STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Old Dominion Rehabilitation and Nursing	4 Ridgewood Parkway Newport News, VA 23602

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to ensure residents were free from sexual abuse for two of nine residents reviewed for abuse (Resident (R) 2 and R122) out of 41 sampled residents. R2 experienced repeat sexual victimization when she was sexually abused by her Power of Attorney (POA2) in the facility, R121, and R100. Additionally, R122 was sexually abused by R99. Even though the facility was aware of R121's, R100's, and R99's incidents of sexual abuse and sexual behavior, the facility failed to put measures in place to protect R2, R122, and other vulnerable residents from sexual abuse, which constituted immediate jeopardy (IJ). Findings include:1. Review of R2's admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included dementia.Review of R2's Care Plan Report, dated 11/14/22 and provided by the facility, revealed, . Resident has displayed wanting and enjoying an intimate relationship with another resident as evidenced by her seeking him out in his room and assisting him into bed and being unclothed. Resident is no longer able to give consent. Resident displayed inappropriate sexual behaviors with another male resident. The goal was, Resident will not display negative outcomes from visits through next review. There was no intervention dated 11/14/22.The Care Plan Report, dated 01/12/23, revealed another focus of . has sexually inappropriate behaviors r/t [related to] history of behaviors of her past as a child . The goal was, . inappropriate behaviors will lessen in frequency through next review . Intervention included, . Distract resident with activities that have meaning to them . Staff to monitor and identify anything that triggers the resident behaviors .Review of R2's annual Minimum Data Set (MDS), with an assessment reference date (ARD) of 09/30/24 and provided by the facility, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated the resident was severely cognitively impaired.Review of the facility's document titled Facility Investigation, dated 12/16/24 and provided by the facility revealed .On 12/16/24 a C.N.A [Certified Nursing Assistant] walked by the room [R2's room] and noted that the bed was shaking. C.N.A immediately walked into the room thinking that [R2] was having a seizure. When C.N.A walked into [the] room she seen [POA2] forcing his penis into [the] resident's mouth and immediately he pulled up his pants when C.N.A saw them. The C.N.A immediately notified the supervisor and POA was asked to leave the room. When [POA2] left room, resident [R2] resident [was] asked if [she was] ok and [R2] said, 'he forced it [penis] in my mouth.' .A psychosocial assessment was done [on] 12/17/24, and she is unable to remember the event due to Dementia.We [facility] are substantiated [sic] that there was sexual contact between residents [sic] and POA. Review of the facility provided document titled, Interviewer Statement-Confidential, dated 12/16/24 revealed the facility interviewed R2's roommate [R76]. Continued review revealed .Resident [R76] heard roomates [sic] [POA] say suck this [explicit word for penis] you [derogatory name], use your tongue.Review of the facility provided document titled, Interviewer Statement-Confidential, dated 12/16/24 revealed the facility interviewed POA2. Continued review revealed .Residents [sic] [POA] expressed resident was pretending to suck my (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[explicit word for penis], because it calms her. Resident asked to perform oral [sex] to feel better. [POA] stated it was all pretend for 1-2 minutes and resident is 'back to normal' after that.Review of R2's Evaluation Report of the Physical/Mental Condition of [R2], dated 03/27/25 and provided by the facility revealed .Patient unable to remember day, month, year, place, or situation.she has poor attention and concentration. She is noted with poor judgment and insight. She is unable to communicate, understand, appreciate, or rationalize.Unable to make decisions regarding her care or finances.Review of R2's Care Plan Report, provided by the facility, revealed no documented evidence R2's care plan was updated with interventions to protect the resident following the incident.2. Review of R121's admission Record, located in the resident's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. R121 was discharged on 07/14/25.Review of R121's quarterly MDS, with and ARD of 06/24/25 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 13 out of 15 which indicated the resident was cognitively intact. The MDS did not indicate the resident engaged in any behaviors during the review period. Review of R121's Care Plan, located in the resident's EMR under the Care Plan tab revealed, .Focus.Resident having sexual seeking behaviors towards residents. Initiated 05/19/25.Review of the facility provided Facility Reported Incident (FRI), dated 05/18/25 revealed on 05/17/25, . [R121] and [R2] were found in bed together with no clothes on. Residents were separated immediately, and [R121] was moved to another unit.Review of an untitled and undated facility a written statement revealed, .Around 10:50 pm CNA alerted writer that two residents ([R2, R121]) were in room.engaging in [sexual] intercourse. Nurse immediately enters the room. Upon entering, nurse (writer) observes [R2] head between [R121's] legs. Both residents were partially clothed.instructed both residents to stop and informed them that the behavior was inappropriate. Review of the facility provided document titled, Interviewer Statement-Confidential, dated 05/17/25 revealed R121 was interviewed. Continued review revealed .Resident [R121] expressed: .She got in the bed, after she sucked my [explicit word for penis], then opened her legs, and I told her, 'I can't do this.' I pulled my clothes up and the nurses came in.Review of R2's Progress Note, dated 05/17/25 and located in the resident EMR under the Progress Notes tab revealed .DON [Director of Nursing] notified by primary nurse that resident was involved in sexual intercourse with another resident.residents were separated immediately due to resident's [R2] cognition did not allow her to provide proper consent to sexual behavior with [R121] [R121] was immediately moved to [another] room.Review of R2's Care Plan Report, dated 05/19/25 and provided by the facility, revealed, . Educate staff on providing frequent monitoring of resident, knowing of residents where-abouts due to resident having sexual behaviors . Resident on frequent rounding by staff due to seeking sexual behaviors with other residents .Review of R121's late entry Progress Note dated 05/18/25 at 1:30 AM and located in the resident's EMR under the Progress Notes tab revealed Police Detectives arrived and interviewed resident regarding sexual incident with other resident tonight [R2]. An in-service was provided by the Regional Director of Clinical Services, on 05/20/25 at 11:00 AM about abuse documentation and documentation/steps for consensual sex for residents. The summary of the in-service was on review of abuse policy- specifically documentation to be completed in resident record completing abuse interview on residents with a brief interview for mental status (BIMS) greater than 10, protocol on residents who wish to have consensual sex, education of residents, care plan, privacy provision. The attendees of the in-service were the Assistant Director of Nursing (ADON), the Director of Nursing (DON), and the Unit Manager (UM).R121 was discharged from the facility on 07/14/25. 3. Review of R100's admission Record, located in the resident's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE].Review of R100's quarterly MDS, with an ARD of 07/29/25 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 13 out of 15 which indicated the resident was cognitively intact. The MDS indicated the resident displayed no behavioral signs or symptoms.Review of the undated facility provided document titled, Facility (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Reported Incident Final Report, revealed .Incident date: July 1, 2025.RE: Resident to Resident Incident.nurse found residents [R2] and [R100] to be engaged in sexual activity.During an interview with [R2], she stated to [the] Assistant Director of Nursing that she did have a male visitor in her room the previous evening. She stated that they were getting to know each other. She went on to say that she does not feel afraid or uncomfortable at the present time.[R100] was more descriptive of the event, but indicated it was consensual.Conclusion: [R2] has history of sexually seeking out male residents as noted in similar reported incident involving another male resident on 05/18/25. Under her current medical diagnosis, she does not have the cognitive ability to make competent decisions.Review of the facility provided document titled, Interviewer Statement-Confidential, dated 07/02/25 revealed the facility interviewed R2. Continued review revealed .This nurse spoke with [R2] .When asked if anything out of the ordinary occurred overnight, resident [R2] replied 'not that I am aware of.' This nurse then asked resident [R2] if any male residents visited with her last night. [R2] then stated, 'Well yes. I don't know where he came from, but he came so that we could get to know each other.This nurse asked [R2] if male resident touched her in any way or if she touched him in any way. [R2] then replied, 'Well yes, we had to get to know each other so we could see if we could be friends.' .Review of an undated handwritten document titled Statement revealed . [R100 statement] 'States he woke up [and] went to wash up at the sink, then went to the bathroom and the [sic] came back out. He then went into resident [R2] room because the door was open to say hi. Resident [R2] said hi back and then they started talking about love. She [R2] stated she never had a husband before, and he said he has some experience but not much. She was turning him on and he asked do you want to feel my penis. He then pulled his penis out of his underwear, and she started rubbing his penis back and forth. He said do you want to put it in your mouth, then she put his penis in her mouth, and started giving him head [oral sex] .[R76's (roommate of R100) statement] 'States he [R100] walked in. She thought it was a CNA, but when they got quite she realized that it was a man. She turned the TV on mute [and] he said why can't you suck it for a little bit, and resident [R2] said once we get moving with the process. Then she heard giggling, then kissing, then it got real quite again. [Nurse's statement] went into resident room due to call light being on. [R100] was standing at the head of bed, resident [R2] latched onto resident [R100] penis performing oral sex.Review of R2's Care Plan Report, dated 07/03/25 and provided by the facility, revealed, . Montor [sic] for signs of flirtatious behaviors .During an interview on 02/18/26 at 6:01 PM, the Administrator stated she started working at the facility on August 25, 2025, and this was the first time hearing about the incidents between R2, R121 and R100. The Administrator stated she was not aware of any concerns with R2's POA. The Administrator also stated she had not read the FRIs; the social worker (SSD) might know about the sexual abuse incidents.During an interview on 02/18/26 at 6:05 PM, the Social Services Director (SSD) stated he started working at the facility in July 2023. The SSD stated, I was here when R2's power of attorney sexually abused R2 and I have to go to court for it. [R2's] roommate told the SW that she saw the POA with his pants down making R2 give him oral sex. The [POA] has not been here since that incident, and R2 has a different guardian now. This sexual abuse incident happened in 2024. The resident is not cognitively intact. The POA had been doing it [sexual abusing R2] for so long that he thought he could continue in the facility. When I interviewed R2, she was not upset. R2 does not consider sexual abuse harmful behavior. R2 said 'That's how I make a friend.' .The SSD continued I was not there for [the sexual abuse incident between] R2 and R100, because it happened in the evening. R100 is not predatory or anything. R2 can be predatory.R2 makes her advances. It was not confirmed [the two residents] did anything physically. I am not aware of any sexual abuse besides the POA [sexual abuse incident] .The next incident, between R2 and R121 was not a concern in his opinion because R121 is not here anymore. His [R121] side of the story was he was trying to avoid R2 by going away from her [and] into his room the best that he could.During an interview on 02/18/26 at 6:20 PM, the Regional Director of Operations stated, I don't remember right off. For the one back in July, with R100, I just faxed it over, I did not know it was a female resident (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and a male resident sexual encounter. I do not recall anything happening here like that. During this survey I was made aware of it [of sexual abuse]. If there is no [mental] capacity, there can still be intent [to engage in sexual abuse]. If one of the residents had a BIMS of six means they were compromised in some way. I would follow the care plan and look at the interventions for full mental capacity of the resident. During an interview on 02/18/26 at 6:27 PM, the Medical Director stated he had been the Medical Director at the facility for the last seven to eight years. The Medical Director also stated he remember vaguely the facility notifying him about sexual abuse with [R2 and R121]. Continued interview revealed that the Medical Director remembered the sexual abuse incident with the POA and the resident [R2]. The Medical Director stated, Usually, they do a head-to-toe assessment and ask the provider to do the same thing and if there are no sign of physical things, if no relative documents were found, we send them to the hospital for a rape kit. I vaguely remember the allegation of sexual abuse [between R2 and her POA]. We write a follow-up note and maybe send the resident to the emergency room. My expectations for protection to prevent future sexual abuse is to not allow the person [perpetrator] on the campus, call the police and report. I would interview other residents and staff. I would assume the facility would not allow the [perpetrator] on the campus. The two other residents would be put on different units or discharged . Every FRI goes to me during the investigation, but I would look them up. Normally, I do a full physical assessment if they said [the abuse] was substantiated. I will look up the FRI and get back to you tomorrow. The Medical Director did not provide any further information.4. Review of R99's admission Record located in the resident's EMR under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R99's quarterly MDS, with an ARD of 07/18/25 located in the resident's EMR under the MDS tab revealed the resident had a BIMS score of 11 out of 15 which indicated the resident was moderately cognitively impaired. MDS revealed R99 used a wheelchair, was partial to moderate assistance for sit to stand, transfer from chair to bed, and was independent wheeling himself for 150 feet.Review of R99's Care Plan, located in the EMR under the Care Plan tab revealed R99 had displayed wanting and enjoying an intimate relationship with another resident as evidence by peruses other female residents. Educated on safe sex and to ask for contraceptives if need. Educated resident with the consequences of seeking out others that are unable to consent. Observe and report any distress noted between either party. Observe resident when interacting with female residents and alert resident if they can give informed consent. Provide privacy during visits, revision date 11/15/24. activity of daily living (ADL) self-care performance deficit related to cerebral vascular accident (CVA) with left hemiparesis, muscle weakness and congestive heart failure (CHF) requiring two (2) assist bars for bed mobility. bed mobility requires physical assist from nursing staff. transfer requires physical assist from nursing staff, revision 11/26/23. Review of R99's quarterly MDS, with an ARD of 12/01/25 and located in the resident's EMR under the MDS tab revealed the resident had a BIMS score of 14 out of 15 which indicated the resident was cognitively intact. R99 was dependent for sit to stand, transfer form chair to bed did not occur, and R99 no longer used a wheelchair. The resident had significantly declined in the areas of ADLs and mobility since the MDS dated [DATE]. Review of R122's admission Record located in the residents EMR under the Profile tab revealed the resident was admitted on [DATE] with diagnoses of Parkinson's disease, Dementia with behavioral disturbance, Neurocognitive disorder with Lewy bodies and depression. Review of R122's Care Plan, revised on 02/03/26 and located under the Care Plan tab of the EMR revealed, ADL self-care performance deficit related to Dementia and Parkinson's disease. bed mobility: the resident requires two staff assist to turn and reposition in bed. transfer: the resident requires by two staff assist to move between surfaces . Review of R122's annual MDS, with an ARD of 01/11/26 located in the residents EMR under the MDS tab revealed the resident was not able to complete a Brief Interview for Mental Status and staff assessed that the resident was moderately cognitively impaired. Review of R99's Progress Note, dated 06/19/25 and located under the Progress Notes tab of the EMR with revealed Certified Nurse Assistant (CNA) staff called for this nurses assistance while entering [R122's] room. [R99] (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	noted at female resident's bedside with right arm under the female resident's shirt. Resident immediately removed from room. Education provided to resident on importance of not entering another resident's room without permission and importance of not touching other resident [sic] without permission. Nursing measure: one to one (1:1) care provided while up in wheelchair. On call provider notified and representative notified. Review of R99's Progress Note, dated 06/20/25 and located under the Progress Notes tab of the EMR revealed .nurse document incorrect resident is not on 1:1 care, resident is on frequent checks. Review of R99's Facility Reported Incident (FRI) provided by the facility, dated 06/19/25 revealed an investigation on 06/19/25 that [R99] was found in [R122's] room beside the bed when the CNA was going in to do activity of daily living (ADL) care. The CNA observed [R99] to have his right hand under [R122's] shirt. The CNA removed [R99] from bedside of [R122's] bed and went and got the nurse. When the nurse entered the room, she observed [R99] from the room and asked what he was doing, and he said, 'I was not doing anything.' [R99] was educated by the nurse that he could not be in other residents' rooms or touch another resident and that he could be charged with assault.[R99] was placed on frequent checks. Skin audit on [R122] with no injuries noted. Care plans have been updated. Psychosocial assessment has been carried out, and [R122] has had no psychosocial effects evidence by no change in behavior or mood. Mealtimes have been staggered so [R99] is not in the day room at the same time as [R122], and if residents are in activities together someone must always be in the activities room. [R99] will continue to be on frequent checks. Psychosocial assessment with [R99] has been conducted and [R99] denies that he did anything wrong. [R99's] room was located directly across the hall from [R122]; [R99] was moved onto a different hallway with mostly male residents and females who are cognitively intact. [R122's] party responsible refused to press charges against [R99]. Conclusion: Based on our investigation, we have substantiated that the incident occurred. Review of R99's Progress Note, dated 07/01/25 and located under the Progress Notes tab of the EMR revealed .the interdisciplinary team (IDT) met to discuss resident's care. Resident with documented incident of being sexually inappropriate with a female resident. Education provided to resident regarding inappropriate touching of others and room change initiated. Resident placed on.every 15-minute checks for observation. Resident is followed by in house provider. Continue current plan of care. During an interview on 02/19/26 at 12:16 PM, the Administrator was asked, Are you aware of a sexual assault incident with R99 and R122 on 06/19/25? She stated, I know we've had more than one case; I'd have to review the chart tomorrow. During an interview on 02/20/26 at 3:27 PM, the Administrator stated she looked over the FRI for R99 having inappropriate sexual contact with R122. She confirmed the allegation was substantiated. She confirmed more consistent monitoring should have occurred for at least 24 hours. The Administrator stated new staff and agency staff were not being educated on the situation with R99 having inappropriate sexual contact with a female resident and that by not informing staff they were not protecting vulnerable female residents.During the survey, R99 was not observed out of his room and was always in his bed. Review of the facility's abuse policy titled, Abuse, Neglect, and Exploitation, reviewed on 12/01/22 revealed .Policy: It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and precent abuse, neglect, exploitation and misappropriation of resident property.Definitions.Sexual abuse is non-consensual sexual contact of any type with a resident.VI. Protection of the resident.The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. B. Examining of the alleged victim for any signs of injury, including a physical examination or psychosocial assessment; C. Increased supervision of the alleged victim and residents.The facility's failure to ensure residents were free from sexual abuse caused or was likely to cause serious injury, harm, impairment, or death to a resident. An Immediate Jeopardy was identified on 02/18/26 and was determined to exist on 12/16/24, in the area of S483.12 Freedom from Abuse, Neglect, and Exploitation at a Scope and Severity (S/S) of a K. The Administrator, Director of Nursing (DON), Regional Director of Clinical (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7:26 PM revealed she had received training on abuse, reporting, and interventions to take if abuse is identified or allegations of abuse are made. Interview with CNA13 at 7:30 PM revealed she had received training on abuse, reporting, and interventions to take if abuse is identified or allegations of abuse are made. Interview with Registered Nurse (RN)1 at 7:33 PM revealed she had received training on abuse, reporting, and interventions to take if abuse is identified or allegations of abuse are made. Review of facility records revealed:- inservice records revealed all active staff had been trained in abuse and neglect and prevention of neglect.- audit tools for behavior monitoring were implemented- care plans for R2, R99, R100, R120, and R122 were updated to reflect current behavior monitoring needs and interventions. Observations of R2 and R100 revealed on 02/20/26 from 9:55 AM through 3:08 PM, the residents remained on 1:1 supervision. At 3:08 PM, the residents were assessed by psychiatric services to no longer require 1:1 supervision. The survey team validated the full implementation of the facility's POR through observations, interviews, and record review. The Administrator was notified on 02/20/26 at 7:40 PM that the Immediacy had been removed and the deficient practice was lowered a scope and severity (S/S) of G (isolated Actual Harm).

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Old Dominion Rehabilitation and Nursing	4 Ridgewood Parkway Newport News, VA 23602

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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 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policy, the facility failed to ensure residents were free from misappropriation for one of three residents (Resident (R) 120) reviewed for misappropriation out of 41 sampled residents. The Business Office Manager (BOM) used the resident's credit card for personal use, totaling over $10,000. This failure resulted in more than minimum consequence harming Resident #120 by deliberately misusing and exploiting significant amounts of money without consent which constituted Immediate Jeopardy past non-compliance. Findings include:Review of R120's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 12/16/21 and located in the resident's EMR under the MDS tab revealed the resident was admitted to the facility on [DATE]. The MDS also revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. Review of the facility's Facility Reported Incident (FRI), dated 02/01/23 and provided by the facility revealed the Business Office Manager (BOM) reported to the previous Administrator on 02/01/23 at 5:30 PM that she used R120's personal credit card to pay for her rent for three months and numerous amazon orders. The BOM was suspended for three days pending the investigation. The facility did an audit of the resident's personal funds and fired the BOM. The staff were in-serviced on 02/01/23 on Abuse, neglect, and misappropriation of funds. The incident was reported to the police the next day on 02/02/23. The Social Service Director (SSD) conducted an audit of four alert residents and their personal credit cards and the audit of four residents whose representatives hold their credit cards regarding misappropriation of funds. This audit was then monitored in QAPI. The FRI was reported to the Department of Health Professionals (DHP) on 02/02/23. On 05/22/23, the Commonwealth of Virginia notified the past Administrator As we discussed, this case was continued for six months to allow the defendant to pay the restitution in full. If the defendant does so, there is a plea agreement that includes the defendant pleasing guilty to the misdemeanor obtaining money by false pretenses charge. If the defendant does not pay restitution, our office will proceed with felony charges. Sincerely, Senior Assistant Commonwealths Attorney. An audit of resident accounts occurred, staff were in-serviced on elder financial abuse How to report an allegation of abuse. Audits were conducted on 02/02/23, 02/20/23, 02/27/23 on misappropriation of funds. The past Administrator was subpoenaed on 05/15/23 to court against the prior BOM. The prior BOM paid three months of rent in the amount of $2,298.95 dated 10/27/22, 11/25/22, 01/04/23 over the course of a four-month period. An audit of resident trust accounts was conducted on 01/22/23. Staff were inserviced on the topic of Elder financial abuse: How to report an allegation of abuse. Audits with the residents were conducted on 02/02/23, 02/20/23, and 02/27/23 on misappropriation of funds.Attempted to reach R120 on 02/18/26 at 11:09 AM, but the telephone number was disconnected. During a telephone call to the Emergency Contact (EC) 120 on 02/18/2026 11:10 AM, stated R120 was reimbursed by the BOM in July 2025. During a joint interview on 02/19/26 at 12:24 PM, with the Administrator and Director of Nursing, the Administrator stated, for embezzlement, we called the police and the police came out. There was no further misappropriation of funds for this resident or any other resident. Review of the facility's abuse policy titled, Abuse, Neglect, and Exploitation, reviewed on 12/01/22 revealed .Policy: It is the policy of this facility to provide protection for the 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 resident property.Definitions.Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary or permanent, use of a resident's belongings or money without the resident's consent.On 02/18/26 at 8:00 PM, the Administrator, Director of Nursing, Regional Director of Clinical Services, Regional Director of Operations were notified that the failure to protect a resident from misappropriation constituted a Past Noncompliance (PNC) Immediate (continued on next page)

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F 0602 Level of Harm - Actual harm Residents Affected - Few	Jeopardy at F602. There was no further misappropriation of funds for this resident or any other resident, and the issue was not identified during the current survey, attributing Past Non-Compliance to this deficient practice.It was determined that the IJ began on 10/24/22 and ended on 03/16/23 when the facility completed their last corrective action of resident and representative interviews. The corrective actions included termination of the BOM; staff education on abuse, neglect, and misappropriation; notifying law enforcement of the misappropriation; audits of resident accounts; report to the Virginia Department of Health Professionals (DHP); interviews with four residents and four representatives for four weeks; and monitoring through the facility's Quality Assurance and Performance Improvement (QAPI) committee. The survey team was able to validate through staff and resident interviews, review of the audits of resident accounts, staff education sign-in sheets with signatures, review of the law enforcement record that all corrective actions had been implemented with a compliance date of 03/16/23.

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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** Based on interviews, record review, and facility policy review, the facility failed to complete an assessment of the building to determine where Legionella and other opportunistic waterborne pathogens can grow and spread. Additionally, the facility failed to ensure staff adhered to Transmission Based Precautions (TBP) for one of 41 sampled residents (Resident (R) 51). These failures had the potential for some of the areas at risk for Legionella growth not to be monitored in the building and placed residents at risk for the spread of infections.Findings include:1. Review of the facility's Water Management Binder, provided by the facility, revealed an assessment of the building was not completed where Legionella could grow and spread. During an interview on 02/18/26 at 12:52 PM, the Maintenance Director confirmed that a building assessment had not been completed to determine the risk of Legionella growth. The Maintenance Director stated he monitored the water system in the building by testing the water temperatures, changing filters in the ice machine and hot water heater, and running water in sinks, showers, and flushing the toilets in empty rooms. The Maintenance Director also stated he had not completed a building assessment and was not aware that one was needed for the water management program. During an interview on 02/20/26 at 2:19 PM, the Administrator verified that she found the blueprint of the building but did not find the assessment of the building where Legionella could grow and spread. The Administrator stated the assessment was important to determine the areas of the building that needed to be monitored to ensure the quality of the water. During an interview on 02/20/26 at 2:20 PM, the Infection Preventionist (IP) stated she was not aware that an assessment of the building had not been completed for the water management program although she had meetings on infection control which the Maintenance Director attended. The IP also stated the assessment should have been completed to determine areas where Legionella could grow in the building. Review of the facility's policy titled Water Management Program, revised 12/01/22, provided by the facility, revealed Policy: It is the policy of this facility to establish water management plans for reducing the risk of Legionella and other opportunistic pathogens . in the facility's water systems .Policy Explanation and Compliance Guidelines: . 3. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. The risk assessment will consider the following elements: a. Premise plumbing: This includes water system components as described in the documentation of the facility's water system. b. Clinical equipment: This includes medical devices and other equipment utilized in the facility that can spread Legionella through aerosols or aspiration. c. At-risk population - This facility's entire population is at risk. High risk areas shall be identified through the risk assessment process .2. Review of R51's admission Record located under the Profile tab of the electronic medical record (EMR) indicated R51 was admitted on [DATE] with a diagnosis of dependence on renal dialysis.Review of R51's Infectious Disease Physician Note located under the Miscellaneous tab of the EMR dated 01/07/26 revealed R51 has a history of end stage renal disease on intermittent dialysis. Resident was afebrile and white blood count (WBC) within normal limits on admission, however blood cultures sent and now positive for methicillin- susceptible staphylococcus aureus (MSSA) bacteria. Review of R51's Order Summary Report located under the Orders tab of the EMR revealed maintain contact precautions all services to be provided in room every shift for methicillin- susceptible staphylococcus aureus (MSSA) for six (6) weeks, start date 01/12/26.Review of R51's Care Plan located under the Care Plan tab of the EMR revealed R51 had MSSA bacteremia, administer antibiotics as per Medical Director (MD) orders, and to maintain contact precautions, start date 01/12/26.During an observation on 02/16/26 at 11:28 AM, a contact precaution sign was on the wall next to the door of R51's room that indicated staff were to clean hands, put on a gown and gloves before entering the room and a personal protective equipment (PPE) cart was outside of residents' room. During an observation on 02/17/26 at 9:01 AM, revealed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	there was no separate trash cans in R51's for used PPE or linens. The only trash can observed in R51's room was his personal trash can. During an interview on 02/17/26 at 9:02 AM, the Director of Nursing (DON) confirmed the appropriate trash cans for R51's contact isolation were not present. During an interview on 02/17/26 at 9:03 AM, the Assistant Director of Nursing (ADON) revealed there should be a red bag by the door for PPE. During an observation and interview on 02/17/26 at 9:08 AM, Licensed Practical Nurse (LPN)8 walk into R51's room and handed him a packet of paperwork for his appointment. The LPN had no PPE on. LPN8 confirmed she should have worn PPE when she went in R51's room. During an interview on 02/20/26 at 1:11 PM, the Infection Preventionist (IP) confirmed staff should always were full PPE when entering a contact isolation room to protect themselves and R51. She also confirmed separate trash cans should be present for disposal of PPE and dirty linens.Review of the facility policy titled, Infection Prevention and Control Program with a revision date of 12/01/22 revealed, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Policy Explanation and Compliance Guidelines: . 2. All staff are responsible for following all policies and procedures related to the program. 4. Standard Precautions: . c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. 5. Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on isolation precautions as recommended by current CDC guidelines.

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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 interview, record review, and facility policy review, the facility failed to report alleged abuse violations timely for five of five Residents (Resident (R) 2, R99, R100, R121 and R122) reviewed for abuse out of a total sample of 41 residents. This had the potential for continued abuse. Findings include:1. Review of the Facility Reported Incident (FRI) provided by the facility revealed there was an allegation of sexual abuse between R2 and R121 which occurred on 05/17/25 at 12:15 PM. The allegation was not reported to the State Agency (SA) until 05/18/25 at 10:50 PM (over 34 hours later). 2. Review of the FRI provided by the facility revealed an allegation of abuse between R2 and R100 occurred on 07/02/25. The FRI was not sent to the SA until 07/11/25 by the Administrator (nine days later).During an interview with the Administrator, on 02/20/26 at 3:29 PM, said her expectation is that abuse investigations should be turned into the state within two hours and confirmed the above-mentioned FRIs were not submitted within two hours. 3. Review of R99's admission Record located under the Profile tab of the EMR indicated the R99 was admitted to the facility on [DATE]. Review of R122's admission Record located in the EMR under the Profile tab revealed the resident was admitted on [DATE].Review of the Facility Reported Incident (FRI) provided by the facility, dated 06/19/25 revealed a Certified Nursing Assistant (CNA) observed R99 in R122's room on 06/19/25 at 7:18 PM. R99 was observed with his right hand under R122's shirt. The facility did not report the abuse to the State Agency (SA) until 06/20/25 (the next day) at 3:25 PM. During an interview on 02/20/26 at 3:27 PM, the Administrator confirmed the FRI should have initially been sent to the SA within two hours of discovery and the facility sent the report to the state the next day. Review of the facility policy titled Abuse, Neglect, and Exploitation implemented on 11/01/20 and revised on 12/01/22 revealed Policy. VII A. 1. Reporting of all alleged violations. within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. (Cross Reference F600)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview, record review, and policy review, the facility failed to ensure residents and/or resident representatives were provided with written notices of transfer and bed hold notices for four of five residents (Residents (R) 5, R8, R51, and R99) reviewed for hospitalizations out of a total sample of 41. This failure had the potential for residents and/or resident representatives (RP) not to have the necessary information to make informed decisions regarding bed holds and to not be informed of the reasons for transfers. Findings include:1. Review of R5's undated admission Record, located under the Profile tab in the electronic medical record (EMR), revealed R5 was admitted to the facility on [DATE]. Review of R5's Health Status Note, dated 09/23/25, located in the EMR under the Prog Notes tab, revealed Writer noted during medication pass at 1400 [2:00 PM], that the resident appeared to be acting out of the resident's norm. Writer noted the resident appeared to be extremely drowsy, right side of the body more contracted than normal, head leaning to the right, right eyeball facing outward more than usual, resident was not able to pick their head up nor hold it up .Order was placed in the system. Resident RP [representative] was informed of the situation that was currently going on and was informed that the resident was being transferred to the Emergency Department. EMS [emergency medical services] arrived and got report of resident and the situation .Resident left with their face sheet, physician note, order summary, care plan, and e-interact transfer form.Review of R5's Health Status Note, dated 09/23/25, located in the EMR under the Progress Notes tab, revealed ordered for the resident to be sent to the ER [emergency room] for Altered Mental Status.During an interview on 02/20/26 at 11:24 AM, the Social Services Director (SSD) stated nursing was responsible for the bed hold notices and transfer to the hospital notices. During an interview on 02/20/26 at 4:12 PM, the Administrator stated the bed hold notice was provided to the residents in the admission packet but confirmed it did not specify the reserve bed payment per day. The Administrator verified she did not find the transfer form with the reason for the transfer to the hospital and appeal rights that were provided to the family in writing. The Administrator indicated that she was not aware that staff were not providing the bed hold and transfer form to the resident and/or representative. 2. Review of R8's admission Record located under the Profile tab of the EMR indicatedR8 was admitted on [DATE] with diagnoses of non-ST elevation (NSTEMI) myocardial infarction, acute ischemic heart disease, and hypertensive heart failure.Review of R8's admission Minimum Data Set (MDS) located under the MDS tab of the EMR with an ARD of 11/03/25 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating R8 was cognitively intact.Review of R8's Progress Notes located under the Progress Notes tab of the EMR dated 12/22/25 at 10:44 PM, revealed R8 called 911 herself and requested to go to the emergency room with 911 transport. During an interview on 02/16/26 at 2:50 PM, R8 stated she was hospitalized twice with a heart attack, that she called the ambulance herself, and that she came back to the same room as when she left. R8 confirmed the facility never gave her any paperwork related to her transfer or bed hold notice. During an interview on 02/20/26 at 9:12 AM, the Director of Nursing (DON) stated she could not find anything for the transfer notice, bed hold, or hospital notification for when R8 was admitted to the hospital. 3. Review of R51's admission Record located under the Profile tab of the EMR indicated R51 was admitted on [DATE] with a diagnosis of dependence on renal dialysis.Review of R51's Progress Notes located under the Progress Notes tab of the EMR dated 01/02/26 at 5:02 PM, revealed R51 was at the hospital.During a review of R51's Infectious Disease Physician Note, dated 01/07/26 and located under the Miscellaneous tab of the EMR revealed R51 had a history of end stage renal disease (ESRD) and received intermittent dialysis. R51 went to dialysis session where he became hypotensive halfway through his dialysis. He was complaining of some nausea and lightheadedness as well as sent in for evaluation. Review of R51's Medicare five (5) day MDS located (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	under the MDS tab of the EMR with an ARD of 01/13/26 revealed a BIMS score of 15 out of 15 indicating R51 was cognitively intact.During an interview on 02/17/26 at 8:44 AM, R51 revealed he was admitted to the hospital for a dialysis port infection. R51 revealed he came back to the same room, but don't know if they gave him any paperwork while he was in the hospital. During an interview on 02/18/26 at 4:21 PM, the Regional Director of Operations (RDOO) confirmed there was no hospital transfer notice or bed hold notice sent out when R51 was admitted to the hospital on [DATE]. 4. Review of R99's admission Record located under the Profile tab of the EMR indicated R99 was admitted on [DATE] Review of R99's MDS list located under the MDS tab of the EMR revealed R99 was DRA with an ARD of 11/18/25 and an entry MDS with an ARD of 11/22/25.Review of R99's Progress Notes, dated 11/18/25 at 4:09 PM and located under the Progress Notes tab of the EMR revealed R99 was eating a tuna sub sandwich in the day room when the staff observed that the resident slumped over and food was falling out of his mouth. Staff were able to slowly arouse the resident. The facility called for emergency medical services to transport the resident to the hospital.Review of R99's quarterly MDS located under the MDS tab of the EMR with an ARD of 12/01/25 revealed a BIMS score of 14 out of 15 indicating R99 was cognitively intact. During an interview on 02/16/26 at 10:20 AM, R99 revealed he went to the hospital because he had a stroke. During an interview on 02/20/26 at 9:12 AM, the DON stated she could not provide any documented evidence that the resident and/or his representative was provided a written notice of transfer or that the resident was provided a bed hold notice for the emergent transfer to the hospital. Review of the facility's policy titled, Bed Hold Notice Upon Transfer, revised12/01/22 indicated, At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. 'Policy Explanation and Compliance Guidelines: Bed Hold Notice Upon Transfer' 1. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies: a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; b. The reserve bed payment policy in the state plan policy, if any; c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed; d. Conditions upon which the resident would return to the facility: The resident requires the services which the facility provides; The resident is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. 2. In the event of an emergency transfers of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies, as stipulated in the State's plan. 5. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file.Review of the facility's policy titled, Transfer and Discharge (including AMA [Against Medical Advice]), dated 12/01/22, revealed, . 6. Non-Emergency Transfers or Discharges - initiated by the facility, return not anticipated. c. Contents of the notice must include: i. The reason for transfer or discharge; ii. The effective date of transfer or discharge; iii. The location to which the resident is transferred or discharged ; iv. A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; and v. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman . 7. Emergency Transfers/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified) . i. Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer. j. Provide transfer notice as soon as practicable to resident and representative . l. In case of discharge, notice requirements and procedures for facility-initiated discharges shall be followed.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and facility policy review, the facility failed to provide a dignified dining experience for two Residents (Resident (R)8 and R30) of two observed during dining. R30 was left waiting for her meal set up after being delivered his tray. This failed practice had the potential to affect and resident who ate their meals in the dining room. Findings include:. During an observation on 02/16/26 at 12:40 PM, a meal tray was delivered to R30 in dining room. At 1:03 PM, (twenty-three minutes later) R30 had her tray sitting in front of her with lids still on the food. During an interview on 02/16/26 at 1:03 PM, Certified Nursing Assistant (CNA)5 confirmed all that R30 needed was the tray set up as she could feed herself. CNA5 confirmed meal tray set up should have occurred when R30 received her meal tray at 12:40 PM.During an interview on 02/16/26 at 12:56 PM, R8 revealed that the resident she sits with is served her meal then staff leave to serve the hallway and by the time they come back everyone else is done eating. R8 revealed her tray is the first one on the third cart but the last one to be served and it is always cold. During an interview on 02/16/26 at 12:57 PM, CNA10 said, it isn't right how they do this. The don't serve the meal right. They serve the dining room, some then serve the hallway, then back to serve dining room. There is no reason behind what they are doing. During an interview on 02/16/26 at 1:29 PM, the Dietary Manager (DM) confirmed all the residents in the dining room should be served their meal at the same time and that staff are to assist with resident tray set up at the time they give the resident the meal. During an interview on 02/19/26 at 11:51 AM, the Registered Dietician (RD) confirmed residents in dining room should be served at the same time and that meal tray set up should occur when meal is delivered. The facility provided a policy titled, Resident Rights with a revision date of 12/01/22 that indicated. Policy Explanation and Compliance Guidelines:. 11. The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents. Resident Rights: 1. Resident Rights: The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 5. Respect and Dignity, including: . c. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, record review, and facility policy review, the facility failed to complete a thorough investigation of resident-to-resident abuse involving one resident (Resident (R)7) out of nine residents reviewed for abuse out of a total sample of 41 residents. This had the potential for unrevealed concerns and the potential for continued abuse. Findings include:Review of R7's electronic medical record (EMR) Face Sheet under the Profile tab revealed an admission date of 10/30/25. R7 had diagnoses including bipolar disorder (a chronic mental health condition characterized by intense, extreme shifts in mood, activity levels, ranging from manic highs to depressive lows), generalized anxiety disorder, delusional disorders (a serious rare psychotic mental illness), and convulsions (otherwise known as epileptic seizures). Review of R7's EMR revealed a Health Status note dated 02/10/26 at 10:37 PM and located under the Progress Notes tab, documenting R7's behavior of threatening a resident, throwing water on the resident, cursing at the resident, and using racial slurs. The staff members were present and intervened.Review of the Facility Reported Incident (FRI) revealed no evidence that residents were asked if they were afraid of any residents or had any concerns with any residents in the facility. During an interview on 02/20/25 at 8:40 PM, the Administrator, the Regent Director of Operations (DOO), and the Social Services Director (SSD) were asked if the facility interviewed other residents to determine if they had any concerns for their safety or were fearful of any residents. The RDOO confirmed questions were not asked of other residents if they felt safe or fearful of any resident. Review of the facility's policy with a revision date of 12/01/22 and titled, Abuse, Neglect, and Exploitation revealed, . An immediate investigation is warranted.

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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, interview, and policy review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASARR) level one screen was completed accurately prior to admission for two residents (Resident (R) 8 and R105) of four residents reviewed for PASARR out of 41 sampled residents. This created a potential failure to identify what specialized or rehabilitative services the residents needed and whether placement in the facility was appropriate prior to admission.Findings include:1. Review of R8's admission Record located under the Profile tab of the electronic medical record (EMR) indicated R8 was admitted on [DATE] with diagnoses which included bipolar disorder.Review of R8's [PASARR] Level I Screening for Mental Illness, Intellectual Disability, or Related Condition dated 10/22/25 provided by the facility indicated R8 did not have a current serious mental illness (SMI) and did not need a referral for Level II evaluation. Continued review revealed the resident did not meet the applicable criteria for a SMI or a related condition. Review of R8's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/03/25 and located in the resident's EMR under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 11/03/25 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. The MDS also indicated R8 had a diagnosis of bipolar disorder and was taking an antipsychotic medication. Review of R8's Care Plan, revised 11/04/25 and located in the resident's EMR under the Care Plan tab revealed R8 received psychotropic medications related to bipolar which were to be administered as ordered by the physician. Review of R8's Order Summary Report located in the resident's EMR under the Orders tab revealed the resident was ordered Zyprexa (an antipsychotic medication) five milligrams (mg) for bipolar disorder and 01/30/26; Lamictal (an anticonvulsant medication used to treat mood disorders) tablet 25 mg with a start date of 02/18/26 (related to bipolar disorder., During an interview on 02/20/26 at 3:43 PM, the Social Services Director (SSD) confirmed R8's PASARR Level I dated 10/22/25 was not completed correctly when the resident's diagnosis of bipolar disorder was not identified on the PASARR.2. Review of R105's admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included schizophrenia. Review of R105's PASARR dated 07/25/22 with questions a few of which were: Does the individual meet nursing facility criteria? with a response of yes. Can a safe and appropriate plan of care be developed to meet all services and supports including medical/nursing/custodial care needed? with a response of yes. Does the individual have a current serious mental illness (MI)? with a response of no. And a checkmark next to Does not meet the applicable criteria for serious MI or IDD or related condition. During an interview on 02/18/26 at 5:44 PM, the Director of Nursing (DON) stated she has not been able to locate another more updated PASARR screening form. Review of the document and discussion regarding the inaccuracy of the document filled out by the previous social worker at the facility 07/25/22. The DON was asked if this should have been corrected by submitting a new form. She responded, looking at it now which this is the first time I have seen it - today. I would say absolutely it should have been redone.Review of the facility's policy titled, Behavioral Health Services, revised 12/01/22 indicated, .2. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care' This process includes: a. PASARR screening.

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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 review of the clinical record and staff interviews, the facility staff failed to conduct and document a thorough assessment for 1 of 27 residents (Resident #125) in the survey sample. The findings included: Resident #125 was admitted to the facility on [DATE] after an acute hospitalization. The residents' diagnoses included dementia with behavioral disturbance, coronary artery disease, heart failure, and diabetes. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 8/4/2022, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 3 out of 15. This indicated that Resident # 125's cognitive abilities for daily decision making were severely impaired. In section G Functional Status, the resident was coded as independent with eating after setup, requiring extensive assistance from one person for bed mobility, dressing, personal hygiene, and toileting, and was totally dependent for bathing. A review of the clinical record revealed the last review of the resident's skin was dated 8/11/2022. It stated there were no changes in the resident's skin integrity, and review of prior reviews identified no skin impairment. A nurse's note dated 8/19/2022. A Nurse Practitioner's progress note dated 8/12/2022 stated that the resident's skin was warm and dry, and with a boggy left heel, a deep tissue injury. The assessment of the upper extremities revealed strength in the bilateral upper extremities of 5/5 and left foot drop. On 8/19/2022 at 10:16 AM, a nurse's note stated that Resident #125 was found on the floor unresponsive, 911 was called, and the resident was transferred to the emergency room. A review of the transfer information under Section B - Key Clinical Information failed to identify an assessment of the resident's condition or a rationale for the transfer to the emergency room. Neither did the transfer information have vital signs or other pertinent information. It did state that the resident was not alert, yet it did not define Resident #125's baseline.The facility did not have a written protocol outlining a nurse's interventions before a transfer to another level of care to ensure a safe transition; therefore, an interview was conducted with the Director of Nursing (DON) on 5/7/2026 at approximately 5:35 PM. The DON stated that the nurse's documentation did not meet the facility's expectations and was unacceptable. The DON further stated that the identified change should have been documented first, and that a comprehensive assessment should have been completed, including blood pressure, heart rate, respirations, oxygen saturation, and blood sugar if the resident was diabetic. The DON also stated that the fall process should have been instituted, with notification to the provider and family. On 5/7/26 at approximately 5:45 PM, a final interview was conducted with the Administrator, Director of Nursing, and the Corporate Nurse Consultant. The above findings were conveyed to the administrative team, who made no comments and voiced no concerns.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents were provided with foot care for one of one resident (Resident (R) 77) reviewed for activities of daily living (ADLs) out of 41 sample residents. This failure had the potential to affect resident care including personal hygiene in the facility. Findings include:Review of R77's admission Record located in the resident's electronic medical record (EMR) under the Profile tab indicated R77 was admitted to the facility on [DATE] with diagnoses which included candidiasis of skin and nail, hemiplegia, and hemiparesis.Review of R77's Care Plan, initiated on 12/03/24 and located in the resident's EMR under the Care Plan tab revealed R77 had potential impairment to skin integrity related to fragile skin and the facility was to conduct weekly skin observations. Review of R77's Minimum Data Set (MDS), with an assessment reference date (ARD) of 11/16/26 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R77 was cognitively intact. The MDS also indicated the resident was dependent on staff for personal hygiene.During an observation on 02/16/26 at 10:56 AM, R77 was lying in bed. Observation of the resident's feet revealed they were dry, with flaking skin all over both feet.During an interview on 02/16/26 at 10:57 AM, R77 stated his feet were dry and felt scratchy against the sheets. R77 also stated, I don't know why they don't lotion them.Review of R77's Weekly Skin Review, dated 02/12/26 and located in the resident's EMR under the Assessments tab indicated R77's skin was intact and not dry.During an observation on 02/19/26 at 2:41 PM, R77 was lying in bed. Observation of his feet revealed both feet had dry skin that was flaking all over both feet. During an observation and interview on 02/20/26 at 4:02 PM at R77's bedside, Licensed Practical Nurse (LPN) 8 confirmed the resident had dry, flaking skin on his feet. LPN8 stated she would have the Certified Nurse Assistant (CNA) wash his feet and apply an emollient for moisture.During an interview on 02/20/26 at 4:08 PM at R77's bedside Certified Nurse Assistant (CNA) 8 confirmed R77 had dry, flaking skin on his feet. Review of the facility's policy titled, Skin Integrity- Foot Care, revised 12/01/22 indicated, It is the policy of this facility to ensure residents receive proper treatment and care to maintain mobility and good foot health. This policy pertains to maintaining the skin integrity of the foot. Policy Explanation and Compliance Guidlelines: 1. The facility will provide foot care and treatment in accordance with professional standards of practice, including the prevention of complications from the resident's medical conditions.2. Assessment of Risk.d. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task. 3. Interventions for Prevention and to Promote Healing a. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and assessment of any foot ulcers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to monitor a resident for safety during a physician's appointment for one of five residents reviewed for accidents/hazards out of 41 sampled residents (Resident (R) 119). This failure had the potential to result in the resident experiencing an accident without an escort to the appointment. Findings include:Review of R119's undated admission Record located in the electronic medical record (EMR) under the Profile tab revealed he was admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following a cerebral infarction (an ischemic stroke), and acute and chronic respiratory failure. Review of R119's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/11/24, located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. The MDS revealed R119 used a wheelchair and had an upper and lower extremity impairment. Review of R119's Daily Nursing Charting, dated 10/12/24, located in the EMR under the Prog [Progress] Notes tab revealed . a. LEVEL OF CONSCIOUSNESS Alert 2. ORIENTATIONResident is alert and oriented to the following person place Time 3. COGNITION intactCOMMUNICATION: Resident speaks Speaks English Are there changes in residents LOC/Orientation/cognition/communication status? no . Hand grasp and Range of Motion hand grasps-left hand Weak hand grasps-right hand Weak Range of Motion-Left side Limited Range of Motion-Right Side Limited .Review of R119's Progress Note, dated 10/17/24, located in the EMR under the Prog Notes tab revealed Resident went out to GI [gastrointestinal] appointment at 10:54 am via wheelchair. Resident returned to the faculty [sic] at 2:05 pm via wheelchair. No new orders has [sic] been given at this time.Review of R119's Weekly Skin Assessment, dated 10/17/24, located in the EMR under the Assmnts [Assessments] tab revealed R119's skin was intact. During an interview on 02/20/26 at 12:47 PM, Family Member (FM) 119 stated R119 was sent to a doctor's appointment with no one to accompany him in October of 2024. FM119 also stated that when a friend arrived to check on the resident at the physician's office, he was sitting outside the office and was not dressed appropriately for the cold weather. During an interview on 02/20/26 at 12:32 PM, the Assistant Director of Nursing (ADON) confirmed R119 was his own responsible party, had a BIMS of 9 per the MDS dated [DATE] which she considered was cognitively intact, he was alert and oriented to person, place, and time, did not have a power of attorney (POA), The ADON verified R119 he went to the appointment alone and returned to the facility unharmed from the GI appointment on 10/17/24. During an interview on 02/20/26 at 1:42 PM, the Director of Quality Assurance (DQA) stated the staff should have notified the family of the appointment, asked the family if they wanted to accompany R119 to the appointment, and if not then they should have arranged for an escort to go with the resident to ensure his safety. During an interview on 02/20/26 at 2:11 PM, Medical Records stated the nurses were making appointments for the residents in 2024 and she did not become responsible for it until 2025. Medical Records also stated the facility's process was to notified the family of the appointment and arranged for an escort to attend the appointments with the residents if the family could not attend the appointment. During an interview on 02/20/26 at 3:08 PM, the Administrator stated she expected the staff to assess the residents' BIMS, level of consciousness (LOC), and physical limitations to determine if they were safe in attending appointments without an escort. The Administrator also stated the family should have been notified of the appointment, asked if they were going to take the resident to the appointment or meet them there, and then arranged for an escort if needed to keep the resident safe. During an interview on 02/20/26 at 9:00 PM, the DQA verified the facility did not have a policy on transportation to appointments, arranging escorts for appointments, appointments, or escorts.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure alternative measures were attempted prior to the use of side rails, educated on the risks and benefits of side rail use, and failed to obtain a consent for the side rails for one of one Resident (Resident (R)63) out of 41 sampled residents. These failures placed the resident at risk of accidents and hazards related to side rail use.Findings include:Review of R63's Census tab located in the resident's electronic medical record (EMR) revealed R63 was readmitted to the facility on [DATE]. Review of R63's Diagnoses, located in the resident's EMR under the Medical Diagnosis tab revealed R63 had diagnoses which included cerebral infarction (stroke), vascular dementia without behavioral disturbance, and acquired absence of right leg above knee. Review of R63's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/04/26 and located in the resident's EMR under the MDS tab revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. Review of R63's Care Plan, and located in the resident's EMR under the Care Plan tab revealed the Care Plan included The resident uses assist bars to maximize independence with turning and repositioning in bed. Review of R63's AHR-Admission/re-admission Screening- V5, dated 02/15/26 and located in the resident's EMR under the Assessments tab revealed R63 was assessed as using bilateral half side rails for safety. There was no mention of alternatives, risks or benefits of side rail use explained to the resident or resident representative. Review of R63's entire EMR revealed no documented evidence the resident and/or their representative was educated on the risks versus benefits of the use of side rails and there was no documented evidence consent was obtained prior to the implementation of side rail use. During an observation on 02/16/26 at 2:21 PM, on 02/17/26 at 10:02 AM, R63 was lying in his bed and the resident's bed had bilateral side rails up.During an interview on 02/19/26 at 9:28 AM, Unit Manager (UM) 1 stated R63 Gets out of bed when he tolerates it. He is a very particular man, [he] doesn't want to be bothered, [he] prefers to be in bed. He uses side rails for repositioning. During an interview on 02/19/26 at 9:58 AM, Certified Nursing Assistant (CNA)10, stated R63 used bed rails to turn and reposition himself. CNA10 verified there were bilateral enablers on the bed now. At the time of the same interview, R63 said he used side rails to turn. During an interview on 02/20/26 at 8:32 AM, Unit Manager (UM) 1 stated the nurses were supposed to do a grab bar assessment, but R63 did not have a new assessment since his last admission on [DATE]. The last side rail assessment dated [DATE] indicated the grab bars increased R63's independence. The nurses do an assessment when the resident is admitted . UM1 confirmed there was no informed consent for side rail use in the medical record.During an interview on 02/20/26 at 9:21 AM, the Director of Nursing (DON) confirmed there were no risks or benefits addressed for the use of the side rails.Review of the facility policy titled Proper Use of Side Rails implemented 11/01/20 and reviewed/revised on 12/01/22 revealed, Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of side rails. Alternative approaches are attempted prior to installing a side or bed rail. under section Policy Explanation and Compliance Guidelines: 1. As part of the resident's comprehensive assessment. determine the resident's needs, and whether or not the use of side/bed rails meets those needs. 2. The facility will attempt to use alternatives prior to using side/bed rails. The alternatives provided shall be appropriate for the intended use of the rail. 3. If after an attempted alternative to side/bed rails has been made, and the alternatives do not meet the resident's needs, the facility shall: a. Evaluate the alternatives and document how these alternatives failed to meet the resident's assessed needs. If there is no appropriate alternative, document reason. b. assess the residents risks for entrapment and other risks associated with the use of side/bed rails. c. Obtain informed consent from the resident. prior to installation/use . f. obtain physician orders for the use of the side/bed rails.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to ensure a medication error rate below five percent. During medication administration three medication errors for three residents (Resident (R) 5, R10, and R62) were made of 27 opportunities resulting in a medication error rate of 11.11 percent. These failures had the potential to increase or decrease the effectiveness of these medications.Findings include: 1. Review of R5's undated admission Record located in the electronic medical record (EMR) under the Profile tab revealed R5 was admitted to the facility on [DATE] with a diagnosis of quadriplegia, dysphasia, and contracture of muscle.Review of R5's Physician's Orders, dated 09/29/25, located in the EMR under the Orders tab revealed orders for hydralazine Hydrochloride (HCL) tablet 100 milligrams (MG) give one tablet via gastrostomy tube (G-tube) every eight hours for hypertension, metoclopramide HCL solution 5 MG/5 milliliters (ML) give 15 ML via G-tube three times a day for gastric issues, G-tube check residual every shift, and check placement of feeding tube per facility protocol every shift. During an observation on 02/19/26 at 2:31 PM, Registered Nurse (RN) 2 donned a gown and then gloves, attached a syringe to the port, and poured 30 milliliters (ML) of water in the syringe before medication administration; however, RN2 did not check residual or placement of the G-tube. During an interview on 02/19/26 at 2:25 PM, RN2 stated she checked the physician's order prior to administration of the medications and there were no orders for checking the residual or placement. During an interview on 02/19/26 at 2:31 PM, the Director of Nursing (DON) stated she expected the nurses to follow the physician's orders and to check for residual and placement to ensure the G-tube is in the right location. During an interview on 02/19/26 at 2:37 PM, Unit Manager (UM) 1 stated she expected the nurses to check residual and placement of the G-tube prior to administering the medications. During an interview on 02/19/26 at 4:47 PM, the Assistant Director of Nursing (ADON) confirmed R5 had orders for checking for residual and placement. The ADON stated the nurses should check for placement so that they were not pushing medications in the wrong location. 2. Review of R10's undated admission Record located in the EMR under the Profile tab revealed he was admitted to the facility on [DATE] with diagnoses that included acute or chronic combined systolic (congestive) and diastolic (congestive) heart failure and hypertensive heart disease with heart failure. Review of R10's Physician's Orders, dated 12/08/25, located in the EMR under the Orders tab revealed an order for carvedilol oral tablet 6.25 MG give one tablet by mouth two times a day for hypertension with meals and hold for systolic less than 120.During an observation on 02/20/26 at 9:25 AM, Licensed Practical Nurse (LPN) 5 placed the carvedilol tablet in the medication cup, took the medication in the cup to R10, R10 swallowed the medication with water, and then LPN5 exited R10's room. LPN5 confirmed she did not take R10's blood pressure and stated she did not do it because the physician's order did not have a parameter on the medication. LPN5 also stated R10's blood pressure had not been taken that morning, but his blood pressure was within normal limits the night before on 02/19/26. During an interview on 02/20/26 at 9:27 AM, UM1 confirmed R10's physician's order stated not to administer carvedilol if the systolic was less than 120 and stated the nurse should have taken R10's blood pressure prior to administering the medication. UM1 also stated the purpose of taking the blood pressure prior to administering the medication was to prevent hypotension (low blood pressure). During an interview on 02/20/26 at 10:06 AM, the ADON stated the nurse should have followed the physician's order which stated to take the resident's blood pressure and hold it if the systolic was less than 120 to prevent hypotension. During an interview on 02/20/26 at 10:08 AM, the DON stated she expected the nurses to follow the physician's order when administering medications. 3. Review of R62's undated admission Record located in the EMR under the Profile tab, revealed R62 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes mellitus (DM) with hyperglycemia.Review of R62's Physician Orders, dated 10/13/25, located in the EMR under the Orders tab, revealed an order for Humalog Kwikpen (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	solution pen-injector 100 unit/milliliters (ML) inject as per sliding scale: .During an observation on 12/19/26 at 9:09 AM, at 12:00 PM, RN3 retrieved R62's insulin pen (a pen contains the vial of insulin inside the pen and has a mechanism where the dose to be administered is set on a dial at the top of the pen, and only that amount can then be injected) from the medication cart, wiped the top with an alcohol wipe, pressed on the plunger before attaching a needle to the pen then dialed the dose to eight units. RN3 carried the pen to R62's room. RN3 washed her hands, applied gloves, observed R62's right side of the abdomen, cleansed her abdomen with an alcohol wipe, gently inserted the pen needle into the flesh, injected the dose, then removed the needle after ten seconds. Next, RN3 carried the pen to the medication cart, disposed of the needle, and performed hand hygiene. During an interview on 02/19/26 at 9:23 AM, RN3 confirmed she did not prime the pen by turning the selector to two units and pushing the insulin out of the pen after attaching the needle. During an interview on 02/19/26 at 2:32 PM, the DON stated that the nurse should have primed the pen after attaching the needle to ensure that the needle worked prior to administration of the insulin. During an interview on 02/19/26 at 2:54 PM, the ADON stated that nursing should prime the pen by turning the selector to two units then pressing the plunger after the needle was attached so the insulin would shoot in the air. The ADON also stated if the needle worked then you would dial the selector to the appropriate units and then administer it to the resident. The ADON indicated priming the pen was done to ensure the needle worked so that the resident received the correct dosage of insulin. Review of the Insulin Lispro Instructions for Use, undated and provided by the facility, revealed . C. Pull off the big outer needle cap . D. Pull off the inner needle cap and throw it away (dispose of it) . Giving the airshot before each injection . E. Turn the dose selector to select 2 units . F. Hold your insulin Aspart FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge . G. Keep the needle pointing upwards, press the push-button all the way in . The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times .Review of the facility's policy titled Medication Administration, revised 12/01/22, revealed Policy: 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, in a manner to prevent contamination or infection . Policy Explanation and Compliance Guidelines: . 10. Review MAR [medication administration record] to identify medication to be administered- .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Old Dominion Rehabilitation and Nursing	4 Ridgewood Parkway Newport News, VA 23602

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 document review, observation, interview, and facility policy review, the facility failed to ensure one Resident (Resident (R)23) of one observed out of a total of 41 sampled residents received the meal that was posted on the menu. The facility further failed to ensure the meal that was served to R23 was pureed. This had the potential for the resident not to have nutritional needs met. Findings include:During dining observation on 02/16/26 at 12:09 PM, lunch menu posted was as follows: -Rosemary pork chop-Shepherd's pie (vegetarian)-Hot dog on bun plus catsup, mustard-Cheeseburger on bun-Chicken tenders plus honey mustard-Grilled cheese sandwich Starch:-Baked sweet potato plus cinnamon butter-French friesVegetable:-Peas & carrots-Mixed vegetables-Onion rings Bread:-Dinner roll with margarine During a dining observation on 02/16/26 at 1:33 PM, R23's tray card noted he was to receive a pureed diet to consist of:-Rosemary pork chop-Mashed sweet potatoes-Creamed spinach-Dinner roll-Chocolate chip cookie cakeR23's puree meal was not observed to be the meal listed on is tray card.During a dining observation on 02/16/26 at 1:33 PM, R23's meal tray had a red sauce for main entree, mashed potatoes with gravy, unidentifiable tan vegetable, and pudding. During an interview on 02/16/26 at 1:33 PM, Certified Nursing Assistant (CNA)11 was assisting R23 with his meal in his room and when asked what the resident was served for lunch CNA11 revealed she thought it was spaghetti with meat sauce, mashed potatoes, and gravy. She was unsure of the vegetable and thought the dessert was chocolate pudding. During an interview on 02/16/26 at 1:39 PM, at R23's bedside the Dietary Manager (DM) revealed she followed the substitutions list and confirmed R23 was served: (Puree)-Spaghetti and meat sauce-Fortified mashed potatoes with gravy-Chocolate muffin-Mix vegetables R23 did not receive the posted meal or any of the offered alternatives listed on the menu. Review of facility Production Spreadsheet Report provided by the facility dated 02/16/26 indicated lunch menu with alternatives:-Tomato soup-Cheeseburger on bud-Chicken tenders-Grilled cheese-Hot dog on bun-Rosemary pork chop-tuna/ chicken salad-Shepherd's pie (vegetarian)-Chef salad-Baked sweet potato-Cheesy mashed potatoes-French fries-Mashed sweet potato-Sweet potato puffs-Corn cobette-Creamed spinach-Spinach-Steamed vegetables-Yellow cup cake-Dinner roll-Chocolate chip cookie cake-Diet jello-Ice cream-Magic cup-Peanut butter and jelly sandwich-Turkey sandwichDuring an interview on 02/17/26 at 11:25 PM, the DM revealed she wrote in the menu substitution(s) yesterday and that she did not serve R23 the pasta and mashed potatoes with his meal and that she does not puree pasta due to its sticky gummy consistency once it is pureed. During an interview of 02/19/26 at 11:51 AM, the Registered Dietician (RD) revealed she was unaware the DM was not pureeing the pasta for spaghetti with meat sauce. The RD revealed the DM needed to try an alternative like a different noodle. She also confirmed R23 should have been served what was on the menu. RD revealed she was unaware the DM was writing in alternatives to the menu. Review of the facility policy titled, Menus and Adequate Nutrition with a revision date of 12/01/22 revealed, The purpose of this policy is to assure menus are developed and prepared to meet resident choices including their nutritional, religious, cultural, and ethnic needs, while using established guidelines . 2. Menus shall be prepared in advance for timely approval and ordering of food . 3. Menus will be followed as posted. Notification of any deviations from the menu shall be made as soon as practicable. Substitutions shall comprise of foods with comparable nutritive value. 7. The facility's dietician or other clinically qualified nutrition professional will review all menus for nutritional adequacy and approve the menus.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and review of the test tray, the facility failed to ensure foods were served at palatable food temperatures for three of 96 residents (Resident (R) 8, R51, and R77) who received meals from the facility's kitchen. This had potential to dissatisfaction with meals and potential weight loss. Findings include:During an interview on 02/16/26 at 12:56 PM, R8 revealed that her meal tray is the first one on the third cart but last one to be served and it is always cold.During an interview on 02/16/26 at 3:03 PM, R8 revealed that her pork chop today was so tough the head nurse could not even cut it with the fork. Everything is always over cooked.During an interview on 02/17/26 at 8:41 AM, R51 said the facility food tastes like (expletive). R51 revealed hot food is not hot, it is cold and cold items like milk are not cold, they are warm.During an interview on 02/16/26 at 11:01 AM, R77 revealed he does not each much of the facility food because it does not smell good. R77 revealed he had requested a grilled cheese sandwich that was cold when he received it. R77 revealed he orders food from door dash frequently because the food is cold and does not smell good.During an interview on 02/17/26 at 3:27 PM, R77 revealed he ordered food today from a local convenient store through door dash saying lunch was gross and cold. During an interview on 02/19/26 at 11:51 AM, the Registered Dietician (RD) confirmed hot food should be served hot and cold foods should be served cold. She confirmed food should not be over cooked and tough.During an observation and interview on 02/19/25 at 1:20 PM, the Dietary Manager (DM) obtained food temperatures on a meal test tray that was the last tray delivered from the food cart. The temperatures of the cold items were: Cold pasta was 62 degrees Fahrenheit (F) Juice 62 degrees F.