at 3:32 PM the Director of Nursing (DON) stated she did not know much about MDS assessments, but she expected them to be completed accurately. The facility did not have a policy addressing MDS accuracy. Review of the Centers for Medicare and Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual dated 10/01/25, An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [interdisciplinary team] completing the assessment.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure that an accurate Preadmission Screening and Resident Review (PASARR) Level I assessment was completed for two residents (Resident (R) 102 and R9) out of 38 sampled residents. This had the potential to affect all residents who were admitted to the facility.Findings include: 1. Review of R102's ''admission Record, located under the ''Profile'' tab of the electronic medical record (EMR), revealed R8 admitted to the facility on [DATE] with diagnoses including unspecified intellectual disabilities. Review of R102's DMAS-95 [Department of Medical Assistance Screening] Level I Screening, dated 12/20/24 and located in the resident's EMR under the Miscellaneous tab, revealed no indication of intellectual developmental disability (IDD) identified. 2. Review of R9's ''admission Record,'' located under the ''Profile'' tab of the EMR, revealed R9admitted to the facility on [DATE] with diagnoses including anxiety disorder, schizoaffective disorder bipolar type. Review of R9's DMAS-95 Level I Screening, dated 04/13/24 and located in the resident's EMR under the Miscellaneous tab, revealed no indication of mental illness identified. During an interview on 02/27/2026 at 10:41 AM the Social Services Director (SSD) stated she was not responsible for the completion of the PASARR Level I. She stated the Administrator completed them, but the Administrator was unavailable at this time for interview. The SSD stated she would find out who was available to answer questions about the PASARR's. During an interview on 02/27/26 at 3:32 PM, the Director of Nursing (DON) stated she expected PASARR assessments to be completed accurately. 3. Review of R30's Face Sheet, located under the Resident tab in the EMR indicated R30 admitted to the facility on [DATE] with the diagnosis of bipolar disorder. Review of R30's admission Minimum Data Set (MDS,) located under the RAI tab in the EMR, with an ARD of 01/29/26 indicated R30 had a BIMS score of 11 out of 15 which indicated R30 had moderately impaired cognition. Review of R30's EMR in its entirety indicated there was no documentation of a PASSAR being completed prior to or within 30 days from admission to the facility. During an interview on 02/27/26 at 6:15 PM, the Regional [NAME] President of Operations (RVPO) stated, I could not find a PASSAR for this resident, but she should have had one completed. The Administrator was unavailable on 02/27/26 for interviews by the survey team.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to develop a care plan for three of four residents (Resident (R) 64, R30, and R5) that included targeted behaviors for the use of anxiety medication out of a total sample of 38 residents. This failure had the potential for residents to experience adverse effects of an anxiety medication which was not specifically monitored. Findings include:1. Review of R64's Face Sheet, located under the Resident tab in the electronic medical record (EMR) indicated R64 was readmitted to the facility on [DATE] with the diagnosis of multiple sclerosis and congested heart failure (CHF).Review of R64's quarterly Minimum Data Set (MDS), located under the Resident Assessment Instrument (RAI) tab in the EMR, with an Assessment Reference Date (ARD) of 01/18/26 indicated R64 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R64 had moderately impaired cognition.Review of R64's Care Plan, located under the RAI tab in the EMR and dated 02/24/26 for a Problem of Resident receives anxiety medication R/T [related to] Terminal [sic] agitation, restlessness, anxiety, insomnia, or hallucinations. The interventions included, Monitor resident's mood and response to medication.Review of R64's Physician Orders, located under the Resident tab in the EMR indicated an order dated 02/23/26 for lorazepam concentrate two milligram [mg] per milliliter [ml] give 0.5 milliliter [a short term, prescription-only benzodiazepine used to treat anxiety, insomnia, acute seizures, and for pre-anesthesia sedation] every four hours as needed for terminal agitation, restlessness, anxiety, insomnia, or hallucinations times 14 days.During an interview on 02/27/26 at 2:37 PM, the Minimum Data Set Coordinator (MDSC) was asked what targeted behaviors R64 exhibited that the staff knew to look for and monitor while R64 was taking lorazepam for anxiety. The MDSC stated, Each resident is different. I guess we could look at how she acts when she has anxiety and add them to the care plan.2. Review of R30's Face Sheet, located under the Resident tab in the EMR indicated R30 admitted to the facility on [DATE] with the diagnosis of generalized anxiety disorder and bipolar disorder.Review of R30's admission MDS, located under the RAI tab in the EMR, with an ARD of 01/29/26 indicated R30 had a BIMS score of 11 out of 15 which indicated R30 had moderately impaired cognition. R30 was also coded for receiving antipsychotic and antianxiety medication.Review of R30's Care Plan, located under the RAI tab in the EMR and dated 01/26/26 indicated a Problem which stated, Resident receives antianxiety medication R/T anxiety/bipolar [sic]. The interventions included, . Monitor resident's mood and response to medication.Review of R30's Physician Orders, located under the Resident tab in the EMR indicated an order dated 01/23/26 for Abilify 15 mg by mouth give one tablet once a day for bipolar disorder [a prescription antipsychotic used to treat schizophrenia, bipolar 1 disorder, depression, Tourette's disorder and irritability in autism) Bupropion HCl tablet extended release 24 hour 150 mg give one tablet once a day for bipolar disorder [an atypical antidepressant], Buspirone 10 mg give one tablet once a day for anxiety, and Xanax one mg give one tablet three times a day for anxiety/bipolar disorder [a fast acting benzodiazepine primarily used for short term management of anxiety disorders].3. Review of R5's Face Sheet, located under the Resident tab in the EMR indicated R5 was admitted to the facility on [DATE] with the diagnosis of adjustment disorder with mixed anxiety and depressed mood.Review of R5's quarterly MDS, located under the RAI tab in the EMR, with an ARD of 11/08/25 indicated R5 was coded as having a BIMS score of 15 out of 15 which indicated R5 was cognitively intact. R5 was also coded as receiving antianxiety and antidepressant medication. Review of R5's Physician's Orders, located under the Resident tab in the EMR indicated an order dated 11/15/25 for duloxetine delayed released capsule 20 mg give one tablet once a day for depression and anxiety [medication used to treat major depressive disorder and generalized anxiety disorder], and mirtazapine 15 mg give one tablet at bedtime for depression/insomnia [a medication used to treat major depressive (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disorder].Review of R5's Care Plan, located under the RAI tab in the EMR and dated 01/29/26 indicated a Problem of Resident is on an antidepressant medication D/T [due to] Depression and Anxiety [sic]. The interventions included Medication per MD [medical doctor] orders Monitor for s/s of adverse side effects Monitor for behaviors psych per MD orders [sic].During an interview on 02/27/26 at 3:33 PM, the Director of Nursing (DON) stated, I expect the resident's care plan to reflect the care they are receiving. This would include the behaviors that the resident is known to exhibit.Review of the facility's policy titled, Comprehensive Care Planning Policy, dated 02/24/26 indicated, . The facility will develop a comprehensive person-centered care plan for each resident that includes measurable goals and timetables to meet the resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure timely review and revision of care plans for one resident (Resident (R) 42) of four reviewed for care plan revisions out of a total sample of 38 residents. The facility failed to ensure R42's care plan was updated to reflect the resident's current smoking status. Failure to ensure care plan accuracy had the potential for the residents who smoke to be at risks for accidents/hazards during smoke breaks by not reflecting accurate smoking assessments for all residents who smoke.Findings include:1. Review of R42's Face Sheet, under the Resident tab of the electronic medical record (EMR) revealed the resident was originally admitted to the facility on [DATE] with diagnoses that included B-cell lymphoma with intrapelvic lymph nodes, unspecified psychosis, glaucoma, dementia, and schizoaffective disorder. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 02/10/26 and located under the Resident Assessment Instrument (RAI), tab of the EMR revealed a Brief Interview for Mental Status (BIMS) of nine out of 15 indicating the resident had moderately impaired cognition. The EMR also revealed that the resident was admitted to hospice care as of 5/16/25 and a significant change MDS was completed. During an observation on 02/25/2026 at 3:59PM, R42 was observed returning from the smoking area without evidence of burns or safety concerns.During an observation on 02/25/2026 at 4:01 PM, Certified Nursing Assistant (CNA) 5 entered the facility following R42. CNA5 was asked if the resident smoked independently, and she confirmed that the resident was an independent smoker and confirmed he could hold his own cigarette. CNA5 added that he was provided with a locker with a key to house his smoking materials. Review of the Smoking Care Plan, initiated on 09/23/25, and located under the RAI tab of the EMR documented the resident as an unsupervised smoker with interventions that included intermittent supervision, required smoking gloves, designated-area smoking, use of a cigarette holder, and 1:1 supervision-many of which were inconsistent with the resident's current abilities.During an interview on 02/26/26 at 8:47AM, R42 confirmed that he does not wear an apron or gloves when smoking, and that he does not need assistance to hold his smoking materials. During an observation on 02/26/26 at 8:58AM, R42 was observed in the smoking area, smoking unassisted. The resident was able to hold his own cigarette/cigar and no concerns were observed. During an interview on 2/26/26 at 4:55 PM, the Director of Nursing (DON) confirmed that although the resident experienced a prior decline, he subsequently regained the ability to smoke independently, and the care plan should have been updated accordingly. The DON stated it was the Minimum Data Set Coordinator's (MDSC) responsibility to update the care plan. During an interview on 2/27/26 at 2:33PM, the MDSC acknowledged that outdated interventions should not remain on the care plan and that revisions are required when resident status changes. Review of the facility's policy titled, Comprehensive Care Planning Policy, dated 01/27/11, revealed the facility will develop a comprehensive person-centered plan for each resident that includes measurable goals and timetables to meet the resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. The plan will be focused on resident choices and abilities with the intent of maintaining or improving resident functional abilities and quality of life. Further review of the policy revealed, The care plan is reviewed on an ongoing basis and revised as indicated by the residents' needs, wishes, or a change in condition. At a minimum, this will occur with each comprehensive and quarterly assessment in accordance with the Resident Assessment Instrument (RAI) requirements.

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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** Based on interviews, record review, and review of facility policy, the facility failed to ensure staff maintained professional standards of practice by ensuring one resident (Resident (R) 122) was not administered crushed medications when there was not a clinical indication to do so. Findings include:Review of R122's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated no cognitive impairment. R122 discharged on 07/25/25. Review of R122's Care Plan, dated 05/01/25 and located in the residents' EMR under the Care Plan tab, revealed R122 was care planned for behavioral symptoms. 07/16/25 Resident pocketing medications and refusing to give to the nurse. Review of R122's Orders located under the Resident tab of the EMR, revealed a physician order, dated 02/10/25, for may crush medications unless contraindicated.Review of R122's Nurse's Note dated 07/21/25 at 8:13 AM and located in the EMR under the "Notes" tab written by the Assistant Director of Nursing (ADON) revealed This writer entered resident room to administer AM medications (11-7 shift). Resident looked into medication cup and threw it in the trash due to medications being crushed.Review of R122's Nurse's Note dated 07/21/25 and located in the EMR under the "Notes" tab written by the Nurse Practitioner (NP) revealed R122, [AGE] years old male, is seen today for reports that he has refused to take his Abilify. Nurses report he was noted taking his Abilify tablet out of medication and refuses to take it several days ago. Nurses obtained a crushed order for medications, however patient refused to take any medications this morning because the medications were crushed and he wants to take them whole.Review of R122's Nurse's Note dated 07/21/25 at 7:33PM and located in the EMR under the "Notes" tab written by the Licensed Practical Nurse (LPN)6 revealed Resident has new order to administer Abilify in the A.M, and medications no longer have to be crushed. Resident aware.During an interview 02/26/2026 at 5:48 PM, LPN6 said R122 wanted to hold his medication, and he didn't want to take it at the time staff administered it. He wanted to hold onto the medication and take it later. She stated staff would crush all his medications. She said if the order says to crush, they will crush all of them. She said they did not have a list on the medication cart that listed medications that should not be crushed and that they would trust the order. She said she assumed the person who put the order in would know which medications could and could not be crushed and she did not double check. If the order says crush, they crushed all the medications. During an interview on 02/27/2026 at 10:06 AM the NP said that R122 medications should not have been crushed. During an interview on 02/27/26 at 3:32 PM the Director of Nursing (DON) said the physician order should state to crush only the particular medication that needed to be crushed and that medications that should not be crushed should not be. She stated she believed that there was only one specific medication (Abilify) of R122 that was crushed, but she was not sure which or if all his medications were crushed. According to a review by the Cleveland Clinic, Abilify should not be crushed, chewed, or divided; they should be swallowed whole. Crushing the tablet can alter how the medications is absorbed by the body. If swallowing is a problem, liquid formulations, or orally disintegrating tablets are available alternatives.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and policy review, the facility failed to administer oxygen in accordance with physician orders for two of four residents (Resident (R) 30 and R76) reviewed for oxygen therapy out of a total of 38 sampled residents. This failure had the potential for the residents not to receive the correct amount of oxygen causing hyperoxia (cells, tissues and organs are exposed to an excess supply of oxygen) or hypoxia (cells, tissues and organs are exposed to a decrease in oxygen). Findings include: 1. Review of R30's Face Sheet, located under the Resident tab in the electronic medical record (EMR) indicated R30 admitted to the facility on [DATE] with the diagnosis of chronic obstructive pulmonary disease (COPD) and congested heart failure (CHF). Review of R30's admission Minimum Data Set (MDS), located under the Resident Assessment Instrument (RAI) tab in the EMR, with an Assessment Reference Date (ARD) of 01/29/26 indicated R30 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R30 had moderately impaired cognition. R30 was also coded as receiving oxygen therapy. Review of R30's Care Plan, located under the RAI tab in the EMR and dated 01/26/26 indicated a Focus which stated, Resident requires oxygen therapy R/T [sic] [related to] SOB [shortness of breath] The intervention indicated, . Administer oxygen at [three] 3L/min [liters per minute] . Review of R30's Physician Orders, located under the Resident tab in the EMR indicated an order dated 01/23/26 for Oxygen: Administer oxygen (O2) via nasal cannula (NC) continuously at: [three] 3 liters/minute [liters per minute] . During observations on 02/24/26 at 3:03 PM, 01/28/26 at 11:25 AM, and 02/25/26 at 10:23 AM, and 02/25/26 at 6:05 PM, R30 was lying in bed with the oxygen concentrator approximately two feet from the left side of the bed, administering oxygen at two LPM via nasal cannula. During an interview and observation on 02/25/26 at 6:07 PM, Registered Nurse (RN)1 confirmed R30's oxygen concentrator setting and stated, It is on two liters right now. RN1 returned to the medication cart outside of R30's doorway and reviewed R30's EMR for orders and confirmed the orders were for three LPM. RN1 went back into the resident's room and adjusted the oxygen concentrator to deliver three LPM to R30. 2. Review of R76's admission Record, located under the Profile tab of the EMR revealed admission to the facility on [DATE] and with diagnoses of COPD. Review of R76's quarterly MDS, under the MDS tab of the EMR, with an ARD of 01/26/26, revealed a BIMS, score of 12 out of 15 which indicated the resident had moderate cognitive impairment. The resident was not coded as receiving oxygen therapy. Review of R76's Care Plan, located under the Care Plan tab of the EMR, dated 02/12/25, revealed The resident required the use of oxygen due to a diagnosis of COPD. The Resident was at risk for altered respiratory status. An intervention in place was to administer oxygen per physician orders. Review of R76's Physician Orders located under the Orders, tab in the EMR, dated 10/17/25, revealed oxygen at two LPM via nasal cannula continuously. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Portsmouth	3610 Winchester Dr Portsmouth, VA 23707

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Medication Administration Record (MAR), located under the Records tab in the EMR, for the month of January and February 2026, revealed the nurses did not document that R76 was on oxygen at two LPM continuously. Further review noted nothing had been documented on the MAR about R76's oxygen administration. During observations on 02/25/26 at 9:59 AM, and again on 02/26/26 at 9:02 AM the resident was lying in bed with nasal cannula and oxygen cannister at three LPM. Further review revealed a sign was on the oxygen concentrator that indicated keep O2 level at [two] 2 LPM. During an observation and interview on 02/25/26 at 10:02 AM, Licensed Practical Nure (LPN) 3 confirmed R76's oxygen setting was at three LPM. She was not sure if that was correct or not. She stated she administered R76 her nebulizer treatment this morning but did not remember looking at the oxygen concentrator. She confirmed she did not document on R76's MAR related to the resident's oxygen order. She was unsure why there was no documentation for the entire month of February related to the resident's continuous oxygen order. During an interview on 02/27/26 at 3:32 PM, the Director of Nursing (DON) stated she expected staff to follow physician orders and monitor oxygen. During an interview on 02/27/26 at 3:33 PM, the DON stated, The staff should follow physician orders. Review of the facility's policy titled, Oxygen Administration Policy, dated 06/23/25 revealed, licensed clinicians with demonstrated competence will administer oxygen and check the order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. Building B. Wing	02/27/2026

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure that staff followed physician orders and weighed (Resident #4) prior to and after dialysis for one of one resident reviewed for dialysis, out of a sample of 38 residents. This had the potential to affect all residents who went out for dialysis treatment. Findings include:Review of R4's Face Sheet in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease with end stage renal disease and dependence on renal dialysis. Review of R4's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/03/26 EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was not cognitively impaired. R4 was documented as receiving hemodialysis. Review of R4's Care Plan dated 08/26/25 and located in the EMR under the Care Plan tab revealed R4was not care planned for dialysis treatment. Review of R4's Physician Orders located under the Orders tab in the EMR dated 12/17/25 revealed hemodialysis every Tuesday, Thursday, and Saturday. Further review revealed an order dated 09/03/25 pre dialysis and post dialysis weights on Tuesday, Thursday, and Saturday. Review of R4's weights revealed weights were only completed in February on 02/05/26 pre and post dialysis, and on 02/21/24 and 02/24/26 post dialysis. During an interview on 02/27/26 at 6:40 PM, Licensed Practical Nurse (LPN)1 stated residents receiving dialysis should be weighed prior to exiting the facility, and again upon their return. He stated there is an option in the MAR to include the weight. He said R4 should have a pre and post. But he said R4 does refuse at time but that should be documented. There should either be a documented weight refusal or a documented weight. He also stated there should not be an unavailable on the MAR where the weight should be documented, and said that was a good question when asked how the resident would not be available for his weight to be taken. He said the pre and post weights were important because it helps staff have a rough estimate of how much fluid was removed from the dialysis process and not having weights could cause hypovolemic or hypervolemic. During an interview on 02/27/26 at 3:32 PM the Director of Nursing (DON) stated she expected staff to absolutely follow physician orders. Review of the facility's policy titled Hemodialysis Care dated 07/02/25 revealed, Licensed staff with demonstrated competence will care for residents who require hemodialysis (via onsite third-party providers or who travel to an outpatient setting). Communication between the dialysis provider and facility staff will occur before and after each hemodialysis treatment and as needed. Document assessment in the Dialysis Communication Tool. Assessment includes Pre-treatment weight and post-treatment weight.