STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Health & Rehabilitation	12475 Lee Jackson Memorial Highway Fairfax, VA 22033

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. For Resident #147 (R147), the facility staff failed to dress the resident in clothes prior to the resident sitting in a common area. R147 was admitted to the facility on [DATE]. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/22/25, the resident scored 2 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. On 2/3/25 at 11:54 a.m. and 3:48 p.m., R147 was observed sitting in the day room. The resident was dressed in a gown and slipper socks. On 2/4/25 at 3:02 p.m., an interview was conducted with CNA (certified nursing assistant) #3 (the CNA caring for R147). CNA #3 stated residents should be dressed in clothes every day. CNA #3 stated R147 did not have clothes so he dressed the resident in a clean gown. CNA #3 stated he would not feel too good if he was dressed in a gown while in the hall or day room because he was not dressed like other people. On 2/4/25 at 4:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 4. For Resident #132 (R132), the facility staff failed to dress the resident in clothes prior to the resident sitting in common areas. R132 was admitted to the facility on [DATE]. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/30/24, the resident scored 0 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. On 2/3/25 at 12:02 p.m., R132 was observed sitting in the hall. The resident was dressed in a gown and slipper socks. On 2/3/25 at 3:48 p.m., R132 was observed sitting in the day room. The resident was dressed in a gown and slipper socks. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at 3:02 p.m., an interview was conducted with CNA (certified nursing assistant) #3 (the CNA caring for R147). CNA #3 stated, Residents should be dressed in clothes every day. CNA #3 stated R147 did not have clothes so he dressed the resident in a clean gown. CNA #3 stated,He would not feel too good if he was dressed in a gown while in the hall or day room because he was not dressed like other people. On 2/4/25 at 4:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide dignity in caring for four of 48 residents in the survey sample, Residents #104, #112, #147, and #132. The findings include: 1. For Resident #104, the facility failed to provide dignity to the resident by keeping his hair cut and his beard groomed. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/24/24, R104 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring the extensive assistance of staff for grooming and personal care. On the following dates and times, R104 was observed sitting up in bed: 2/3/25 at 12:53 p.m. and 4:01 p.m., 2/4/25 at 9:38 a.m., and 2/5/25 at 10:17 a.m. At all observations, R104's hair was long and thin, extending to just below his chin. The resident's beard was grown out to approximately five inches below his chin. He stated he is accustomed to having short hair and to having his beard trimmed very short. He reported that the staff have told him there is no one to shave him or cut his hair currently working at the facility. He stated: I have never had to look this bad in my life. On 2/5/25 at 8:53 a.m., CNA (certified nursing assistant) #6 was interviewed. She stated, I am familiar with the care of R104. She stated she does not know who is responsible for cutting his hair or for assisting him to shave. She stated it would not be dignified care if the resident was accustomed to having short hair and a trimmed beard. On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. A review of the facility policy, Dignity, revealed, in part: Each resident shell be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Residents will be treated with dignity and respect at all times .When assisting with care, residents are supported in exercising their rights. For example, residents are groomed as they wish to be groomed (hair styles, nails, facial hair, etc.). No additional information was provided prior to exit. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For Resident #112 (R112), the facility staff failed to provide dignity when they delayed answering a call bell on 2/4/25. On 2/5/25 at 1:16 a.m., CNA (certified nursing assistant) #10 was observed sleeping in the first floor dining/activity room. On 2/5/25 at 1:48 a.m., observation revealed R112 had activated her call light. At this time, CNA #10 was still sleeping in the first floor dining/activity room, and four other staff members were observed sitting behind the nurses' desk closest to R112's room. LPN (licensed practical nurse) #7, the charge nurse, was asked if any staff members were currently on dinner break. She stated dinner breaks had not yet started, and no staff was on break. At 1:56 a.m., CNA #10 emerged from the dining/activity room and sat behind the nurses' desk with the other staff members. Between 1:48 a.m. and 2:08 a.m., while R112's call bell continued to ring, between four and five staff members were behind the nurses' desk at all times. Some looked at their phones, while one nurse worked on the computer. At 2:08 a.m., CNA #10 got up from her chair behind the nurses' desk and went in to answer R112's call bell. On 2/5/25 at 9:54 a.m., LPN (licensed practical nurse) #6, a unit manager, was interviewed. He stated it was unacceptable for a staff member to sleep while on duty, and stated R112's call bell should have been answered by anyone in the immediate area once the bell rang initially. He stated that a delay in answering a call bell can be seen as a matter of dignity. On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. No additional information was provided prior to exit.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, resident interview, staff interview and clinical record review and facility document review, the facility staff failed to accommodate resident's needs for three of 48 residents in the survey sample, Residents #121, (R121), R144, R99 and R72. provide accommodations of resident needs by ensuring the call bell was within reach The findings include: 1. For R121, the facility staff failed to keep the call bell (a device with a button that can be pushed to alert staff when assistance is needed) within reach. R121 was admitted to the facility with a diagnosis that included by not limited to muscle weakness. On the most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/01/2025, R121 scored 7 (seven) out of 15 on the BIMS (brief interview for mental status), indicating R121 was moderately impaired of cognition for making daily decisions. On 02/03/25 at approximately 11:59 a.m., an observation revealed R121's call bell was placed inside the top drawer of the bedside table. When asked to locate and activate the call bell R121 stated he was unable to locate it. On 02/03/25 at approximately 2:31p.m., an observation revealed R121's call bell was placed inside the top drawer of the bedside table. When asked to locate and activate the call bell R121 stated he was unable to locate it. On 02/03/25 at approximately 4:25 p.m., an observation revealed R121's call bell was placed inside the top drawer of the bedside table. When asked to locate and activate the call bell R121 stated he was unable to locate it. On 02/04/2025 an interview was conducted with CNA (certified nursing assistant) #5 about the placement of a resident's call bell. She stated the call bell should always be placed within reach of the resident. When how often the call bell placement should be checked CNA #5 stated it should be checked each time someone goes into the resident's room. The facility's policy Answering the Call Light documented in part, General Guidelines - 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. On 02/04/2025 at approximately 4:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, director of clinical reimbursement, and ASM # 5regional director of operations, were made aware of the above findings. No further information was provided prior to exit. 2. For R144, facility staff failed to provide a communication aide to effectively express needs and wants. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R144 was admitted to the facility with a diagnosis that included by not limited to anxiety (fear). On the most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 01/07/2025, R144 was coded as having both short and long term memory difficulties and was coded as being severely impaired of cognition for making daily decisions. Under section GG Functional Abilities - Admission R144 was coded as being dependent, requiring the assistance of two staff members for toileting hygiene, showering/bathing, lower body dressing and putting on/off footwear. R144 was coded as requiring maximal assistance with oral hygiene, upper body dressing and personal hygiene including combing hair, applying makeup, washing/drying face and hands. On 02/03/25 at approximately 4:04 p.m., an observation during the initial screening of R144 revealed R144 was unable to speak English and did not understand simple yes/no questions. Further observations of R144's room failed to evidence a communication aid. On 02/05/2025 at approximately 9:27 a.m., an interview was conducted with CNA (certified nursing assistant) #8. When asked about R144's language she stated that she thought R144 spoke Arabic. When asked if she could speak Arabic to R144 CNA #8 stated no. When asked how she communicates to meet the daily needs and/or wants of R144, CNA #8 stated R144's son translates using Video Chat on R144's cell phone. CNA #8 further stated it was not the most effective or efficient way to communicate with R144. On 02/05/2025 at approximately 9:35 a.m., a video chat was conducted with R144's son. He stated he had concerns about the language barrier between orrR144 and the facility staff. When asked about R144's primary language he stated it was a Moroccan dialect. The son further stated he had concerns about R144 using the bathroom by herself and being unable to communicate her needs. The facility's policy Translation and/or Interpretation Of Facility Services documented in part, POLICY: The organization is committed to offering a language access program to ensure that individuals with limited English proficiency (LEP) will have meaningful access to information and services provided by the facility. On 02/04/2025 at approximately 4:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, director of clinical reimbursement, and ASM # 5regional director of operations, were made aware of the above findings. No further information was provided prior to exit. 3. For R99, facility staff failed to provide a communication aide to effectively express needs and wants. R99 was admitted to the facility with a diagnosis that included by not limited to muscle weakness. On the most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 12/23/2024, R99 was coded as having both short and long term memory difficulties and was coded as being severely impaired of cognition for making (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/03/25 at approximately 12:57 p.m., an observation during the initial screening of 99 revealed R99 was unable to speak English and did not understand simple yes/no questions. Further observations of R99's room failed to evidence a communication aid. On 02/04/2025 at approximately 3:00 p.m., an interview was conducted with CNA (certified nursing assistant) #5 regarding R99's ability to communicate her needs and/or wants effectively. CNA #5 stated she was usually assigned to R99. When asked if R99 spoke English, she stated no and R99 spoke Spanish. When asked if she spoke or understood Spanish CNA #5 stated no. When asked about communicating with R99 she stated R99's roommate would translate at times, R99 would use some gestures. When asked if R99 used a communication aid CNA #5 stated she was not aware of any communication device or system for R99 and offered to look in R99's room for a communication aid. After looking in R99's room, CNA #5 stated she was unable to find a communication aid for R99. On 02/04/2025 at approximately 4:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, director of clinical reimbursement, and ASM # 5regional director of operations, were made aware of the above findings. No further information was provided prior to exit. 4. For Resident #4 (R4), the facility staff failed to provide laboratory services at a time of the resident's preference. On 2/3/24 at 12:11 p.m., R4 was interviewed. He stated he was concerned that staff came to draw blood at all hours of the night, and added that this usually occurred between 2:00 a.m. and 4:00 a.m. He stated it startled him to be awakened at this time, and interrupted his sleep in such a manner that he could not get back to sleep. He stated he would prefer blood to be drawn during the day or afternoon when he was already awake. On 2/4/25 at 1:48 a.m., OSM (other staff member) #13, a contract phlebotomist, was observed entering the facility and obtaining a cart with phlebotomy supplies from behind a nurses' desk. She stated: I'm here to draw labs. OSM #13 stated she comes to the facility Monday through Friday at about this time. She stated she understands that it might not be a desirable time for residents, and stated she would not want to be awakened at 2:00 a.m. to have her blood drawn, but she has no control over her schedule. She stated she cannot worry about that part because this is her job. On 2/4/25 at 4:36 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, ASM #4, the regional clinical reimbursement director, and ASM #5, the regional director of operations, were informed of these concerns. These staff members agreed that they would not want to be awakened in the middle of the night to have their blood drawn. No additional information was provided prior to exit.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and facility document review, it was determined the facility staff failed to notify the RP (responsible party) of a change in condition for one of 48 residents in the survey sample, R47. The findings include: The facility failed to notify the RP for R47's genital warts. R47's genital warts last outbreak began in July 2024. R47 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident) with hemiparesis/hemiplegia, diabetes mellitus and epilepsy. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/8/24, coded the resident as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 8/13/24 revealed, FOCUS: Urinary & bowel incontinence related to Impaired Mobility, Physical Limitations due to Left hemiparesis/Hemiplegia secondary to CVA & Dementia. INTERVENTIONS: Provide incontinent care as needed. Report changes in skin integrity found during daily care. A review of the physician's order dated 10/7/24 revealed, Imiquimod External Cream 5 % (Imiquimod) Apply to genital warts topically at bedtime every Mon, Wed, Fri for genital warts for 16 Weeks Apply to penis/scrotum topically every evening shifts every Mon, Wed, Fri for genital warts apply a thin layer 3 times/week prior to bedtime leave on for 10 hours then remove with mild soap and water. A review of the NP (nurse practitioner's) progress note dated 10/9/24 at 5:48 PM revealed, [AGE] year-old male seen today for a follow up physical exam and review of his genital warts. Several [NAME] scrotal genital warts - largest one about 5.5x8.0, no bleeding, no drainage noted. He has immune suppression secondary to his PCM with more than 10% of his usual body weight. He has worsening HPV (human papillomavirus) that presented with the weight loss. Plan: He has some warts on his scrotum and a diagnosis of HPV due to this. He has occasional bleeding from the warts. He as scheduled dermatologist consult with dermatology on10/16/24. Will order house wound MD to follow status. Will continue Imiquimod every Monday-Wednesday-Friday and monitor. On 2/4/25 at 3:30 PM, an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. When asked about R47, LPN #4 stated, the staff and NP were aware of the genital warts. The warts would go away on their own in previous outbreaks. He was incontinent so they were putting barrier cream on him to protect his skin from the wetness. I am not sure if the wife was informed that he had the genital warts. After he went to his father's funeral and the emergency room in Delaware, we had a care plan meeting and we agreed that I would call her on a regular basis. I called her regularly, multiple times a week. The genital warts were about resolved when he was discharged . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 10:49 AM, an interview was conducted with ASM (administrative staff member) #6, the nurse practitioner. When asked about R47, ASM #6 stated, he has had these lesions come and go, we are working him up for weight loss. We were physically getting him out of bed, then he did not want to get out of bed. Between July and August there was another genital wart outbreak and they were not going away. I did not initiate any additional treatment as these flare ups had always resolved on their own. He was incontinent and they were putting on a barrier cream to protect his skin from his incontinence. He would refuse incontinence care. He was on a blood thinner, and that is why he started bleeding. This time the warts did not resolve on their own and was different as he was sitting up in the car for an extended period of time, so a lot of pressure on the genital area. He was on the blood thinner so all these things combined so his wife saw bleeding from the warts when she went to change him. I have known him for many years and cared for him at another facility. These genital warts flare ups were not new to him. His wife was upset that no one had told her about the genital warts. I did not know she was not informed. I do not know if anyone had told her before about his previous flare ups. During this time, we usually would talk about every little thing with the family, but since resident's father was dying, and the focus was having his wife work with therapy to get him in and out of the car for his father's funeral. I did not discuss the warts with her at this time. When he came back from the funeral, I ordered the Imiquimod External Cream, had him followed by the wound care team and sent him to a dermatologist. They were resolving when he was discharged . On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. A review of the facility's Change In A Resident's Condition policy revealed, The facility will promptly notify the resident, his or her physician/practitioner, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) No further information was provided prior to exit.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide required Medicare discharge notice for three of three resident records reviewed, Residents #82, #104, and #26. The findings include: 1. For Resident #82 (R82), the facility failed to issue the resident an ABN (advance beneficiary notice) prior to his discharge from Medicare Skilled Nursing services on 10/2/24. A review of R82's clinical record revealed he was discharged from Medicare Skilled Nursing services on 10/2/24. At the time of his discharge, he still had days remaining in his Skilled Nursing benefit. Further review of R82's clinical record failed to reveal the required ABN prior to the resident's discharge from Skilled Nursing services. On 2/5/25 at 9:46 a.m., ASM (administrative staff member) #4, the regional director of clinical operations, was interviewed. She stated that the ABNs were the responsibility of the therapy department, but at the time of the discharge, the therapy department was not aware the ABN was their responsibility. She stated R82 should have had an ABN issued prior to his discharge from Skilled Nursing services. On 2/5/25 at 1:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. A review of the facility policy, Advanced Beneficiary Notice, revealed, in part: It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage .The facility shall inform Medicare beneficiaries of his or her potential liability for payment. A liability notice shall be issued to Medicare beneficiaries upon admission or during a resident's stay before the facility provides .an item or service that is usually paid for by Medicare, but may not be paid in this instance because it is not medically reasonable and necessary .For Part A items and services, the facility shall use the Skilled Nursing Advance Beneficiary Notice. No additional information was provided prior to exit. 2. 1. For Resident #104 (R104), the facility failed to issue the resident an ABN (advance beneficiary notice) prior to his discharge from Medicare Skilled Nursing services on 12/11/24. A review of R104's clinical record revealed he was discharged from Medicare Skilled Nursing services on 12/11/24. At the time of his discharge, he still had days remaining in his Skilled Nursing benefit. Further review of R104's clinical record failed to reveal the required ABN prior to the resident's discharge from Skilled Nursing services. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 9:46 a.m., ASM (administrative staff member) #4, the regional director of clinical operations, was interviewed. She stated that the ABNs were the responsibility of the therapy department, but at the time of the discharge, the therapy department was not aware the ABN was their responsibility. She stated R104 should have had an ABN issued prior to his discharge from Skilled Nursing services. On 2/5/25 at 1:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. No additional information was provided prior to exit. 3. For Resident #26 (R26), the facility failed to issue the resident an ABN (advance beneficiary notice) prior to his discharge from Medicare Skilled Nursing services on 12/21/24. A review of R26's clinical record revealed he was discharged from Medicare Skilled Nursing services on 12/21/24. At the time of his discharge, he still had days remaining in his Skilled Nursing benefit. Further review of R26's clinical record failed to reveal the required ABN prior to the resident's discharge from Skilled Nursing services. On 2/5/25 at 9:46 a.m., ASM (administrative staff member) #4, the regional director of clinical operations, was interviewed. She stated that the ABNs were the responsibility of the therapy department, but at the time of the discharge, the therapy department was not aware the ABN was their responsibility. She stated R26 should have had an ABN issued prior to his discharge from Skilled Nursing services. On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. No additional information was provided prior to exit.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence of required physician documentation after a resident is transferred to the hospital for one of 48 residents in the survey sample, R59. The findings include: The facility staff failed to evidence required physician documentation after a resident is transferred to the hospital for R59. R59 was transferred to the hospital on 3/14/24. R59 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ESRD (end stage renal disease), CHF (congestive heart failure) and diabetes mellitus. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/28/24, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 9/5/24 revealed, FOCUS: Renal insufficiencies related to chronic renal failure. INTERVENTIONS: Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis as needed. On 2/5/25 at 10:49 AM, an interview was conducted with ASM #6, the NP (nurse practitioner). When asked if the physician or NP is to document a progress note when a resident is transferred to the hospital, ASM #6 stated, yes, we are. When asked what is to be included in the documentation, ASM #6 stated, we write a note for resident upon transfers to the hospital, reason for transfer, medications and any other pertinent information. On 2/5/25 at 11:50 AM, ASM #3, the regional director of clinical operations stated, there are no physician notes for this resident when he was transferred to the hospital. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. A review of the facility's Attending Physician Responsibility policy revealed, The Attending Physician will follow up (as needed) with another physician or health-care practitioner who is to assume the care of an acutely ill or unstable patient, either in the facility or in another setting. The Attending Physician / NPP will provide a summary of pertinent medical discharge information within 30 days of discharge or transfer of a resident. No further information was provided prior to exit.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide required notification to the ombudsman following resident discharge for four of 48 residents in the survey sample, Residents #74, #104, #26, and #62. The findings include: 1. For Resident #74 (R74), the facility staff failed to notify the ombudsman in writing of the resident's discharge to the hospital on [DATE]. A review of R74's clinical record revealed he was discharged to the hospital on [DATE]. Further review of his record failed to reveal evidence that the ombudsman was notified in writing of the resident's discharge. On 2/5/25 at 10:36 a.m., OSM #10, the director of social services, was interviewed. She stated she thought she had faxed a written notification to the ombudsman of R74's discharge, but she had not retained any records to evidence this. She stated: I don't have it. I haven't kept a notebook as I should have. On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. A review of the policy, Facility Initiated Transfer, revealed, in part: The facility will consistently deploy systems to identify resident needs and preferences .The facility will send a copy of the [discharge] notice to a representative of the Office of the State Long-Term Care Ombudsman. No additional information was provided prior to exit. 2. For Resident #104 (R104), the facility staff failed to notify the ombudsman in writing of the resident's discharge to the hospital on [DATE]. A review of R104's clinical record revealed he was discharged to the hospital on [DATE]. Further review of his record failed to reveal evidence that the ombudsman was notified in writing of the resident's discharge. On 2/5/25 at 10:36 a.m., OSM #10, the director of social services, was interviewed. She stated she thought she had faxed a written notification to the ombudsman of R104's discharge, but she had not retained any records to evidence this. She stated: I don't have it. I haven't kept a notebook as I should have. On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided prior to exit. 3. For Resident #26 (R26), the facility staff failed to notify the ombudsman in writing of the resident's discharge to the hospital on [DATE]. A review of R26's clinical record revealed he was discharged to the hospital on [DATE]. Further review of his record failed to reveal evidence that the ombudsman was notified in writing of the resident's discharge. On 2/5/25 at 10:36 a.m., OSM #10, the director of social services, was interviewed. She stated she thought she had faxed a written notification to the ombudsman of R26's discharge, but she had not retained any records to evidence this. She stated: I don't have it. I haven't kept a notebook as I should have. On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. No additional information was provided prior to exit. 4. The facility staff failed to evidence provision of required written ombudsman notification at the time of discharge for R62. R62 was transferred to the hospital on [DATE] and 11/28/24. R62 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident) with hemiparesis/hemiplegia, diabetes mellitus and osteomyelitis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/4/25, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 11/4/24 revealed, FOCUS: The resident has an ADL self-care performance deficit. INTERVENTIONS: Physical assist as needed. On 2/5/25 at 10:35 AM, an interview was conducted with OSM (other staff member) #10, the director of social services. When asked about the ombudsman notification for R62, OSM #10 stated, the ombudsman has been called and I am trying to get confirmation from them. There is a fax receipt of the transfers/discharges that are sent monthly to the ombudsman but I have not been keeping them in a notebook. I am changing that process now. When asked how long she had been in the role, OSM #10 stated, one year. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. No further information was provided prior to exit.

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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 staff interview, facility document review, and clinical record review, the facility staff failed to implement PASARR (preadmission screening and resident review) requirements for one of 48 residents in the survey sample, Resident #2. The findings include: For Resident #2 (R2), the facility staff failed to ensure a level I PASARR was completed. R2 was admitted to the facility on [DATE]. A review of R2's clinical record failed to reveal a level I PASARR. On 2/5/25 at 10:39 a.m., an interview was conducted with OSM (other staff member) #10 (the director of social services). OSM #10 stated all residents should have a level I PASARR completed, and the admissions department is responsible for making sure it is done prior to admission. OSM #10 stated that if a PASARR is not completed prior to admission then she completes it. OSM #10 stated R2 was admitted to the facility from a sister facility, prior to her (OSM #10's) employment, and someone should have checked to ensure she had a level I PASARR completed. On 2/5/25 at 1:39 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Long-Term Services and Supports (LTSS) Screening, Preadmission Screening and Resident Review (PASRR) Policy documented, PASRR 1) Level 1 Screening a. If a Level 1 Screening has not been completed prior to admission and the resident is already Medicaid member OR financially eligible by way of application as verified by the ePAS system, the Social Worker, Admissions Coordinator, or designee will request that the referral provider and/or Community Screening Team complete the screen prior to admission. b. If the resident is not Medicaid or Medicaid eligible by way of application, the nursing facility will be responsible for completion of the Level 1 screening. No further information was presented prior to exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 7. For R76, facility staff failed to follow the comprehensive care plan for the administration of Gabapentin (for pain), Oxycodone (for pain), Lidocaine External Patch (for pain) and Tylenol (for pain), Lorazepam (for anxiety), Mirtazapine (for depression) and Sertraline (for depression). R76 was admitted with diagnoses that included but were not limited to depression, anxiety and muscle weakness. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/10/2025, R76 scored 8 (eight) out of 15 on the BIMS (brief interview for mental status), indicating R76 was moderately impaired of cognition for making daily decisions. The POS (physician's order sheet) for R76 dated 02/05/2025 documented in part, Gabapentin Oral Capsule 100 MG (milligrams) (Gabapentin) Give 2 capsule by mouth two times a day for NEUROPATHIC PAIN. Oder Date: 01/04/2025. Start Date: 01/04/2025. Lidocaine External Patch 4 % (Lidocaine) Apply to LOWER BACK topically one time a day for PAIN MANAGEMENT and remove per schedule. Oder Date: 01/04/2025. Start Date: 01/05/2025. Lorazepam Oral Tablet 1 (one) MG (Lorazepam) Give 1 mg by mouth every 24 hours as needed for ANXIETY for 3 Week. Oder Date: 01/04/2025. Start Date: 01/05/2025. Mirtazapine Oral Tablet 15 MG (Mirtazapine) Give 15 mg by mouth one time a day for DEPRESSION. Oder Date: 01/04/2025. Start Date: 01/05/2025. Oxycodone HCl (hydrochloride) Oral Tablet 5 MG (Oxycodone HCl) Give 5 mg by mouth one time a day for PAIN MANAGEMENT. Oder Date: 01/04/2025. Start Date: 01/05/2025. Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) Give 100 mg by mouth one time a day for DEPRESSION. Oder Date: 01/04/2025. Start Date: 01/05/2025. Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 500 mg by mouth two times a day for PAIN MANAGEMENT Do not exceed > 3 (three) gram per day. Oder Date: 01/04/2025. Start Date: 01/05/2025. The eMAR (electronic medication administration record) for R76 dated January 2025 revealed the physician's orders as stated above. Further review of the eMAR revealed blanks on 01/12/2025 for the medications listed above. The facility's nursing progress notes and eMAR notes for R76 dated 01/12/2025 through 01/13/2025 failed to evidence documentation regarding the blanks on 01/12/2025 for the medications listed above. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan for R76 dated 01/05/2025 documented in part, Focus. The resident has a risk for pain or pain related to a recent fall and depression. Date Initiated: 01/06/2025 Revision on: 01/06/2025. Under Interventions it documented in part, Administer medication as ordered Date Initiated: 01/06/2025. Focus. The resident is at risk for complications related to psychoactive (antidepressant, anxiolytic or hypnotic) medications use secondary to diagnoses of: depressive disorder, insomnia Date Initiated: 01/09/2025. Under Interventions it documented in part, Administer medications as ordered. Date Initiated: 01/09/2025. On 02/04/2025 at 9:05 a.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked the purpose of the care plan, LPN #2 stated, it is to set the goals and interventions for each resident, so it is individualized for them. When asked if the care plan has interventions based on physician orders that are not followed, has the care plan been implemented and followed, LPN #2 stated, no, it is not being followed. On 02/05/2025 at approximately 1:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, director of clinical reimbursement, and ASM # 5regional director of operations, were made aware of the above findings. No further information was provided prior to exit. Based on observations, staff/resident interviews, facility document review and clinical record review, it was determined the facility staff failed to develop and/or implement the care plan for seven of 48 residents in the survey sample, R47, R46, R130, R23, R59, R62 and R76. The findings include: 1. The facility staff failed to develop the comprehensive care plan for genital warts for R47. R47 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident) with hemiparesis/hemiplegia, diabetes mellitus and epilepsy. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/8/24, coded the resident as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 8/13/24 revealed, FOCUS: Urinary & bowel incontinence related to Impaired Mobility, Physical Limitations due to Left hemiparesis/Hemiplegia secondary to CVA & Dementia. INTERVENTIONS: Provide incontinent care as needed. Report changes in skin integrity found during daily care. There was no evidence that a care plan was developed for genital warts. A review of the physician's order dated 10/7/24 revealed, Imiquimod External Cream 5 % (Imiquimod) Apply to genital warts topically at bedtime every Mon, Wed, Fri for genital warts for 16 Weeks Apply to penis/scrotum topically every evening shifts every Mon, Wed, Fri for genital warts apply a thin layer 3 times/week prior to bedtime leave on for 10 hours then remove with mild soap and water. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at 3:30 PM, an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. When asked if a care plan should be developed for genital warts, LPN #4 stated, yes, there should be a care plan. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. A review of the facility's Care Plans-Comprehensive Person Centered policy revealed, Each resident's comprehensive care plan will describe the following: services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental and psychosocial well-being. The comprehensive care plan will incorporate identified problem areas and incorporate risk factors associated with identified problems. No further information was provided prior to exit. 2. The facility staff failed to develop the comprehensive care plan for PTSD (post-traumatic stress disorder) for R46. R46 was admitted to the facility on [DATE] with diagnosis that included but were not limited to PTSD (post-traumatic stress disorder), viral hepatitis and pulmonary fibrosis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/1/24, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. Section I: Active Diagnosis (dated 8/31/24) I6100. Post Traumatic Stress Disorder (PTSD)-coded as yes. A review of the comprehensive care plan dated 6/12/24 revealed, FOCUS: At risk for adverse effects related to use of antianxiety and antidepressant medication. INTERVENTIONS: Report to physician signs of adverse reaction such as decline in mental status, decline in positioning/ambulation ability, lethargy, complaints of dizziness, tremors. Psych consult and follow up as needed. There was no evidence that a care plan was developed for PTSD. A review of the physician's order dated 4/8/24 revealed, Psych consult. On 2/4/25 at 8:30 AM, an interview was conducted with R46. When asked what care and services are provided for her regarding PTSD, R46 stated, there is a psychologist that I see. When asked if social services visits with her to discuss PTSD and her triggers, R46 stated, they do not know my triggers as they have never asked me. When asked her triggers, R46 stated, seeing anything violent, even on television and sometimes loud noises. I get migraines then. On 2/4/25 at 3:30 PM, an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. When asked if a care plan should be developed for PTSD, LPN #4 stated, yes, there should be a care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. A review of the facility's Care Plans-Comprehensive Person Centered policy revealed, Each resident's comprehensive care plan will describe the following: services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental and psychosocial well-being. The comprehensive care plan will incorporate identified problem areas and incorporate risk factors associated with identified problems. No further information was provided prior to exit. 3. The facility staff failed to develop the comprehensive care plan for anticoagulation monitoring for R130. R130 was admitted to the facility on [DATE] with diagnosis that included but were not limited to pulmonary embolism, spondylosis and cord compression. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/7/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 1/24/25 revealed, FOCUS: CARDIAC: the resident is at risk for cardiac complications secondary to atrial fibrillation. INTERVENTIONS: Administer medications as ordered. Observe for signs and symptoms of cardiac complications. Care plan does not evidence any Anticoagulation information until after end of day on 2/4/25. A review of the physician's order dated 6/30/24 revealed, Rivaroxaban Oral Tablet 20 MG (Rivaroxaban) Give 20 mg by mouth one time a day for A fib take with dinner. On 2/3/25 at 2:30 PM, an interview was conducted with R130. When asked monitoring is provided for his anticoagulation, R130 asked what do you mean. When asked if staff ask him about bruising or bleeding or assess his arms, R130 stated, no, not that I know of. On 2/4/25 at 3:30 PM, an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. When asked if a care plan should be developed for anticoagulation, LPN #4 stated, yes, there should be a care plan. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. No further information was provided prior to exit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The facility staff failed to implement the comprehensive care plan for oxygen therapy for R23. R23 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CHF (congestive heart failure), osteoarthritis and CVA (cerebrovascular accident). The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 11/13/24, coded the resident as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. Section O: oxygen: yes. A review of the comprehensive care plan dated 11/29/24 revealed, FOCUS: Has/At risk for respiratory impairment related to SOB due to OSA (obstructive sleep apnea) & chronic respiratory failure with hypoxia, cough. CHF. INTERVENTIONS: Administer oxygen as per physician order: Via nasal cannula for shortness of breath related to CHF. A review of the physician's order dated 11/16/21 revealed, O2 via nasal cannula at 2 liters per minute every shift. Observed R23's oxygen setting at 4 liters nasal cannula (lnc) on 02/03/25 at 11:33 AM, 02/03/25 at 3:33 and 02/04/25 at 08:30 AM. An interview was conducted on 2/4/25 at 9:05 AM with LPN (licensed practical nurse) #2. When asked to verify R23's oxygen order, LPN #2 stated, she is to be on 2 lnc. When asked to come to the room and verify setting, LPN #2 stated, she is on 4-5 lnc. I will adjust it. When asked where you would read the oxygen setting, LPN #2 stated, you would read it with the line in the middle of the ball. An interview was conducted on 2/4/25 at 9:05 AM with LPN (licensed practical nurse) #2. When asked the purpose of the care plan, LPN #2 stated, it is to set the goals and interventions for each resident, so it is individualized for them. When asked if the care plan has interventions based on physician orders that are not followed, has the care plan been implemented and followed, LPN #2 stated, no, it is not being followed. When asked if the oxygen was at 4 lnc but ordered for 2lnc and care plan was oxygen as ordered, was the care plan being followed, LPN #2 stated, no, it was not being followed. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. No further information was provided prior to exit. 5. The facility staff failed to implement the comprehensive care plan for communication with dialysis facility for R59. R59 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ESRD (end stage renal disease), CHF (congestive heart failure) and diabetes mellitus. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/28/24, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 9/5/24 revealed, FOCUS: Renal insufficiencies related to chronic renal failure. INTERVENTIONS: Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis as needed. A review of the physician's order dated 2/17/22 revealed, Transportation to dialysis center - (Tue/Thu/Sat) at 9:58 AM Hemodialysis. Check AV fistula site thrill/bruit LUE one time a day for AV fistula site thrill/bruit check. Requested dialysis communication sheets 11/1/24 to 2/4/25. Dialysis communication sheets evidenced were on following dates: Communication sheets evidenced for 11/14/24, 12/12, 12/17/12/19/12/21, 12/24, 12/31, 1/7, 1/9, 1/11, 1/16, 1/18, 1/21, 1/23, 1/25, 1/28, 1/30, 2/1, 2/4. No other sheets were found. An interview was conducted on 2/4/25 at 9:05 AM with LPN (licensed practical nurse) #2. When asked the purpose of the care plan, LPN #2 stated, it is to set the goals and interventions for each resident, so it is individualized for them. When asked if the care plan has interventions based on physician orders that are not followed, has the care plan been implemented and followed, LPN #2 stated, no, it is not being followed. 02/05/25 11:21 AM ASM #3 stated, we do not have the missing dialysis sheets. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. No further information was provided prior to exit. 6. The facility staff failed to implement the comprehensive care plan for ADL (fingernail and toenail) care for R62. R62 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident) with hemiparesis/hemiplegia, diabetes mellitus and osteomyelitis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/4/25, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 11/4/24 revealed, FOCUS: The resident has an ADL self-care performance deficit. INTERVENTIONS: Physical assist as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of nails 3/4 inch long on both hands, and left foot nails 1/2 inch thick and curled over top of toes on 02/03/25 11:45 AM and 02/04/25 09:15 AM. An interview was conducted on 2/3/25 at 11:45 AM with R62. When asked about his fingernails, R62 stated, they need trimming bad, they are so long. I have bit them down to get them this short. My toenails are long also. An interview was conducted on 2/4/25 at 9:05 AM with LPN (licensed practical nurse) #2. When asked the purpose of the care plan, LPN #2 stated, it is to set the goals and interventions for each resident, so it is individualized for them. When asked if the care plan has interventions based on physician orders that are not followed, has the care plan been implemented and followed, LPN #2 stated, no, it is not being followed. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. No further information was provided prior to exit.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for one of 48 residents in the survey sample, Resident #10. The findings include: For Resident #10 (R10), the facility staff failed to review and revise the resident's current comprehensive care plan for the use of a left-hand splint. R10's comprehensive care plan dated 6/12/24 documented, ADL (activities of daily living) Self care & mobility deficits as evidenced by muscular weakness, and left hemiplegia (paralysis) related to CVA (cerebrovascular accident [stroke]). Splint wear Left hand resting splint on as ordered. R10's care plan was cancelled, and the current care plan was initiated on 1/10/25. The current care plan failed to reveal documentation regarding a left-hand splint. On 2/4/25 at 3:51 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated a corporate decision was made to revamp care plans, so they were more aligned and cohesive across the company so new care plans were initiated for residents. LPN #4 stated the left-hand splint that was documented on R10's old care plan should have carried over and the current care plan should have been reviewed and revised to include the splint. On 2/4/25 at 4:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Care Planning- Comprehensive Person-Centered documented, 11. Each resident's comprehensive care plan will describe the following: a. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. No further information was presented prior to exit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for five of 48 residents in the survey sample, Residents #147, #132, #62, #104, and #70. The findings include: 1. For Resident #147 (R147), the facility staff failed to dress the resident in clothes. R147 was admitted to the facility on [DATE]. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/22/25, the resident scored 2 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. On 2/3/25 at 11:54 a.m. and 3:48 p.m., R147 was observed sitting in the day room. The resident was dressed in a gown and slipper socks. On 2/4/25 at 1:01 p.m., R147 was observed lying in bed. The resident was dressed in a gown. On 2/4/25 at 3:02 p.m., an interview was conducted with CNA (certified nursing assistant) #3 (the CNA caring for R147). CNA #3 stated residents should be dressed in clothes every day, even if the residents are in their room or in bed. CNA #3 stated R147 did not have clothes so he dressed the resident in a clean gown. CNA #3 stated he was not sure if anyone had attempted to obtain clothes for R147. On 2/4/25 at 3:51 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated R147 recently transferred to her floor from another unit, she was not sure why the resident did not have clothes, and she planned on discussing this with the resident's son. LPN #4 stated that generally when a resident does not have clothes, the staff try to obtain donated clothes. On 2/4/25 at 4:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Activities of Daily Living (ADLs) documented, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. No further information was presented prior to exit. 2. For Resident #132 (R132), the facility staff failed to dress the resident in clothes. R132 was admitted to the facility on [DATE]. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/30/24, the resident scored 0 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/3/25 at 12:02 p.m., R132 was observed sitting in the hall. The resident was dressed in a gown and slipper socks. On 2/3/25 at 3:48 p.m., R132 was observed sitting in the day room. The resident was dressed in a gown and slipper socks. On 2/4/25 at 1:01 p.m., R132 was observed lying in bed. The resident was dressed in a gown. On 2/4/25 at 3:02 p.m., an interview was conducted with CNA (certified nursing assistant) #3 (the CNA caring for R132). CNA #3 stated residents should be dressed in clothes every day, even if the residents are in their room or in bed. CNA #3 stated R132 did not have clothes so he dressed the resident in a clean gown. CNA #3 stated he was not sure if anyone had attempted to obtain clothes for R132. On 2/4/25 at 3:51 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated she has tried to reach out to R132's sister but she never returns her calls. LPN #4 stated that generally when a resident does not have clothes, the staff try to obtain donated clothes. On 2/4/25 at 4:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 4. For Resident #104 (R104), the facility staff failed to assist him to transfer from bed to chair, failed to assist him with a haircut and shaving, and failed to maintain his fingernails in a clean and trimmed manner. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/24/24, R104 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring the extensive assistance of staff for grooming and personal care, and for transferring from bed to chair. On the following dates and times, R104 was observed sitting up in bed: 2/3/25 at 12:53 p.m. and 4:01 p.m., 2/4/25 at 9:38 a.m., and 2/5/25 at 10:17 a.m. At all observations, R104's fingernails were approximately two to three centimeters beyond his finger tips, and many of his fingernails had dark material underneath them. R104's hair was long and thin, extending to just below his chin. The resident's beard was grown out to approximately five inches below his chin. R104 stated the staff never offers to get him out of bed, and that he would like to get up each day he feels up to it. He stated sometimes he asks the staff to get him up; sometimes they do it and sometimes they do not. He stated he is accustomed to having short hair and to having his beard trimmed very short. He reported that the staff have told him there is no one to shave him or cut his hair currently working at the facility. He stated he is unable to trim his own fingernails, and staff have never cleaned or trimmed his fingernails. A review of R104's orders, progress notes, and care plan revealed no evidence that the resident refused ADL (activities of daily living) care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/25 at 8:53 a.m., CNA (certified nursing assistant) #6 was interviewed. She stated she is familiar with the care of R104. She stated the aides provide fingernail care each time they give the resident a bed bath. She stated: We give him a bed bath all the time; we put cream on his back every day and every night. She stated the resident does not like to get out bed, but added she has not asked him recently if he would like to get out of bed. She stated she does not know who is responsible for cutting his hair or for assisting him to shave. On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. No additional information was provided prior to exit. 5. For Resident #70 (R70), the facility staff failed to get the resident out of bed at any point during the survey. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/24/24, R70 was coded as being moderately cognitively impaired for making daily decisions. She was coded as requiring the extensive assistance of staff for transferring from bed to chair. On the following dates and times, R70 was observed to be sitting up in her bed: 2/3/25 at 12:48 p.m. and 3:49 p.m.; 2/4/25 at 9:37 a.m.; and 2/5/25 at 10:47 a.m. On 2/5/25 at 8:53 a.m., CNA (certified nursing assistant) #6 was interviewed. She stated she is familiar with the care of R70. She stated she has never offered or attempted to get R70 out of her bed. She stated: I don't know why she stays in bed. I have only seen her in the wheelchair a few times. On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. No additional information was provided prior to exit. 3. The facility staff failed to provide ADL (activities of daily living) specifically fingernail care for a dependent resident, R62. Observations of nails 3/4 inch long on both hands, and left foot nails 1/2 inch thick and curled over top of toes on 02/03/25 11:45 AM and 02/04/25 09:15 AM. R62 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident) with hemiparesis/hemiplegia, diabetes mellitus and osteomyelitis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/4/25, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the comprehensive care plan dated 11/4/24 revealed, FOCUS: The resident has an ADL self-care performance deficit. INTERVENTIONS: Physical assist as needed. The ADL record does not evidence fingernail care. An interview was conducted on 2/3/25 at 11:45 AM with R62. When asked about his fingernails, R62 stated, they need trimming bad, they are so long. I have bit them down to get them this short. My toenails are long also. An interview was conducted on 2/4/25 at 8:45 AM with CNA (certified nursing assistant) #1. When asked the process for cutting a resident's nails, CNA #1 stated, we tell the nurse and they are put on the podiatrist list, we are not to cut the nails. An interview was conducted on 2/4/25 at 9:20 AM with RN (registered nurse) #2. When asked the process for getting a resident's nails cut, RN #2 stated, we put them on the podiatrist list for the feet and we can cut their fingernails. When asked how often the podiatrist visits, RN #2 stated, they come monthly, but we do not know the day. When asked to look at R62's finger and toenails, RN #2 stated, yes, they need cut. I will put him on the list for the podiatrist and after I give them meds and he finished his breakfast; I will cut his fingernails. When asked if his nails looked like they were cut a month ago, RN #2 stated no. R62 stated, these are good now, I bit them down to this length. On 2/4/25 at 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. No further information was provided prior to exit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to administer medications according to the physician's orders for one of 48 residents in the survey sample, Resident #76 (R76). For R76, the facility staff failed to administer Furosemide (for swelling), Gabapentin (for pain), Lorazepam (for anxiety), Losartan Potassium (for high blood pressure), Metoprolol (for high blood pressure), Mirtazapine (for depression), Oxycodone (for pain), Sertraline (for depression), Tamsulosin (for (BPH) benign prostatic hypertrophy (1)), Aspirin (for (CAD) coronary artery disease (2)), Lidocaine External Patch(for pain), Tylenol (for pain) according to the physician's order. The findings include: R76 was admitted with diagnoses that included but were not limited to depression, high blood pressure, BPH, high cholesterol, anxiety and muscle weakness. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/10/2025, R76 scored 8 (eight) out of 15 on the BIMS (brief interview for mental status), indicating R76 was moderately impaired of cognition for making daily decisions. The POS (physician's order sheet) for R76 dated 02/05/2025 documented in part, Aspirin Oral Tablet Chewable 81 MG (milligram) (Aspirin) Give 81 mg by mouth one time a day for CAD. Oder Date: 01/04/2025. Start Date: 01/05/2025. Furosemide Oral Tablet 20 MG (Furosemide) Give 20 mg by mouth one time a day for EDEMA Oder Date: 01/04/2025. Start Date: 01/05/2025. Gabapentin Oral Capsule 100 MG (Gabapentin) Give 2 capsule by mouth two times a day for NEUROPATHIC PAIN. Oder Date: 01/04/2025. Start Date: 01/04/2025. Lidocaine External Patch 4 % (Lidocaine) Apply to LOWER BACK topically one time a day for PAIN MANAGEMENT and remove per schedule. Oder Date: 01/04/2025. Start Date: 01/05/2025. Lorazepam Oral Tablet 1 MG (Lorazepam) Give 1 mg by mouth every 24 hours as needed for ANXIETY for 3 Week. Oder Date: 01/04/2025. Start Date: 01/05/2025. Losartan Potassium Oral Tablet 25 MG (Losartan Potassium) Give 25 mg by mouth one time a day for HYPERTENSION HOLD FOR SBP (systolic blood pressure) < (less than) 110. Oder Date: 01/04/2025. Start Date:01/05/2025. Metoprolol Tartrate Oral Tablet 50 MG (Metoprolol Tartrate) Give 50 mg by mouth one time a day for HYPERTENSION HOLD FOR SBP < 115 HR (heart rate) < 55. Order Date: 01/04/2025. Start Date: 02/02/2025. Mirtazapine Oral Tablet 15 MG (Mirtazapine) Give 15 mg by mouth one time a day for DEPRESSION. Oder Date: 01/04/2025. Start Date: 01/05/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Oxycodone HCl (hydrochloride) Oral Tablet 5 MG (Oxycodone HCl) Give 5 mg by mouth one time a day for PAIN MANAGEMENT. Oder Date: 01/04/2025. Start Date: 01/05/2025. Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) Give 100 mg by mouth one time a day for DEPRESSION. Oder Date: 01/04/2025. Start Date: 01/05/2025. Tamsulosin HCl Oral Capsule 0.4 MG (Tamsulosin HCl) Give 0.4 mg by mouth one time a day for BPH. Oder Date: 01/04/2025. Start Date: 01/05/2025. Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 500 mg by mouth two times a day for PAIN MANAGEMENT Do not exceed > 3 (three) gram per day. Oder Date: 01/04/2025. Start Date: 01/05/2025. The eMAR (electronic medication administration record) for R76 dated January 2025 revealed the physician's orders as stated above. Further review of the eMAR revealed blanks on 01/12/2025 for the medications listed above. The facility's nursing progress notes and eMAR notes for R76 dated 01/12/2025 through 01/13/2025 failed to evidence documentation regarding the blanks on 01/12/2025 for the medications listed above. Review of the facility's Omnicell (3) inventory sheet documented the medications Furosemide, Gabapentin, Lorazepam, Losartan Potassium, Metoprolol, Mirtazapine, Oxycodone, Sertraline, and Tamsulosin were available in the Omnicell cabinets. On 02/05/2025 at approximately 12:23 p.m., an interview was conducted with LPN (licensed practical nurse) #4, unit manager. When asked how it is evidenced that medication was administered to a resident, she stated the nurse's initials and a check mark for the date and time on the eMAR. LPN #4 also stated if a medication is not available in the nurse's medication cart, the nurse should check the Omnicell and if it is in the Omnicell or if it is part of the facility's stock of medications it should be administered to the resident. LPN #4 stated if the medication is not available in either the facility stock or the Omnicell, the pharmacy should be notified. On 02/05/2025 at approximately 2:30 p.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing regarding R76's medications. After reviewing the medications from the POS listed above ASM #2 stated the Aspirin, Lidocaine External Patch and Tylenol were facility stock, stored in her office and available to the nurse. When asked about access to her office when she is not in the building, ASM #2 stated the nursing has a key to access the office to obtain the medications. On 02/05/2025 at approximately 1:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, director of clinical reimbursement, and ASM # 5regional director of operations, were made aware of the above findings. No further information was provided prior to exit. References: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. (2) A common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html. (3) automated dispensing cabinets for medications and supplies in hospitals and other healthcare facilities. This technology employs the use of storage units that operate somewhat like vending machines for the medical products, but also have sophisticated software on the back-end that handles patient orders, medication dosing documentation, inventory management, and billing transactions. This information was obtained from the website: https://healthcareitskills.com/automated-dispensing-cabinets-pharmacy-automation/

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. For R98, facility staff failed to implement the use of a Heelzup (1) cushion according to the physician's orders for the prevention of pressure injuries. R98 was admitted with diagnoses that included but were not limited to protein-calorie malnutrition. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/24/202, the R98 scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section M050 Risk of Pressure Ulcers/Injuries coded R98 as Yes. On 02/03/25 at approximately 12:25 p.m., an observation revealed R98 lying on his back in bed with heels in contact with the surface of the bed. Further observation of R98's room revealed the Heelzup cushion laying on floor next to left side of R98's bed. On 2/4/25 at 1:22 am, an observation revealed R98 was lying on his back in bed. Both feet were propped on a pillow. However, the pillow was flat and insufficient to lift the resident's heels off the bed surface. Both heels rested in contact with the bed surface. On 02/04/25 at approximately 7:35 a.m., an observation revealed R98 was lying on his back in bed. Both feet were propped on a pillow. However, the pillow was flat and insufficient to lift the resident's heels off the bed surface. Both heels rested in contact with the bed surface. The physician's order for R98 dated 01/09/2025 documented, Heelzup cushion [NAME] in bed. The comprehensive care plan for R98 with a revision date of 01/08/2025 documented in part, Focus. Skin Impairment: the resident has a skin impairment of pressure ulcer of sacrum, non-pressure wound to left great toe, and pressure wound to right toe. Revision on: 01/08/2025. Under Interventions it documented in part, Heelz up cushion in place while resident in bed. Revision on: 01/08/2025. On 02/04/2024 at approximately 3:05 p.m., an interview and observation of R98 was conducted with CNA (certified nursing assistant) #5. The observation revealed R98 was lying on his back in bed. Both lower legs (calves) were propped on a pillow. However, the pillow was flat and insufficient to lift the resident's heels off the bed surface. Both heels rested in contact with the bed surface. When asked why the pillow was placed under R98's calves she stated it was to keep R98's heels off the bed to prevent the development of pressure injuries. When asked to describe the position of R98's heels she stated that R98's heels were resting on the bed. CNA #4 then moved the pillow from under R98's lower legs and placed it under R98's heels, putting R98's heels in contact with the surface of the pillow. On 02/05/2024 at approximately 12:23 p.m., an interview was conducted with LPN (licensed practical nurse) #4, unit manager regarding the use of an Heelzup cushion or a pillow placed under a resident's lower legs. LPN #4 stated they would be used for the prevention of pressure injuries and the cushion or pillow would keep the heels above the surface of the bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/04/2025 at approximately 4:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, director of clinical reimbursement, and ASM # 5regional director of operations, were made aware of the above findings. No further information was provided prior to exit. References: (1) Designed to aid in the prevention and treatment of heel pressure injuries. HeelZup® Heel Elevators suspend the heels to eliminate pressure, while the patented raised side bolsters serve as a gentle reminder of the edge of the cushion. This information was obtained from the website: https://heelzup.com. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to provide care and services to prevent and treat a pressure injury (1) for two of 48 residents in the survey sample, Residents #74 and #98. The findings include: 1. For Resident #74 (R74), the facility staff failed to implement treatment for a pressure injury to the right ischium on 4/30/24. A review of R74's clinical record revealed the following progress note dated 4/30/24: Weekly wound assessment completed. Unstageable Pressure Ulcer to Right ischium. Overall impression: new wound - first observation. A review of R74's Weekly Wound assessment dated [DATE] revealed the following treatment recommendation for the right ischium wound: Calcium alginate and foam dressing. A review of R74's May 2024 TAR (treatment administration record) revealed this order was not implemented until 5/27/24, a total of 27 days after the wound was discovered. On 2/5/25 at 9:21 a.m., RN (registered nurse) #1 was interviewed. She stated when a pressure injury is identified, orders are put in place until the wound practitioner can see the resident. She stated these orders should be entered by a member of the nursing staff and signed by a provider so treatment can begin immediately. She stated: This gives the wound a better chance of getting better instead of worse. When asked how she provides evidence of wound treatments that she has completed, she stated she signs the treatment off on the TAR. On 2/5/25 at 9:54 a.m., LPN (licensed practical nurse) #6, a unit manager, was interviewed. LPN #6 stated there was a signed order for R74's right ischium wound treatment to begin on 5/1/24. However, he stated he could not find evidence in the TAR that the order had been implemented until 5/27/24. On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy, Pressure Injury Prevention and Management, revealed, in part: The intent of this organization is to develop and maintain systems and processes to ensure that the resident does not develop pressure ulcers/injuries .unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice to: Promote the prevention of pressure ulcer/injury development; Promote the healing of existing pressure ulcers/injuries .Preventive interventions will be implemented based on the pressure ulcer/injury risk assessment, other related factors, and resident preferences .Treatments will be ordered by the physician/practitioner. No additional information was provided prior to exit. Reference (1) A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. This information is taken from the National Pressure Ulcer Advisory Panel website https://cdn.ymaws.com/npiap.com/resource/resmgr/2014_guideline.pdf\.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide toenail care for two of 48 residents in the survey sample, Residents #104 and #62. The findings include: 1. For Resident #104 (R104), the facility staff failed maintain R104's toenails in a trimmed and clean manner, and failed to wash and apply lotion to his feet to prevent them from being dry and scaly. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/24/24, R104 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring the extensive assistance of staff for grooming and personal care. On the following dates and times, R104 was observed sitting up in bed: 2/3/25 at 12:53 p.m. and 4:01 p.m., 2/4/25 at 9:38 a.m., and 2/5/25 at 10:17 a.m. At all observations, R104's toenails on the left foot were thick and extending beyond the toenail bed, with some containing dark material underneath. R104's left foot was dry and had profuse scaly flecks. R104 stated no staff member had attempted to cut his toenails or lotion his feet or legs. He stated someone had told him he needed to see a podiatris, but this had not happened yet. A review of R104's orders, progress notes, and care plan revealed no evidence that the resident refused any type of toenail care. On 2/5/25 at 8:25 a.m., evidence that R104 had received foot care from a staff member or a podiatrist was requested of facility staff. On 2/5/25 at 8:53 a.m., CNA (certified nursing assistant) #6 was interviewed. She stated she is familiar with the care of R104. She stated the nurses are responsible for toe and foot care for residents. On 2/5/25 at 9:21 a.m., RN (registered nurse) #1 was interviewed. She stated she was familiar with R104's care. She stated the resident's toenails are long and thick, and that he needs to be seen by the podiatrist. She added: We put him on the list. When asked to provide a current list of residents for the podiatrist to see, she stated she would have to look and see. RN #1 never provided this list to the survey team prior to exit. On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. A review of the facility policy, Activities of Daily Living, failed to reveal any information specific to toenail/foot/podiatry care. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided prior to exit. 2. The facility failed to evidence provision of foot care for Resident #62. Observations of nails 3/4 inch long on both hands, and left foot nails 1/2 inch thick and curled over top of toes on 02/03/25 11:45 AM and 02/04/25 09:15 AM. R62 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident) with hemiparesis/hemiplegia, diabetes mellitus and osteomyelitis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/4/25, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 11/4/24 revealed, FOCUS: The resident has an ADL self-care performance deficit. INTERVENTIONS: Physical assist as needed. The medical record does not evidence podiatrist visit for R62. An interview was conducted on 2/3/25 at 11:45 AM with R62. When asked about his fingernails, R62 stated, they need trimming bad, they are so long. I have bit them down to get them this short. My toenails are long also. An interview was conducted on 2/4/25 at 8:45 AM with CNA (certified nursing assistant) #1. When asked the process for cutting a resident's nails, CNA #1 stated, we tell the nurse and they are put on the podiatrist list, we are not to cut the nails. An interview was conducted on 2/4/25 at 9:20 AM with RN (registered nurse) #2. When asked the process for getting a resident's nails cut, RN #2 stated, we put them on the podiatrist list for the feet and we can cut their fingernails. When asked how often the podiatrist visits, RN #2 stated, they come monthly, but we do not know the day. When asked to look at R62's finger and toenails, RN #2 stated, yes, they need cut. I will put him on the list for the podiatrist and after I give them meds and he finished his breakfast; I will cut his fingernails. When asked if his nails looked like they were cut a month ago, RN #2 stated no. R62 stated, these are good now, I bit them down to this length. On 2/4/25 at approximately 3:00 PM, ASM #3, the regional director of clinical operations stated, we do not have evidence of the podiatrist seeing this resident. On 2/4/25 at 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. No further information was provided prior to exit.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services for a resident with limited range of motion for one of 48 residents in the survey sample, Resident #10. The findings include: For Resident #10 (R10), the facility staff failed to implement a left-hand splint. A review of R10's clinical record revealed an occupational Discharge summary dated [DATE] that documented, Skill: Pt (Patient) and Caregiver Training: Instructed patient and primary caregivers in splinting/orthotic schedule in order to facilitate improved functional abilities. Instruction in proper use, care and wearing time of prosthetic device and therapeutic stretch techniques. Patient Response: Progress and Response to Tx (treatment): patient tolerated wearing L (left) hand resting splint for up to 7 hrs with no redness, swelling or pain. Orthotic Management: Splint/Orthotic Recommendations: It is recommended the patient wear a resting hand splint on left hand for 8 hours in order to manage tone. Discharge Recommendations: Splint/brace. RNP/FMP (Restorative Nursing Program/Functional Maintenance Program): To facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs has been completed with the IDT (interdisciplinary team): splint or brace Care. On 2/3/25 at 12:15 p.m., 2/3/25 at 3:45 p.m., 2/4/25 at 8:17 a.m., and 2/4/25 at 1:02 p.m., R10 was observed in bed and presented with a left-hand contracture. During all observations, no splint or brace was observed on the resident's left hand. A splint was observed on the windowsill. On 2/4/25 at 1:08 p.m., an interview was conducted with OSM (other staff member) #6 (the occupational therapist who signed the above discharge summary). OSM #6 stated R10 should wear a left-hand splint for seven hours at a time. OSM #6 stated the splint should be placed on the resident's left hand in the morning and removed during activities of daily living care and at night. OSM #6 stated the last week of therapy, she completes training with CNAs (certified nursing assistants), nurses, and unit managers, informing them instructions regarding splints. On 2/4/25 at 1:19 p.m., an interview was conducted with CNA #4 (the CNA caring for R10). CNA #4 stated she did not know anything about a splint for R10's hand. On 2/4/25 at 3:38 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated therapy staff educates the nursing staff regarding residents who need splints, but she was not aware of R10 needing a splint. On 2/4/25 at 4:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, RESIDENT MOBILITY AND RANGE OF MOTION documented, 3. Residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility unless reduction is unavoidable. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was presented prior to exit.

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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 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. Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide an environment to prevent avoidable accidents for one of 48 residents in the survey sample, Resident #90. The findings include: For Resident #90 (R90), the facility staff failed to assess the resident's bed for weight restrictions to ensure safety per the manufacturer's instructions. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/17/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. A review of R90's clinical record revealed the resident's weights as followed: 9/2/24- 495.6 pounds 12/23/24- 484 pounds Further review of R90's clinical record failed to reveal an assessment to determine if the resident's bed met weight restrictions and was safe for use. On 2/3/25 at 12:04 p.m., R90 was observed sitting on the bed. The bed contained a trapeze bar and an air mattress. An interview was conducted with R90. The resident voiced concern regarding the size and functionality of the bed. On 2/4/25 at 1:41 p.m., an interview was conducted with OSM (other staff member) #7 (the director of maintenance). OSM #7 stated there are weight restrictions for beds, the nurses must determine if those weight restrictions are met, and usually the administrator orders larger beds as necessary. OSM #7 was not familiar with R90. On 2/4/25 at 3:51 p.m., an interview was conducted with LPN (licensed practical nurse). LPN #4 stated the nurses do not address weight restrictions compared to bed manufacturer's instructions. The manufacturer's instructions for R90's bed documented, Bed safe working load is 500 pounds. This is total weight counting resident/patient, mattress, bedding accessories and any other equipment or persons likely to be on the bed. Do not exceed 500-pound safe working load. Exceeding the safe working load could result in property damage, injury or death .NEVER exceed the weight capacity of this bed. The weight capacity of this bed is 500 lbs. (227 kg) including accessories and options. On 2/5/25 at 1:39 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Bed Inspection and Safety documented, Our facility shall strive to provide a safe sleeping environment for the resident . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SPECIFIC PROCEDURES/GUIDANCE 1. The resident's sleeping environment shall be evaluated by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. No further information was presented prior to exit.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to administer tube feeding in a sanitary manner for one of 48 residents in the survey sample, Resident #131. The findings include: For Resident #131 (R131), the facility staff failed to utilize clean tubing to administer a tube feeding to R131 on 2/3/25. On the following dates and times, R131 was observed lying in bed, receiving tube feeding at 45 mls (milliliters) per hour. At each observation, the outside of the tubing contained a brown sticky substance over approximately 50% of the tubing: 2/3/25 at 12:58 p.m., 1:52 p.m., and 3:45 p.m. On 2/5/25 at 9:21 a.m., RN (registered nurse) #1 was interviewed. She stated if a nurse discovers a sticky brown substance on the outside of tube feeding tubing, the nurse should stop the feeding and replace the tubing. She stated the brown sticky substance is likely tube feed material that has leaked out from the bottle onto the tubing. She stated the resident may not be getting the full amount of tube feeding if there is a leak. Additionally, this could be an infection concern. On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. No additional information was provided prior to exit.

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Fair Oaks Health & Rehabilitation	12475 Lee Jackson Memorial Highway Fairfax, VA 22033

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. For R56, facility staff failed to place a C-PAP (continuous positive airway pressure) (1) mask is a plastic bag when not in use. R56 was admitted to the facility with diagnosis that included but not limited to sleep apnea (2). On the most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/23/2025, R56 scored 13 out of 15 on the BIMS (brief interview for mental status), indicating R56 was cognitively intact for making daily decisions. On 02/03/25 at approximately 12:19 p.m., an observation revealed R56's C-PAP mask lay on top of bedside table uncovered. On 02/03/25 at approximately 2:49 p.m., an observation revealed R56's C-PAP mask lay on top of bedside table uncovered. On 02/03/25 at approximately 4:25 p.m., an observation revealed R56's C-PAP mask lay on top of bedside table uncovered. On 02/04/25 at approximately 8:20 a.m., an observation revealed R56's C-PAP mask lay on top of bedside table uncovered. The physician's order for R56 documented in part, Apply CPap q (every) hs (night) & (and) PRN (as needed) for naps .as needed for OSA (obstructive sleep apnea). Apply CPap PRN for nap. Oder Date: 1/22/2025. On 02/04/2025 at approximately 3:12 p.m., an observation of R56's C-PAP mask and interview was conducted with RN (registered nurse) #2 regarding the storage of a C-PAP mask when not in use. After observing R56's C-PAP mask on the bedside table RN #3 stated the C-PAP mask should be placed in a plastic bag when not in use to keep it clean and prevent contamination. On 02/04/2025 at approximately 4:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, director of clinical reimbursement, and ASM # 5regional director of operations, were made aware of the above findings. No further information was provided prior to exit. References: (1) The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(2) a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html. 3. For R140, the facility staff failed to maintain the oxygen flow rate at three liters per minute according to the physician's orders. R140 was admitted to the facility with diagnoses that included but were not limited to (COPD) chronic obstructive pulmonary disease (1). On the most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/16/2025, R140 scored 6 (six) out of 15 on the BIMS (brief interview for mental status), indicating R140 was severely impaired of cognition for making daily decisions. Section O Special Treatments, Programs and Procedures coded R140 as receiving oxygen therapy while a patient. On 02/03/25 at approximately 12:38 p.m., an observation revealed R140 lying in bed receiving O2 (oxygen) by nasal cannula. Observation of the flow meter on the O2 concentrator revealed a flow rate between two and three liters per minute. 02/03/25 at approximately 2:53 p.m., an observation revealed R140 lying in bed receiving O2 by nasal cannula. Observation of the flow meter on the O2 concentrator revealed a flow rate between two and three liters per minute. 02/03/25 at approximately 4:25 p.m., an observation revealed R140 lying in bed receiving O2 by nasal cannula. Observation of the flow meter on the O2 concentrator revealed a flow rate between two and three liters per minute. 02/03/25 at approximately 7:35 a.m., an observation revealed R140 lying in bed receiving O2 by nasal cannula. Observation of the flow meter on the O2 concentrator revealed a flow rate between two and three liters per minute. The physician's order for R140 documented in part, O2 @ (at) 3 (three) liters per minute via (by) NC (nasal cannula). Every shift for Hypoxia (low level of oxygen) secondary to COPD .Order Date: 12/27/2024. On 02/04/2025 at approximately 3:12 p.m., an interview and observation of R140's O2 flow meter on the O2 concentrator was conducted with RN (registered nurse) #3. When asked to describe how to read the flow meter on the O2 concentrator she stated the liter line should pass through the middle of the float ball inside the flow meter. After observing the flow meter on R140's O2 concentrator RN #3 stated R140 was receiving two-and-a-half liters of O2 per minute. On 02/04/2025 at approximately 4:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, director of clinical reimbursement, and ASM # 5regional director of operations, were made aware of the above findings. No further information was provided prior to exit. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	References: (1) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 4. For Resident #131, the resident's oxygen tubing was not labeled with the date it was most recently changed. On the following dates and times, R131 was observed lying in bed, receiving oxygen at 2 liters per minute from a concentrator, by way of nasal cannula tubing: 2/3/25 at 12:58 p.m., 1:52 p.m., and 3:45 p.m.; 2/4/25 at 9:50 a.m. and 3:47 p.m. At each of these observations, R131's oxygen tubing did not have any kind of label indicating the date it was last changed. On 2/5/25 at 9:21 a.m., RN (registered nurse) #1 was interviewed. She stated R131 was on continuous oxygen. She stated the tubing is changed every week at a minimum, and more often as needed. When asked how the staff knows the last time the tubing was changed, she stated the staff member who changes the tubing should label the tubing with the date. She stated clean tubing is important to prevent possible respiratory infections for residents who are on oxygen. On 2/5/25 at 9:54 a.m., LPN (licensed practical nurse) #6, a unit manager, was interviewed. He stated oxygen tubing should be changed every week and labeled with the new date it was changed. He stated this is how the staff knows when the tubing is due to be changed again. On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. No additional information was provided prior to exit. 5. For Resident #104 (R104), the facility failed to store his CPAP(1) mask in a sanitary manner, and to clean the mask and tubing regularly. On the following dates and times, R104 was observed sitting up in bed: 2/3/25 at 12:53 p.m. and 4:01 p.m., 2/4/25 at 9:38 a.m., and 2/5/25 at 10:17 a.m. At all observations, R104's CPAP machine was visible on his bedside table. The tubing for the CPAP extended below the top of the table, and ended with the mask at its tip. The mask rested in the top drawer of the bedside table, uncovered. R104 stated he used his BPAP every night to sleep, but no staff member ever cleaned the mask or stored the mask in a sanitary plastic bag. A review of R104's orders revealed he was to use the CPAP to sleep. Further review of these orders revealed no instructions regarding cleaning of the CPAP mask. A review of R104's care plan, MAR (medication administration record) and TAR (treatment administration record) also failed to reveal interventions for cleaning the CPAP mask. On 2/5/25 at 8:53 a.m., CNA (certified nursing assistant) #6 was interviewed. She stated she was not aware that the resident used the CPAP, and did not know anything about cleaning or storing the CPAP mask. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/25 at 9:21 a.m., RN (registered nurse) #1 was interviewed. She stated R104 used the CPAP for sleep each night, and the mask should always be stored in a plastic bag. She stated the mask should be cleaned after each use, but could not identify who is responsible for cleaning the mask. After reviewing R104's clinical record, she stated she did not see any evidence that R104's CPAP mask was being cleaned regularly. She stated this is dangerous because the mask could collect harmful germs and be an infection control concern. On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. No additional information was provided prior to exit. Reference (1)CPAP (Continuous Positive Airway Pressure) is a treatment that uses mild air pressure to keep your breathing airways open .It involves using a CPAP machine that includes a mask or other device that fits over your nose or your nose and mouth, straps to position the mask, a tube that connects the mask to the machine ' s motor, and a motor that blows air into the tube. CPAP is used to treat sleep-related breathing disorders including sleep apnea. This information is taken from the website https://www.nhlbi.nih.gov/health-topics/cpap. Based on observations, staff /resident interviews facility document review and clinical record review, it was determined the facility staff failed to provide respiratory care services for five of 48 residents, R23, R56, R140, R131 and R104. The findings include: 1. The facility staff failed to provide respiratory care services per physician orders for R23. Observed R23's oxygen setting at 4 liters nasal cannula (lnc) on 02/03/25 at 11:33 AM, 02/03/25 at 3:33 and 02/04/25 at 08:30 AM. R23 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CHF (congestive heart failure), osteoarthritis and CVA (cerebrovascular accident). The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 11/13/24, coded the resident as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. Section O: oxygen: yes. A review of the comprehensive care plan dated 11/29/24 revealed, FOCUS: Has/At risk for respiratory impairment related to SOB due to OSA (obstructive sleep apnea) & chronic respiratory failure with hypoxia, cough. CHF. INTERVENTIONS: Administer oxygen as per physician order: Via nasal cannula for shortness of breath related to CHF. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the physician's order dated 11/16/21 revealed, O2 via nasal cannula at 2 liters per minute every shift. An interview was conducted on 2/3/25 at 3:33 PM with R23, when asked her oxygen setting, R23 stated, it is on two. An interview was conducted on 2/4/25 at 9:05 AM with LPN (licensed practical nurse) #2. When asked to verify R23's oxygen order, LPN #2 stated, she is to be on 2 lnc (liters/nasal cannula). When asked to come to the room and verify setting, LPN #2 stated, she is on 4-5 lnc. I will adjust it. When asked where you would read the oxygen setting, LPN #2 stated, you would read it with the line in the middle of the ball. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. A review of the facility's Equipment Change and Cleansing policy revealed, The following procedures have been developed to emphasize the importance of proper handling and processing of certain equipment. All disposable equipment will be dated and initialed. All patients will receive a complete set-up bag with the necessary equipment associated with Respiratory Care. Items will not be share between patients. No further information was provided prior to exit.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide dialysis care and services for one of 48 residents in the survey sample, R59. The findings include: The facility failed to provide evidence of communication with dialysis facility for R59. R59 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ESRD (end stage renal disease), CHF (congestive heart failure) and diabetes mellitus. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/28/24, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 9/5/24 revealed, FOCUS: Renal insufficiencies related to chronic renal failure. INTERVENTIONS: Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis as needed. A review of the physician's order dated 2/17/22 revealed, Transportation to dialysis center - (Tue/Thu/Sat) at 9:58 AM Hemodialysis. Check AV fistula site thrill/bruit LUE one time a day for AV fistula site thrill/bruit check. Facility to dialysis center communication sheets evidenced for 11/14/24, 12/12, 12/17/12/19/12/21, 12/24, 12/31, 1/7, 1/9, 1/11, 1/16, 1/18, 1/21, 1/23, 1/25, 1/28, 1/30, 2/1, 2/4. The remaining sheets for 11/1/24-2/4/25 were missing. On 2/4/25 at 8:10 AM an interview was conducted with R59, when asked if his dialysis communication book contains communication for each dialysis visit, R59 stated, not sure what they put in there, if there are forms for every treatment or not. On 2/05/25 at 11:21 AM, ASM #3, the regional director of clinical operations stated, we do not have the missing dialysis sheets. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. A review of the facility's End Stage Renal Disease-Care of Resident policy, reveals, Agreements between the facility and the contracted ESRD facility will include all aspects of how the resident's care will be managed including but not limited to the communication process between the nursing facility and the dialysis center that will reflect ongoing communication, coordination and collaboration. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide trauma informed care for one of 48 residents in the sample R46. The facility failed to evidence provision of trauma informed care for R46. R46 was admitted to the facility on [DATE] with diagnosis that included but were not limited to PTSD (post traumatic stress disorder), viral hepatitis and pulmonary fibrosis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/1/24, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. Section I: Active Diagnosis (dated 8/31/24) I6100. Post Traumatic Stress Disorder (PTSD)-coded as yes. A review of the comprehensive care plan dated 6/12/24 revealed, FOCUS: At risk for adverse effects related to use of antianxiety and antidepressant medication. INTERVENTIONS: Report to physician signs of adverse reaction such as decline in mental status, decline in positioning/ambulation ability, lethargy, complaints of dizziness, tremors. Psych consult and follow up as needed. A review of the physician's order dated 4/8/24 revealed, Psych consult. 02/04/25 01:00 PM ASM (administrative staff member) #3, the regional director of clinical services, informed me that there was no PTSD screening, no provision of medically related social services. On 2/04/25 at 2:50 PM, an interview was conducted with R46. When asked what care she is receiving for PTSD, R46 stated, psychiatry is seeing me. When asked if staff know her triggers for PTSD and if social services is working with her; R46 stated, No, they do not know my triggers and social services is not working with me. When asked her triggers, R46 stated, Seeing violence, even on television, sometimes loud noise, it gives me migraines. On 2/4/25 at 3:30 PM and interview was conducted with LPN (licensed practical nurse) #4. When asked what should be included in a post-traumatic disorder assessment, LPN #4 stated, What are the triggers, what behaviors and moods the resident has and what staff can do to minimize any triggers. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. A review of the facility's Trauma Informed Care revealed, The facility will provide appropriate and compassionate care specific to individuals who have experienced trauma. As part of the comprehensive assessment, identify history of trauma or interpersonal violence when possible. Identifying past trauma or adverse experiences may involve record review or the use of screening tools. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence a physician writing a recommendation for a resident be admitted to the facility (admission note) for one of 48 residents in the survey sample, R59. The findings include: R59 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ESRD (end stage renal disease), CHF (congestive heart failure) and diabetes mellitus. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/28/24, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 9/5/24 revealed, FOCUS: Renal insufficiencies related to chronic renal failure. INTERVENTIONS: Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis as needed. R59 was transferred to the hospital on 3/14/24 and readmitted to the facility on [DATE]. There is no evidence of either the physician notes detailing reason for hospitalization or readmission to the facility on 3/17/24. On 2/5/25 at 11:50 AM, ASM #3, the regional director of clinical operations, stated, we do not have any evidence of a physician note on readmission to the facility on 3/17/24. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. A review of the facility's Attending Physician Responsibilities policy which reveals, The Attending Physicians shall be the primary practitioners responsible for providing medical services and coordinating the healthcare of each resident in the facility. The Attending Physician will assess new admissions in a timely fashion, according to the individual's medical stability and in accordance with federal and state law. No further information was provided prior to exit.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence of the frequency of physician visits at least every 60 days for two of 48 residents in the survey sample, R59 and R46. The findings include: 1. R59 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ESRD (end stage renal disease), CHF (congestive heart failure) and diabetes mellitus. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/28/24, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 9/5/24 revealed, FOCUS: Renal insufficiencies related to chronic renal failure. INTERVENTIONS: Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis as needed. R59 was transferred to the hospital on 3/14/24 and readmitted to the facility on [DATE]. There is no evidence of either nurse practitioner or physician notes from 6/5/24 to 2/4/25. On 2/5/25 at 11:50 AM, ASM #3, the regional director of clinical operations, stated, we do not have any evidence of nurse practitioner or physician visits from 6/5/24 to 2/4/25 for R59. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. A review of the facility's Attending Physician Responsibilities policy which reveals, The Attending Physicians shall be the primary practitioners responsible for providing medical services and coordinating the healthcare of each resident in the facility. The Attending Physician will visit residents in a timely fashion, consistent with applicable state and federal requirements, and depending on the individual's medical stability, recent and previous medical history, and the presence of medical conditions or problems that cannot be handled readily by phone. The visit schedule will be at least every 30 days for the first 90 days after admission, and then at least every 60 days thereafter. No further information was provided prior to exit. 2. R46 was admitted to the facility on [DATE] with diagnosis that included but were not limited to PTSD (post-traumatic stress disorder), viral hepatitis and pulmonary fibrosis. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/1/24, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. Section I: Active Diagnosis (dated 8/31/24) I6100. Post Traumatic Stress Disorder (PTSD)-coded as yes. A review of the comprehensive care plan dated 6/12/24 revealed, FOCUS: At risk for adverse effects related to use of antianxiety and antidepressant medication. INTERVENTIONS: Report to physician signs of adverse reaction such as decline in mental status, decline in positioning/ambulation ability, lethargy, complaints of dizziness, tremors. Psych consult and follow up as needed. There is no evidence of either nurse practitioner or physician notes from 6/19/24 to 12/8/24. On 2/5/25 at 11:50 AM, ASM #3, the regional director of clinical operations, stated, we do not have any evidence of nurse practitioner or physician visits from 6/19/24 to 12/8/24 for R46. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. No further information was provided prior to exit.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post daily nurse staffing information that contained all required information. The findings include: The facility staff failed to post nurse staffing information that included the name of the facility and facility census. On 2/3/25 at 11:55 a.m., an observation was made of the posted nurse staffing information in the entrance lobby area of the facility. Observation of the nurse staffing information failed to evidence the facility census information or the name of the facility. Additional observations on 2/4/25 at 8:08 a.m. failed to evidence the facility census or name of the facility on the nurse staffing document. Review of the previous 30 days staff posting failed to evidence facility census information or the name of the facility on the nurse staffing data sheets. On 2/4/25 at 8:45 a.m., an interview was conducted with OSM (other staff member) #4, staffing coordinator who stated that they were responsible for posting the daily nurse staffing data sheets in the lobby area. She stated that she had never completed the census part of the form since she had worked in the position because it was on the nursing schedules and changed from time to time. She stated that she had never noticed that the facility name was not on the form, and it could be added. The facility policy, Posting Nursing Staffing Information Policy dated 10/6/22 documented in part, .The facility will post the following information daily, at the beginning of each shift. The posting shall include: a. The facility name . e. Resident Census . On 2/4/25 at 4:36 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, ASM #4, the regional clinical reimbursement director, and ASM #5, the regional director of operations were made aware of the concern. No further information was presented prior to exit.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide medically related social services for one of 48 residents in the sample R46. The findings include: For R46 the facility staff failed to provide psychosocial follow up following the resident being admitted with a diagnosis of PTSD (post-traumatic stress disorder). R46 was admitted to the facility on [DATE] with diagnosis that included but were not limited to PTSD (post-traumatic stress disorder), viral hepatitis and pulmonary fibrosis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/1/24, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. Section I: Active Diagnosis (dated 8/31/24) I6100. Post Traumatic Stress Disorder (PTSD)-coded as yes. A review of the comprehensive care plan dated 6/12/24 revealed, FOCUS: At risk for adverse effects related to use of antianxiety and antidepressant medication. INTERVENTIONS: Report to physician signs of adverse reaction such as decline in mental status, decline in positioning/ambulation ability, lethargy, complaints of dizziness, tremors. Psych consult and follow up as needed. A review of the physician's order dated 4/8/24 revealed, Psych consult. 02/04/25 01:00 PM ASM (administrative staff member) #3, the regional director of clinical services, informed me that there was no PTSD screening, no provision of medically related social services. On 2/04/25 at 2:50 PM, an interview was conducted with R46. When asked what care she is receiving for PTSD, R46 stated, psychiatry is seeing me. When asked if staff know her triggers for PTSD and if social services is working with her; R46 stated, no, they do not know my triggers and social services is not working with me. When asked her triggers, R46 stated, seeing violence, even on television, sometimes loud noises. It gives me migraines. On 2/4/25 at 3:30 PM an interview was conducted with LPN (licensed practical nurse) #4. When asked what should be included in a post-traumatic disorder assessment, LPN #4 stated, what are the triggers, what behaviors and moods the resident has and what staff can do to minimize any triggers. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/25 at 4:15 PM an interview was conducted with OSM (other staff member) #10, the Director of Social Services. When asked her role with R46 and her diagnosis of PTSD, OSM #10 stated, we complete assessments and coordinate with the psych nurse practitioner. My role is to ask questions regarding problems, to make sure there are no triggers for the resident. Typically, we do a social services quarterly assessment. I did not know about this resident. Normally, there is a referral process, it populates in my system and pops up, giving me a due date. On 2/5/25 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. A review of the facility's Social Worker job description which revealed, Responsible for providing medically related social work services so that each resident may attain or maintain the highest practicable level of physical, mental, and psychosocial well-being. Liaison with consultant psych professionals. Identifies cognitive impairments, signs of mood problems, and psychosocial needs and follows up as needed. No further information was provided prior to exit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on clinical record review and staff interview it was determined that the facility staff failed to provide pharmacy services for one of 48 residents in the survey sample, Resident #76 (R76). For R76, facility staff failed maintain the availability of Diltiazem (for high blood pressure), Ezetimibe (for cholesterol), and Methylcobalamin (for low iron) for administration. The findings include: R76 was admitted with diagnoses that included but were not limited to high blood pressure and high cholesterol. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/10/2025, R76 scored 8 (eight) out of 15 on the BIMS (brief interview for mental status), indicating R76 was moderately impaired of cognition for making daily decisions. The POS (physician's order sheet) for R76 dated 02/05/2025 documented in part, Diltiazem HCl (hydrochloride) ER (extended release) Beads Oral Capsule Extended Release 24 Hour 360 MG (milligrams). Give 360 mg by mouth one time a day for HYPERTENSION HOLD FOR SBP (systolic blood pressure) < (less than) 110. Order Date:01/04/2025. Start Date: 01/05/2025. Ezetimibe Oral Tablet 10 MG (Ezetimibe) Give 10 mg by mouth one time a day for HYPERLIPIDEMIA. Date Ordered: 01/04/2025. Start Date: 01/05/202. Methylcobalamin Sublingual (under the tongue) Tablet Sublingual 1000 MCG (micrograms). Give 1000 mcg sublingually one time a day for ANEMIA. Order Date: 01/04/2025. Start Date: 01/05/2025. The eMAR (electronic medication administration record) for R76 dated January 2025 revealed the physician's orders as stated above. Further review of the eMAR revealed blanks on 01/12/2025 for the medications listed above. The facility's nursing progress notes and eMAR notes for R76 dated 01/12/2025 through 01/13/2025 failed to evidence documentation regarding the blanks on 01/12/2025 for the medications listed above. Further review failed to evidence documentation of the pharmacy being notified of the need for Diltiazem, Ezetimibe and Methylcobalamin. Review of the facility's Omnicell (3) inventory sheet failed to evidence Diltiazem, Ezetimibe and Methylcobalamin were available in the Omnicell. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/2025 at approximately 12:23 p.m., an interview was conducted with LPN (licensed practical nurse) #4, unit manager. When asked how it is evidenced that medication was administered to a resident, she stated the nurse's initials and a check mark for the date and time on the eMAR. LPN #4 also stated if a medication is not available in the nurse's medication cart, the nurse should check the Omnicell and if it is in the Omnicell or if it is part of the facility's stock of medications it should be administered to the resident. LPN #4 stated if the medication is not available in either the facility stock or the Omnicell, the pharmacy should be notified. On 02/05/2025 at approximately 2:30 p.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing regarding R76's medications. After reviewing the medications from the POS listed above ASM #2 stated the Diltiazem, Ezetimibe and Methylcobalamin were not in the Omnicell nor were they facility stock. ASM #2 stated the medications would have to come from the pharmacy. On 02/05/2025 at approximately 1:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, director of clinical reimbursement, and ASM # 5regional director of operations, were made aware of the above findings. No further information was provided prior to exit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident/staff interview, clinical record review and facility document review, it was determined the facility staff failed to ensure residents were free of unnecessary medications for one of 48 residents in the survey sample, R130. The findings include: The facility staff failed to ensure R130 was free of unnecessary medications by monitoring anticoagulant as ordered. R130 was admitted to the facility on [DATE] with diagnosis that included but were not limited to pulmonary embolism, spondylosis and cord compression. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/7/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 1/24/25 revealed, FOCUS: CARDIAC: the resident is at risk for cardiac complications secondary to atrial fibrillation. INTERVENTIONS: Administer medications as ordered. Observe for signs and symptoms of cardiac complications. Care plan does not evidence any Anticoagulation information until after end of day on 2/4/25. A review of the physician's order dated 6/30/24 revealed, Rivaroxaban Oral Tablet 20 MG (Rivaroxaban) Give 20 mg by mouth one time a day for A fib take with dinner. R130's MAR (medication administration record) does not evidence any monitoring of anticoagulation monitoring. On 2/3/25 at 2:30 PM, an interview was conducted with R130. When asked what monitoring is provided for his anticoagulation, R130 asked what do you mean. When asked if staff ask him about bruising or bleeding or assess his arms, R130 stated, no, not that I know of. On 2/4/25 at 3:30 PM, an interview was conducted with LPN (licensed practical nurse) #4, the unit manager. When asked if anticoagulation side effects were monitored and where it would be evidenced, LPN #4 stated, no, we do not document anything for anticoagulation monitoring. 02/05/25 07:45 AM, ASM (administrative staff member) #2, the director of nursing, brought in updated order, care plan and MAR (medication administration record) to reflect monitoring for anticoagulation side effects dated 2/4/25 after end of day conference On 2/4/25 at 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations, ASM #4, the regional director of clinical reimbursement and ASM #5, the regional director of operations was made aware of the findings. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Medication and Treatment Orders policy, revealed, Orders for anti-coagulants will be prescribed only with appropriate clinical and laboratory monitoring. The attending physician/practitioner must periodically record in the progress notes the results of the laboratory monitoring and the review for potential complications. No further information was provided prior to exit.

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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. Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure a medication error rate less than five percent for one of three residents observed during the medication administration observation, Resident #88 (R88). During the medication administration observation, two errors out of 38 used to treat glaucoma opportunities occurred, resulting in a six and twenty-five hundredths' percent (6.25%) percent medication error rate. The findings include: For R88, the facility staff failed to administer eye drops according to physician's orders. RN (registered nurse) #3 administered two drops of Timoptic Ophthalmic Solution (1) in each eye and failed to administer one drop of Trusopt Ophthalmic Solution in the left eye. The POS (physician's orders sheet) for R88 dated 02/05/2025 documented in part, Timoptic Ophthalmic Solution 0.5% (five tenths of a percent). Instill 1 (one) drop in both eyes one time a day for glaucoma. Order Date: 09/19/2024. Trusopt Ophthalmic Solution 2% (two percent). Instill 1 (one) drop in left eye two times a day for glaucoma. Order Date: 09/19/2024. The eMAR (electronic medication administration record) for R88 dated February 2025 documented the orders as listed above. On 02/04/2025 at approximately 7:45 a.m., an observation of RN #3 administering medications to R88 was conducted. RN #3 administered one drop of Timoptic Ophthalmic Solution in both of R88's eyes, waited a full minute and administered Timoptic Ophthalmic Solution again in both of R88's eyes. Further observation of the medication administration to R88 failed to evidence the administration of Trusopt Ophthalmic Solution in R88's left eye. On 02/04/2025 at approximately 3:30 p.m., an interview was conducted with RN #3. After informed of the observation of the medication administration described above RN #3 stated she thought she gave R88 the Trusopt Ophthalmic Solution and stated she didn't realize that she gave the Timoptic Ophthalmic Solution twice in both of R88's eyes. When asked to describe how to prevent administering the same eye drops twice and not administering another one, she stated after giving one eye drop medication, separate the medication from other eye drops that haven't been given. The facility's policy Medication Administration Policy documented in part, The 5 Rights (right resident, right medication, right dose, right route, right time) must be confirmed at the following stages during medication administration. On 02/05/2025 at approximately 1:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, director of clinical reimbursement, and ASM # 5regional director of operations, were made aware of the above findings. No further information was provided prior to exit. References: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Used to treat glaucoma. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682043.html (2) Used to treat glaucoma. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697049.html

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store food in a sanitary manner in one of one kitchen and in two of three nourishment rooms. The findings include: The facility staff failed to store food in a sanitary manner in A) one of one kitchen and B) two of three nourishment rooms. A) On 02/03/25 at 11:11 a.m. an observation was conducted of the facility kitchen. Observation of the dry storage area revealed an 11 lb. container of chocolate fudge icing that was approximately 1/2 full, with a label which documented a prep date of 12/19/24 and a use by date of 1/19/25. A five-pound bag of white cake mix approximately one-quarter full was observed with a label which documented a prep date of 12/27/24 and a use by date of 1/25/25. A ten-pound bag of elbow noodles was observed with approximately one-quarter of the bag remaining which was observed to be opened with the end of the bag open to air. Observation of the walk-in refrigerator revealed a plastic bin which contained nine individually plastic wrapped sandwiches. A label on the outside of the plastic bin documented that they were peanut butter and jelly sandwiches with a prep date of 12/24/24. Thirteen 8 ounce thickened dairy drinks were observed in a plastic bin with a best by date of 12/4/24. A box containing three bags of 12-inch tortillas were observed with a best by date of 11/14/24. One package of the tortillas was previously opened with approximately three tortillas inside and two bags were unopened. On 2/3/25 at 11:25 a.m., OSM (other staff member) #5, cook, observed the chocolate icing with the use by date of 1/19/25 and the white cake mix with the use by date of 1/25/25 and stated that the product should have been discarded and should not have been left on the shelf available for use. OSM #5 observed the bag of elbow noodles open to air and stated that the staff labeled it correctly, but they should have closed it with saran wrap to keep the product from being exposed to air. She stated that this was done to keep the product from getting contaminated by being exposed. OSM #5 observed the nine sandwiches in walk in refrigerator dated 12/24/24 and stated that she thought that the plastic bin was probably mislabeled, and she did not think that the sandwiches were that old because they were made daily and discarded after two days if not used. She observed the 13 thickened dairy drinks with best by date of 12/4/24 and stated that they were expired and needed to be discarded. OSM #5 observed the tortillas with the best by date of 11/14/24 and stated that they were expired and needed to be discarded. On 2/4/25 at 10:12 a.m., an interview was conducted with OSM #3, dietary manager who stated that when the staff opened dry goods like the pasta, cake mix and frosting it was labeled and dated to be discarded a month after opening. He stated that the pasta should be stored closed and wrapped in plastic wrap and used first. OSM #3 stated that the peanut butter and jelly sandwiches were made daily and used within two days or discarded if not used. He stated that as they put away new products, they placed the older items to the front to use them first, had stickers that they used to alert staff to use first and they discarded any expired products. He stated that this was done with each shipment twice a week. (continued on next page)

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Fair Oaks Health & Rehabilitation	12475 Lee Jackson Memorial Highway Fairfax, VA 22033

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. On 2/4/25 at 9:25 a.m., an observation was made of the second-floor nourishment room. Observation of the resident freezer revealed a dried brown substance on the bottom of the freezer surface approximately 8 inches wide by 10 inches long. The resident refrigerator contained a lunchbox with no name or date, a plastic food container with rice visible on the inside with no date or name and an 8-ounce carton of milk with an expiration date of [DATE]. On 2/4/25 at 9:35 a.m., an observation was made of the first-floor nourishment room. Observation revealed a plastic bag with two plastic food containers inside with no name or date observed. On 2/4/25 at 9:30 a.m., an interview was conducted with LPN (licensed practical nurse) #4 who observed the second-floor nourishment room freezer and refrigerator. She stated that housekeeping was responsible for cleaning the refrigerator and checking for dates and names on the contents inside the refrigerator. She stated that they should check it daily. LPN #4 observed the dried brown substance in the freezer and stated that it needed to be cleaned. She observed the lunchbox with no name or date, plastic food container with rice inside with no date or name and the 8-ounce carton of milk with an expiration date of [DATE] and stated that she did not know who they belonged to, and the milk needed to be thrown away. On 2/4/25 at 9:40 a.m., an interview was conducted with CNA (certified nursing assistant) #2 who stated that housekeeping was responsible for cleaning out the refrigerator and throwing out any expired or unlabeled food. He stated that he thought that they came in once a week to clean the refrigerator. He stated that the CNA staff put the food in the refrigerators that the residents or family members brought in, and everything should be labeled with the date and residents name or room number. On 2/4/25 at 9:45 a.m., an interview was conducted with LPN #1 who stated that all items in the refrigerator should have the residents name, room number and the date on them. LPN #1 observed the plastic bag with two plastic food containers inside with no name or date observed and stated that she did not know who they belonged to or when they were placed in the refrigerator. On 2/4/25 at 9:50 a.m., an interview was conducted with OSM #2, the director of housekeeping. OSM #2 stated that housekeeping was responsible for the nourishment rooms on the nursing units. He stated that the foods had to have a date and if they did not have a date and name, they threw them out. He stated that his staff checked the refrigerators and cleaned them each day and anything that was left longer than three days was thrown away. OSM #2 observed the second-floor nourishment room with the dried brown substance in the freezer on the bottom surface and stated that it needed to be cleaned. He observed the lunchbox with no name or date, plastic food container with rice inside with no date or name and stated that it looked like it may belong to a staff member, but he could not say who it belonged to. The facility policy Receiving and Storage of Food dated 10/1/2021 documented in part, .Foods shall be received and stored in a manner that complies with safe food handling practices . Food items and snacks kept on the nursing units must be maintained as indicated below: .All foods belonging to residents must be labeled with the resident's name, the item and the use by date . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Resident's Right to Make Personal Dietary, Food and Meal Choices documented in part, . The facility also promotes a home-like diverse environment for all residents through reasonable accommodation of foods brought in from families and visitors, providing safe and sanitary storage, handling and consumption of the food are followed . Food/Drinks brought in that do require refrigeration. i. The facility provides for storage of labeled and dated resident food in designated refrigerators for resident use. ii. All items must be identified by resident name and date when placed in the refrigerator . On 2/4/25 at 4:36 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, ASM #4, the regional clinical reimbursement director, and ASM #5, the regional director of operations were made aware of the findings. No further information was provided prior to exit.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. Based on clinical record review, staff interview and facility document review, the facility staff failed to provide rehabilitation services for one of 48 residents in the survey sample, Resident #76 (R76). For R76, speech therapist failed to follow the physician's order to evaluate and treat. The findings include: R76 was admitted with diagnoses that included but were not limited to communication. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/10/2025, R76 scored 8 (eight) out of 15 on the BIMS (brief interview for mental status), indicating R76 was moderately impaired of cognition for making daily decisions. The POS (physician's order sheet) for R76 dated 02/04/2025 documented in part, ST (speech therapy) eval (evaluate) and treat as indicated. Order Date: 01/04/2025. Review of R76's EHR (electronic health record) failed to evidence documentation of intervention by speech therapy. On 02/04/2025 at approximately 1:46 p.m., an interview was conducted with OSM (other staff member) #8, speech-language pathologist. When asked to describe the procedure for evaluating and/or treating residents who are new admissions she stated the director of the rehabilitation department assigns new residents to her schedule. After reviewing the POS for R76 and the order as stated above, OSM #8 stated she was not aware of the order to evaluate and treat. On 02/04/2025 at approximately 2:27 p.m., an interview was conducted with OSM #9, director of the rehabilitation. When asked to describe the procedure for evaluating and/or treating residents who are new admissions she stated she schedules each new admission for each discipline (physical therapy, occupational therapy and speech therapy). When asked how she determines which discipline needs to evaluate and/or treat the resident she stated she reviews the chart for every newly admitted resident. After reviewing the POS for R76 and the order as stated above, OSM #9 stated the physical therapy did not see a clinical need or a change in condition for R76 therefore was not put on OSM #8's schedule. The facility's job description for Speech Language Pathologist documented in part, Speech Language Pathologist Responsibilities. Reviews and evaluates physician's referral and resident/resident's medical records to determine therapy treatment required. On 02/04/2025 at approximately 4:35 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, director of clinical reimbursement, and ASM # 5regional director of operations, were made aware of the above findings. No further information was provided prior to exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. For Resident #132 (R132), a resident with a wound, the facility staff failed to implement enhanced barrier precautions (1). A review of R132's clinical record revealed a physician's order dated 12/27/24 that documented to cleanse the resident's sacral wound with normal saline, pat dry, apply calcium alginate and cover with a foam border dressing every day shift. Further review of R132's clinical record failed to reveal a physician's order for enhanced barrier precautions. On 2/4/25 at 10:11 a.m., an observation of LPN (licensed practical nurse) #4 changing a dressing on R132's sacrum was conducted. LPN #4 wore gloves during the dressing change but did not wear a gown. Also, there was no signage communicating enhanced barrier precautions to staff in the room. On 2/4/25 at 3:51 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated gloves and a gown should be worn when caring for residents on enhanced barrier precautions. LPN #4 stated enhanced barrier precautions were not implemented for R132 because an employee with the local health department instructed facility staff that enhanced barrier precautions only needed to be implemented for residents with wounds that were draining and R132's wound was not draining. On 2/4/25 at 4:45 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Enhanced Barrier Precautions (EBP) Policy documented, The purpose of this policy is to outline the guidelines for implementing Enhanced Barrier Precautions (EBP) in order to reduce the transmission of multidrug-resistant organisms (MDROs) within our facility. EBP will be utilized in conjunction with standard precautions to provide targeted gown and glove use during high-contact resident care activities .1. Criteria for Implementing EBP: Residents with wounds and/or indwelling medical devices, irrespective of MDRO infection or colonization status .4. High-Contact Resident Care Activities Requiring EBP: Wound care (any skin opening requiring a dressing). No further information was presented prior to exit. Reference: 1. Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). This information was obtained from the website: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html 5. For Resident #90, a resident with a wound, the facility staff failed to implement enhanced barrier precautions (1). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of R90's clinical record revealed a physician's order dated 2/4/25 that documented to cleanse the resident's right thigh and perineum wound with soap and water, pat dry, apply gentamicin 0.1% (antibiotic) cream and calcium alginate with AG, and cover with a foam dressing every day shift. Further review of R90's clinical record failed to reveal a physician's order for enhanced barrier precautions. On 2/4/25 at 10:27 a.m., an observation of LPN (licensed practical nurse) #4 changing a dressing on R90's right thigh/perineum was conducted. LPN #4 wore gloves during the dressing change but did not wear a gown. Also, there was no signage communicating enhanced barrier precautions to staff in the room. On 2/4/25 at 3:51 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated gloves and a gown should be worn when caring for residents on enhanced barrier precautions. LPN #4 stated enhanced barrier precautions were not implemented for R90 because an employee with the local health department instructed facility staff that enhanced barrier precautions only needed to be implemented for residents with wounds that were draining and R90's wound was not draining. On 2/4/25 at 4:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. Reference: 1. Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). This information was obtained from the website: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html 6. For Resident #104 (R104), the facility staff failed to change a sheet which contained blood stains and other debris. On the following dates and times, R104 was observed sitting up in bed. At each observation, his bed linens contained stains of red and dark brown material around both feet and lower legs: 2/3/25 at 12:53 p.m. and 4:01 p.m., 2/4/25 at 9:38 a.m. On 2/4/25 at 9:38 a.m., R104 stated staff had provided care for him multiple times, including incontinence care and applying lotion to his back, giving them opportunity to notice his sheets were soiled. On 2/5/25 at 8:53 a.m., CNA (certified nursing assistant) #6 was interviewed. She stated she checked on R104 multiple times during each shift during which she cared for him. She stated she had the opportunity to see his bed linens whenever she assisted him to turn in bed or to put lotion on his back. She stated if she noticed R104's sheets were blood stained or otherwise dirty, she would change the sheets immediately. She stated dirty sheets were a concern for infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/5/25 at 1:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations, and ASM #5, the regional director of operations, were informed of these concerns. No additional information was provided prior to exit. Based on observation, resident interview, clinical record review, staff interview and facility document review it was determined the facility staff failed to maintain a complete infection control program for one of one facility and for five of 48 residents in the survey sample, Residents #123, #65, #132, #90 and #104. The findings include: 1. The facility staff failed to evidence a water management program to minimize the risk of Legionella and other opportunistic pathogens in building water systems. On 2/3/25 at 11:25 a.m., a request was made to ASM (administrative staff member) #2, the director of nursing, for the facility Legionella/water management policy, procedures and assessment. On 2/4/25 at 2:04 p.m., a second request was made to ASM #2 to review the Legionella/water management plan. ASM #2 provided the facility policy Legionella/Water Management Plan which documented in part, .The facility is committed to establishing and maintaining an effective water management system to minimize the occurrence of Legionnaire's Disease . The facility will develop and maintain a water management program that includes the following elements . Describe the building water system using test and diagrams. i. Resident care areas. ii. Clinical support areas. iii. Components and devices that can expose residents to contaminated water; and will iv. Develop an ongoing dialogue with the drinking water provider so that the facility is aware of changes that may affect the building's water supply. c. Identify areas where Legionella could grow and spread. d. Decide where control measures should be applied, monitor and log compliance quarterly . g. Document all activities [i.e. monitoring, response to variances, etc.]. i. Routine safety logs will be maintained . On 2/4/25 at 4:36 p.m., a request was made to ASM #1, the administrator, ASM #2, ASM #3, the regional director of clinical operations, ASM #4, the regional clinical reimbursement director and ASM #5, the regional director of operations for the facility Legionella/water management plan as described in the facility policy. On 2/5/25 at 10:36 a.m., ASM #1 stated that they did not have any additional information regarding the Legionella/water management plan to provide. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/5/25 at 10:39 a.m., an interview was conducted with OSM (other staff member) #7, the director of maintenance who stated that they had been at the facility for about three months and had not been doing any water testing or was not aware of any water management interventions being done since he had been at the facility. He stated that at the prior facility he worked at he would have a monthly task that would be completed going to four different areas in the building and testing samples of water and then annually they would send out a sample to the lab for full testing. He stated that he had reached out to his corporate contact about a week ago about getting the supplies to start the water monitoring at the facility and they had been approved to be sent. He stated that the former maintenance director had taken some paperwork when they left and perhaps the water management plan was there, and they had tried to reach out to him, but he was not being cooperative with them. On 2/5/25 at 11:05 a.m., ASM #1, ASM #2, ASM #3, and ASM #5 were made aware of the concern. No further information was presented prior to exit. Reference: (1) Legionella is found naturally in [NAME], such as lakes and [NAME]. It can also be found in soil. But people usually only get sick from it when if it grows and spreads in man-made water systems. These systems can include hot tubs, fountains, and the plumbing systems of large buildings, such as hotels or nursing homes. This information was obtained from the website: https://medlineplus.gov/legionnairesdisease.html 2. For Resident #123 (R123), the facility staff failed to follow contact isolation (1) as ordered. The physician orders for R123 documented in part, Contact Isolation Precautions for +CRE (2) colonized. Order Date: 11/6/2024. The comprehensive care plan for R123 documented in part, Contact isolation: the resident required (Contact Isolation Precautions for +CRE colonized.) Date Initiated: 01/21/2025. Revision on: 02/03/2025. A lab report for R123 dated 10/29/24 documented CPO colonization testing completed with Carbapenem resistance gene detected. On 2/3/25 at 4:25 p.m., an observation was made of R123's room. No signage was observed indicating contact precautions for R123. A PPE (personal protective equipment) (3) was observed in the hallway between neighboring resident rooms. On 2/4/25 at 8:13 a.m., no contact isolation signage was observed on R123's room indicating isolation. No PPE was observed near R123's room at that time. On 2/4/25 at 8:35 a.m., a staff member was observed entering R123's room delivering a breakfast observed to be served in a Styrofoam container. The staff member did not don any PPE prior to entrance. On 2/4/25 at 8:39 a.m., another staff member entered R123's room delivering a breakfast observed to be served in a Styrofoam container. The staff member did not don any PPE prior to entrance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/4/25 at 3:42 p.m., a staff member was observed entering R123's room with linens in their hand and closed the door. The staff member did not don any PPE prior to entrance. On 2/4/25 at 3:06 p.m., an interview was conducted with CNA (certified nursing assistant) #3 who stated that if a resident was on contact precautions there was a sign on the door and a cart in front of the door with PPE inside. CNA #3 stated that this was done so that everyone knew before they went in the room. On 2/4/25 at 3:38 p.m., an interview was conducted with CNA #9 who stated that they were not aware of any resident on the unit on contact precautions. She stated that if a resident was on contact precautions they normally had a yellow cart in front of the room and a sign on the door to tell them what precautions to take and what to wear. On 2/4/25 at 3:43 p.m., an interview was conducted with RN (registered nurse) #5 who stated that if a resident was on contact precautions they put a sign on the door and an isolation cart outside of the room. He stated that he only had one resident on droplet precautions currently which was a new admission that had not arrived yet, but he had set up the room for isolation as a precaution. RN #5 reviewed R123's order and care plan for contact precautions and stated that he thought that the isolation should be discontinued but needed to verify with the infection preventionist. The facility policy Isolation- Categories of Transmission-Based Precautions documented in part, .When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. Signs and notifications comply with the resident ' s right to confidentiality or privacy . Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident ' s environment . Staff and visitors wear gloves (clean, non-sterile) when entering the room. While caring for a resident, staff will change gloves after having contact with infective material (for example, fecal material and wound drainage). Gloves are removed and hand hygiene performed before leaving the room. Staff avoid touching potentially contaminated environmental surfaces or items in the resident ' s room after gloves are removed. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed . On 2/4/25 at 4:36 p.m., ASM #1, the administrator, ASM #2, ASM #3, the regional director of clinical operations, ASM #4, the regional clinical reimbursement director and ASM #5, the regional director of operations were made aware of the concern. No further information was provided prior to exit. Reference: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(1) Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission .Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. This information was obtained from the website: https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html (2) CRE- Enterobacterales are a group of bacteria (germs) that are a normal part of the human and animal gut but can also cause infections. Carbapenem-resistant Enterobacterales (CRE) are germs resistant to one or several antibiotics called carbapenems. In 2017, CRE caused about 13,100 infections in hospital patients and about 1,100 deaths in the United States . How it spreads: Person-to-person contact from dirty hands, wounds, or stool (poop). Contaminated medical equipment and devices . This information was obtained from the website: https://www.cdc.gov/cre/about/?CDC_AAref_Val=https://www.cdc.gov/hai/organisms/cre/cre-patients.html (3) Personal protective equipment (PPE) is special equipment you wear to create a barrier between you and germs. This barrier reduces the chance of touching, being exposed to, and spreading germs. PPE helps prevent the spread of germs in the hospital. This can protect all people including health care workers from infections. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000447.htm 3. For Resident #65 (R65), the facility staff failed to follow contact isolation as ordered. The physician orders for R65 documented in part, Contact Isolation Precautions for +CRE colonized. Order Date: 11/6/2024. The comprehensive care plan for R65 documented in part, Contact isolation precautions for CRO colonization) Date Initiated: 01/22/2025. Revision on: 01/22/2025. A urine C&S (culture and sensitivity) for R65 dated 1/11/25 documented in part, >100,000 CFU/ml Enterobac aerogenes CRE (A), >100,000 CFU/ml Klebsiella aerogenes (A) . On 2/3/25 at 4:25 p.m., an observation was made of R65's room. No signage was observed indicating contact precautions for R65. A PPE (personal protective equipment) was observed in the hallway between neighboring resident rooms. On 2/4/25 at 8:13 a.m., no contact isolation signage was observed on R65's room indicating isolation. No PPE was observed near R65's room at that time. On 2/4/25 at 8:35 a.m., a staff member was observed entering R65's room delivering a breakfast observed to be served in a Styrofoam container. The staff member did not don any PPE prior to entrance. On 2/4/25 at 8:39 a.m., another staff member entered R65's room delivering a breakfast observed to be served in a Styrofoam container. The staff member did not don any PPE prior to entrance. On 2/4/25 at 3:42 p.m., a staff member was observed entering R65's room with linens in their hand and closed the door. The staff member did not don any PPE prior to entrance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/4/25 at 3:06 p.m., an interview was conducted with CNA (certified nursing assistant) #3 who stated that if a resident was on contact precautions there was a sign on the door and a cart in front of the door with PPE inside. CNA #3 stated that this was done so that everyone knew before they went in the room. On 2/4/25 at 3:38 p.m., an interview was conducted with CNA #9 who stated that they were not aware of any resident on the unit on contact precautions. She stated that if a resident was on contact precautions they normally had a yellow cart in front of the room and a sign on the door to tell them what precautions to take and what to wear. On 2/4/25 at 3:43 p.m., an interview was conducted with RN (registered nurse) #5 who stated that if a resident was on contact precautions they put a sign on the door and an isolation cart outside of the room. He stated that he only had one resident on droplet precautions currently which was a new admission that had not arrived yet, but he had set up the room for isolation as a precaution. RN #5 reviewed R65's order and care plan for contact precautions and stated that he thought that the isolation should be discontinued but needed to verify with the infection preventionist. On 2/4/25 at 4:36 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, ASM #3, the regional director of clinical operations, ASM #4, the regional clinical reimbursement director and ASM #5, the regional director of operations were made aware of the concern. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Health & Rehabilitation	12475 Lee Jackson Memorial Highway Fairfax, VA 22033

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to implement a complete immunization program for two of five record reviews for immunizations, Resident #2 and Resident #97. The findings include: 1. For Resident #2 (R2), the facility staff failed to evidence that the resident and/or representative was offered the pneumonia vaccine or educated on the vaccine. R2 was admitted to the facility on [DATE]. Review of R2's immunization documentation evidenced a pneumovax 23 completed on 3/7/2019 prior to admission. An undated entry for Prevnar 20 documented Consent pending. On 2/4/25 at 2:04 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing, for evidence of offering, education or administration of the pneumonia vaccine for R2. On 2/5/25 at 8:49 a.m., LPN (licensed practical nurse) #4 provided a vaccine consent form for R2 which documented education provided to R2's representative, consent for the vaccine and administration of the Prevnar 23 vaccine on 2/5/25. At that time an interview was conducted with LPN #4 who stated that usually pneumonia vaccines were offered upon admission if the resident was eligible. She stated that they reviewed the immunization report on admission and asked the resident or the responsible party if they wished to have the vaccine. She stated that she was not sure why there was a delay and that the infection preventionist normally handled the vaccinations and she no longer worked at the facility. On 2/5/25 at 9:54 a.m., an interview was conducted with ASM #2, the director of nursing who stated that pneumonia vaccines were offered to residents if they were eligible for them on admission and was not sure of the reason for the delay. According to CDC (Centers for Disease Control and Prevention) Pneumococcal Vaccine Recommendations for an adult aged 50 or above with a previous dose of PPSV23 and no known other doses it documented the following recommendation, Give one dose of PCV15, PCV20, or PCV21 at least 1 year after the last dose of PPSV23. Regardless of which vaccine is used (PCV15, PCV20, or PCV21), their pneumococcal vaccinations are complete. This information was obtained from the website: https://www2a.cdc.gov/vaccines/m/pneumo/pneumo.html The facility policy Pneumococcal Vaccine documented in part, .Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated . Re-vaccinations of the pneumococcal vaccine will be administered to those residents who are deemed appropriate by the physician. These may include, but are not limited to: Residents who received their initial pneumococcal vaccination prior to age [AGE], if 5 or more years have passed . (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 11:05 a.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations and ASM #5, the regional director of operations were made aware of the findings. No further information was provided prior to exit. 2. For Resident #97 (R97), the facility staff failed to evidence administration of the pneumonia vaccine. R97 was admitted to the facility on [DATE]. Review of R97's immunization documentation evidenced no prior pneumonia vaccines and a Pneumovax 23 with the status of Pending Immunization. Further review of the details of the Pneumovax 23 pending immunization documented 12/20/2023 education provided: Yes, Notes: Daughter consented for the resident to receive the pneumonia vaccine when available. The clinical record failed to evidence documentation regarding administration of the pneumonia vaccine to R97. On 2/4/25 at 2:04 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing, for evidence of administration of the pneumonia vaccine for R97. On 2/5/25 at 8:49 a.m., LPN (licensed practical nurse) #4 provided a vaccine consent form for R97 which documented education provided to R97's representative, consent for the vaccine and administration of the Prevnar 20 vaccine on 2/5/25. At that time an interview was conducted with LPN #4 who stated that usually pneumonia vaccines were offered upon admission if the resident was eligible. She stated that they reviewed the immunization report on admission and asked the resident or the responsible party if they wished to have the vaccine. She stated that she was not sure why there was a delay and that the infection preventionist normally handled the vaccinations and she no longer worked at the facility. On 2/5/25 at 9:54 a.m., an interview was conducted with ASM #2, the director of nursing who stated that pneumonia vaccines were offered to residents if they were eligible for them on admission. She stated that she was not sure why there was a delay with the administration of R97's pneumonia vaccine after the consent was obtained. According to CDC (Centers for Disease Control and Prevention) Pneumococcal Vaccine Recommendations for an adult aged 50 or above with no prior doses of pneumonia vaccines, it documented the following recommendation, Give one dose of PCV15, PCV20, or PCV21. If PCV20 or PCV21 is used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV23[1] to complete their pneumococcal vaccinations. The recommended interval between PCV15 and PPSV23 is at least 1 year. The minimum interval is 8 weeks and can be considered in adults with immunocompromising conditions, cochlear implants, or cerebrospinal fluid leaks. Footnotes: [1]. If PPSV23 was inadvertently given before PCV15, one dose of PCV15, PCV20, or PCV21 should be given at least 1 year after PPSV23 . This information was obtained from the website: https://www2a.cdc.gov/vaccines/m/pneumo/pneumo.html (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 11:05 a.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical operations and ASM #5, the regional director of operations were made aware of the findings. No further information was provided prior to exit.