STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495230	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhurst Health & Rehabilitation	4238 James Madson Highway Fork Union, VA 23055

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to protect the resident's right to be free from neglect by failure to provide timely identification and management of a pressure wound for one resident, Resident #4 (R4) in a survey sample of six residents, which deprived the resident of needed care to avoid physical harm of severe wound deterioration. by facility staff with regards to identification and treatment of a pressure ulcer until it was at an advanced stage and neglected to implement and treat a pressure ulcer for one resident, Resident #4 (R4) in a survey sample of six residents which resulted in harm for R4. The findings included: For Resident #4, the facility staff neglected to identify an in-house acquired pressure wound until it was at an advanced stage, as evidenced by having greater than 70% slough (dead tissue), and then facility staff neglected to obtain and implement treatment orders for ongoing treatment of the sacral/coccyx wound. When the resident was seen five days later by a wound specialist provider, the wound required sharps debridement and 33 days after discovery R4 had 10% exposed bone in the wound. The facility neglected to implement wound care orders and failed to obtain an x-ray that was ordered to rule out osteomyelitis for 18 days, all of which constituted harm. On 4/28/25 a tour of the nursing unit, 400 wing, was conducted. R4 was observed lying in bed on her back, with an alternating pressure mattress in place. R4 was observed to not have her feet/heels floated nor any pressure reducing boots in place on her feet. R4 was non-verbal, so no interview was conducted with the resident. On 4/29/25 at 9:30 a.m., an observation of R4's sacral wound and treatment was requested. Licensed practical nurse (LPN#1) said, All of [R4's name redacted] treatments were already done. On 4/29/25 at 9:30 a.m., R4 was observed laying on her back with her heel protectors on and chewing on the corner of a sheet. LPN#1 stated that R4 would chew on her sheets and had a diagnosis of pica. On 4/29/25 at 11:50 a.m., an observation of R4 was conducted. R4 was still in the same position, lying on her back, chewing on the corner of her sheet, with heel protectors on, but heels were not floating or off loaded off the bed. R4's certified nursing assistant was in the room assisting R4's roommate and stated she would be over to take care of R4 shortly. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/28/25-4/29/25, a review of R4's clinical record was conducted and noted that on 3/22/25, there was documentation that R4 had been newly identified with a facility acquired pressure wound that day. A progress note written by RN#1 was reviewed. On 3/22/25 RN#1 found a pressure ulcer on R4's sacral area and wrote a progress note that read, Patient brief changed after bm [bowel movement], noted an unstageable pressure ulcer to sacrum/coccyx. Wound bed >70% slough 25% beefy red granulating tissue. Dark red bruising to peri wound. Wound measures 2 cm x 2 cm x 0.2 cm. This RN#1, using aseptic technique cleansed with wound cleanser, patted dry with 4x4, applied Medi honey to wound bed, covered with silver alginate and bordered sacral foam dressing. Patient tolerated well. Review of the physician orders and TAR (treatment administration record) revealed the facility staff neglected to obtain a physician order for the wound care treatment performed by RN #1 on 3/22/25. According to the progress notes, physician orders, assessment tab and documents tab of R4's clinical record, the facility staff neglected to assess or provide any treatment to the sacral wound following the identification on 3/22/25 by RN #1, until 3/27/25. On 3/27/25, R4 was seen by a wound specialist nurse practitioner. That provider's progress note read in part, . Staff have asked this writer to evaluate new concern for injury to pt's [patients] sacrum . Staff report the new injury to sacrum was noted this past weekend while staff were completing routine care and deny any changes to pt's elimination routine. Staff note applying foam dressing since injury first noted .Sacrum/coccyx: full thickness ulceration that measures 5.0 x 3.5 x 02 cm. Wound base 80% slough, 20% granular prior to debridement, 50% adherent slough, 50% granular after. Edges adherent to wound base, moderate non-odorous serous drainage, peri wound without erythema, no induration, no cellulitis. Patient does not demonstrate evidence of pain when area is palpated. (Please note, when debridement is completed, measurements are always taken post debridement.) Plan: SACRUM/COCCYX - unstageable PI contributing factors to dx: poor mobility, type 2 DM, dementia, LE contractions, malnutrition, dysphagia, LTC, incontinence Wound care to SACRUM/COCCYX as follows:- Cleanse site with normal saline or sterile water (Do not use wound cleanser, this may decrease effectiveness of Santyl (collagenase).- Apply Santyl (collagenase) ointment (nickel thickness) to wound base- (tx [treatment] for enzymatic debridement).- Apply alginate. - Cover with foam dressing. - Provide this care daily and as needed for saturation or soilage . As patient allows and tolerates, recommend the following interventions: Turn/reposition at least every 2 hours . PROCEDURE: Performed excisional debridement of COCCYX wound(s) consisted of: Ulceration site(s) was/were prepped, and conservative sharp debridement was performed. Depth of debridement was at level of subcutaneous tissue, and within wound margins. Removal of devitalized necrotic tissue with a 5mm curette. There was scant bleeding that quickly subsided with light pressure and cleansing. Patient appeared to tolerate procedure without pain or signs of discomfort. On 4/29/25, a review of the progress notes, care plan, assessments, TAR [treatment administration record] and physician orders was completed. From 3/22/25 through 3/29/25, there were no treatment orders for R4's pressure ulcer/wound. There was no evidence of any treatment being provided to R4's sacral wound from 3/23/25-3/29/25. The first treatment order was written on 3/27/25 by the wound care provider and the facility staff neglected to implement the order until 3/30/25. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/31/25, R4 was seen again by the wound specialist nurse practitioner. The progress note read in part, . On exam, wound to COCCYX is enlarged compared to last week. Staff report pt frequently prefers to remain in her wheelchair. Wheelchair is reclinable with pressure redistribution mattress to support offloading. Still recommend side lying placement in bed routinely throughout the day to offload SACRUM . SACRUM/COCCYX (+) full thickness ulceration that measures 7.0 x 4.0 x 0.2 cm. Wound base 30% intact deep maroon and purple intact, with two open areas consisting of 50% slough, 20% granular prior to debridement, 30% intact, 50% thinner adherent slough, 20% granular after. Edges adherent to wound base, moderate non-odorous serous drainage, peri wound without erythema, no induration, no cellulitis. Patient does not demonstrate evidence of pain when area is palpated . PLAN: Wound care to SACRUM/COCCYX as follows:- Cleanse site with normal saline or sterile water (Do not use wound cleanser, this may decrease effectiveness of Santyl (collagenase).- Apply Santyl (collagenase) ointment (nickel thickness) to wound base-(tx for enzymatic debridement).- Apply zinc to peri wound.- Apply alginate. - Cover with foam dressing. - Provide this care daily and as needed for saturation or soilage . As patient allows and tolerates, recommend the following interventions: Turn/reposition at least every 2 hours . PROCEDURE: Performed excisional debridement of COCCYX wound(s) consisted of: Ulceration site(s) was/were prepped, and conservative sharp debridement was performed. Depth of debridement was at level of subcutaneous tissue, and within wound margins. Removal of devitalized necrotic tissue with a 5mm curette. There was scant bleeding that quickly subsided with light pressure and cleansing. Patient appeared to tolerate procedure without pain or signs of discomfort According to the physician orders and treatment administration record, the facility staff neglected to change the pressure ulcer treatment orders following the wound specialist seeing the resident on 3/31/25 and staff were not applying the zinc to the peri wound as ordered. Reviewing the TAR revealed that the staff neglected to provide wound care treatments on 4/21/25, 4/23/25, 4/25/25, and 4/26/25. R4 had an active physician order dated 2/25/25 that read, offloading boots to BLE [bilateral lower extremities], as tolerated every shift for skin integrity. Another physician order dated 4/3/25, that remained active read, reposition q2h [every 2 hours]. The order did not include the wound specialis's recommendations for side-lying positioning to offload pressure to the wound. On 4/10/25, R4's wound was seen and treated by the wound specialist nurse practitioner. According to the note, which read in part, . On exam, wound to coccyx is slightly enlarged, but intact skin no longer with maroon and purple. Recommend x-ray to sacrum to r/u OM [rule out osteomyelitis] . SACRUM/COCCYX (+) full thickness ulceration that measures 9.0 x 6.0 x 0.2 cm. Wound base 30% intact, 20% eschar, 50% adherent yellow slough prior to debridement, 30% intact, 15% eschar, 55% adherent slough after. Edges adherent to wound base, moderate non-odorous serous drainage, peri wound without erythema, no induration, no cellulitis . Plan: Recommend x-ray to rule out OM. Site declined, CHANGE care- Wound care to SACRUM/COCCYX as follows: - Cleanse with NS or wound cleanser, pat dry. - Apply 1/4 strength Dakin's moistened gauze to wound bed. - Cover with foam dressing. - Provide this care daily and as needed for saturation or soilage . PROCEDURE: Performed excisional debridement of COCCYX wound(s) consisted of: Ulceration site(s) was/were prepped, and conservative sharp debridement was performed. Depth of debridement was at level of subcutaneous tissue, and within wound margins. Removal of devitalized necrotic tissue with a #10 scalpel. There was scant bleeding that quickly subsided with light pressure and cleansing. Patient appeared to tolerate procedure without pain or signs of discomfort. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/17/25, R4 was again seen by the wound specialist. The note read, . SACRUM/COCCYX (+) full thickness ulceration that measures 6.5 x 6.0 x 1.5 cm. Wound base 100% thick slough prior to debridement, 100% thinner slough after. Edges adherent to wound base, moderate mildly malodorous serous drainage, peri wound without erythema, no induration, no cellulitis . Recommend x-ray to rule out OM. Site improved, depth increased d/t removal of necrotic tissue, wound is cleaner with decreased length, continue care- Wound care to SACRUM/COCCYX as follows: - Cleanse with NS or wound cleanser, pat dry. - Apply 1/4 strength Dakin's moistened gauze to wound bed. - Cover with foam dressing. - Provide this care daily and as needed for saturation or soilage . On 4/24/25, R4's wound was seen and assessed by the wound specialist. According to the note, it read in part, .Of note, wound base is now visible and can now be staged as stage 4 PI d/t the presence of exposed bone. Recommend a 21-day course of Doxycycline 100 mg BID d/t dusky color and mild malodor noted to the wound bed, and increased peri wound erythema. Also recommend an XRAY to rule out OM . SACRUM/COCCYX (+) full thickness ulceration that measures 6.2 x 6.5 x 3.5 cm. Wound base 15% eschar, 85% slough prior to debridement, 5% eschar, 15% thinner slough, 70% dusky granular, 10% exposed bone after. Edges adherent to wound base, moderate mildly malodorous serous drainage, peri wound erythema, no induration, no cellulitis . PLAN: Please treat empirically for wound infection with Doxycycline 100mg PO BID x 21 days. Recommend x ray to rule out OM. Site declined, increased depth related to removal of necrotic tissue, d/t malodor and peri wound erythema, CHANGE care- Wound care to SACRUM/COCCYX as follows: - Cleanse with NS or wound cleanser, pat dry. - LIGHTLY PACK silver alginate to wound bed. - Apply zinc to peri wound. - Cover with foam dressing. - Provide this care daily and as needed for saturation or soilage . On 4/25/25, R4's physician orders for treatment of the pressure ulcer were discontinued prior to the treatment being done that day, and no new treatment was implemented until 4/27/25. Leaving R4's pressure ulcer with exposed bone without any evidence of any wound care treatment for two days. According to the wound specialist notes and physician orders, the x-ray ordered by the wound specialist on 4/10/25, 4/17/25, and 4/24/25, but there was no corresponding physician's order. The facility staff neglected to transcribe and initiate R4's physician order for the xray until 4/25/25, which read, X ray of patient with sacral pressure wound with concerns for osteo. Please perform x-ray of sacrum and coccyx one time only for sacral wound for 16 days. According to the treatment administration record, the staff signed off that the x-ray was completed on 4/26/25. There was no other evidence within the clinical record that the x-ray had been completed, or any x-ray results were on file. There was a progress note dated 4/24/25 that read, : DON [director of nursing] spoke to patients POA [power of attorney], [name redacted], on Wednesday afternoon. [POA name redacted] is aware the the sacral wound is not improving [sic]. Per IDT [interdisciplinary team] discussion .will place pt on abx [antibiotic], place foley, culture wound, CBC [complete blood count- a lab test], BMP [basic metabolic panel- a lab test] and sacral xray to assess for osteo have been ordered . On 4/28/25, there was another progress note that read, Called [contracted mobile x-ray company name redacted] regarding X-ray, will call facility on expected date and time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/29/25 at 9:40 a.m., an interview was conducted with LPN#1. LPN#1 said, A hole in the MAR [medication administration record] or TAR [treatment administration record] means it wasn't done. When a wound is found we report to the doctor, complete a change in condition, report to the unit manager and director of nursing and obtain a treatment order from the doctor. We are to put the information in the wound provider book to schedule evaluation with wound provider. LPN#1 stated that the xray company will come to the facility timely and sometimes it was taking long periods of time. She stated that xray results were received in the same day if obtained early morning but at least within 24 hours. LPN#1 stated that orders were put into the system by the provider. LPN#1 stated that wound provider recommendations were reviewed by the in-house nurse practitioner (NP) and if they agree an order was written. On 4/29/25 at 9:50 a.m., an interview was conducted with LPN#2. LPN#2 said, Holes in the treatment and med record means it was not done. LPN#2 stated that the wound care provider was coming to the facility weekly. She stated that the wound care provider was uploading her orders as a document and the nurses were to follow up and put the orders into the resident's record/chart. LPN#2 stated that when a xray was ordered that it will be obtained within one hour if stat, but non-stat orders were taking up to one to two days to be obtained. She stated that if results were not received within 24 hours the nurses would follow up with the results being sent to the facility. LPN#2 stated that R4 had an order for repositioning every 2 hours and that was being monitored by the unit manager and the charge nurses. LPN#1 stated that there was no documentation about R4's repositioning being completed every two hours. On 4/29/25 at 10:00 a.m., an interview was conducted with the director of nursing (DON). The DON said, A blank on the MAR means it wasn't given and, on the TAR, means it wasn't done. The DON stated, When the nurse found a new wound that it was to be reported to me and the unit manager, cleaned with soap and water, nurse practitioner notified and obtain treatment orders until the wound provider evaluated the wound and the responsible party notified of the findings. Weekly skin sweeps were completed by 2 nurses, and one must be a registered nurse. When questioned further, the DON stated there was no documentation for the repositioning of R4 every two hours and that the nurses were . talking with the aides to make sure it was done. The DON stated that she checked every morning that xray's and labs were obtained when ordered and results were received in a timely manner. The DON said, I review the wound provider recommendations and her documentation. Wound provider recommendations were put in as orders and reviewed by our in-house NP. The NP agrees with the wound providers' recommendations. The DON said, Wound care provider orders and recommendations are put into the system the next business day, within 24 hours. If an order is obtained on the 28th the treatment should begin on the 28th. On 4/29/25 at 10:45 a.m., a meeting was conducted with the administrator, the DON and corporate staff. They were informed of the above concerns and that R4's sacral wound may be considered harm. The regional director of clinical services (RDCS) was present in the meeting and stated that the facility was working on a QAPI (Quality Assurance Performance Improvement) Action Plan for wounds. The RDCS was asked to present all the evidence and any new information that they wanted to provide. The RDCS stated the xray was obtained that morning at 5:00 a.m. and was asked to provide the survey team with a copy of the xray report. According to the xray report, the x-ray was obtained on 4/29/25 at 5 a.m. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/29/25 at 10:50 a.m., the RDCS presented a form that was titled, QAPI Action Plan. The form had the date of 3/15/25 on the top of the form. The issue/concern area was blank, the root cause analysis/related factors area was blank, there was no responsible person listed to perform the tasks, there was no projected completion date listed, and the section with the review (date and status report) was blank. The RDCS was informed that the submitted form was blank, appeared to be a template, and the only information completed on the form was the date at the top of the form. On 4/29/25 at 10:55 a.m., The administrator provided a second form that was filled out with the persons responsible section, one projected date of 3/30/25 for skin sweeps to be performed, noting that an audit will be performed to each identified impairment has a current, appropriate treatment order and/or interventions and an audit for each resident with skin impairment has a corresponding care plan. On 4/29/25 at 11:00 a.m., the DON, who was assigned as the responsible person for the QAPI action plan submitted, was asked if she completed the audits, and she shrugged her shoulders and stated she would check at the nurse's station in the wound notebook. The DON stated at 11:10 a.m., that she was not able to find any audits that she completed. The DON went on to show the survey team in a skin/wound book, that the weekly sheets listing residents with wounds, she was signing the sheets and dating she reviewed those sheets weekly. Upon reviewing the skin impairment weekly report, the DON had signed off on only one form with the findings of skin impairment. The DON also provided evidence of a skin sweep that was conducted on 4/28/25, but wasn't noted on the submitted QAPI form. On 4/29/25 at 11:15 a.m., the DON was interviewed about the xray not being completed timely. The DON was asked why there was recommendations by the wound provider on 4/10/25, 4/17/25 and 4/24/25, which was not ordered until 4/25/25 but the xray was not obtained until 4/29/25. The DON said, Our in-house NP did not agree with doing the xray, though it was too early to obtain an xray. The DON stated she texted the in-house nurse practitioner. The DON said that she would find the documentation about the in-house NP not agreeing with the recommendation for an Xray. When she was not able to provide any documentation by the in-house NP not wanting the xray obtained, the DON said, That was a miss on my behalf, usually they don't take that long to come. They were here over the weekend getting chest x-rays on two residents and we questioned why it was not done. They came and it resulted this morning. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The DON was interviewed about the QAPI Action Plan that was provided for review and was asked what they identified as the issue. The DON first stated that when .we noticed R4's wound getting worse was when we QAPI'ed that. When questioned further, the DON stated that R4 . was the only one we had with a pressure ulcer. When asked again what the QAPI issue was that was identified, since that area was blank on the form submitted, the DON said, Lack of documentation and poor documentation was the issue. The DON stated that education was being provided to the nursing staff. The DON said, A lot was wrapped around agency staff saying they did not know who to call but our numbers are posted at the desk, the unit managers and mine. The DON was then asked to provide evidence of education. The DON provided a sign in sheet, without a topic listed, and no date on the sheet, which read, see attached but no attachment was included. When asked about the education given, the DON said, We weren't getting any documentation done or any change in condition. No paper, just verbalized about the change in condition, didn't give a policy or anything just verbalized about change in condition. It was observed that only six staff had signed the in-service sheet and one of those was a certified nursing assistant. The DON also provided evidence of a skin sweep that was conducted but not signed by who completed the audit or dated when it was completed. This evidence was a Midnight Census report dated 4/27/25 that had a print date of 4/28/25 at 7:27 p.m. and was color coded to indicate if a resident had refused the skin evaluation, had wounds or no skin impairments. On 4/29/25 at 11:45 a.m., the RDCS asked if the survey team saw the note from the provider that stated the wound was unavoidable and provided a medical progress note to be reviewed. The progress note read in part, .Being seen per nursing request for high risk for skin breakdown. High risk for skin breakdown - Severe protein/calorie malnutrition- significant weight loss- c/w [continue with] Prostat-follow wound team recommendations for sacral/coccyx wound-LTC [long term care] supportive care, assistance with ADL's [activities of daily living] DNR [do not resuscitate] Rehab potential: fair. The RDCS was asked if she expected a wound to be found at the stage it needed debridement and the RDCS said, I would not necessarily expect a wound to be found at needing debridement for the wound. The RDCS stated that the staff was working with her family to get R4 on hospice because of her condition and has not been able to get that started due to the responsible party issues the family was having. The RDCS was told that there was no evidence in R4's clinical record of hospice care being discussed. No additional information was provided. On 4/29/25 at 12:00 p.m., a review of the facility document titled, Abuse Prevention Program, was reviewed and read in part, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation . As part of the abuse prevention, the facility will: . 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents . On 4/29/25 at 12:10 p.m., a review of the facility document titled, Abuse read in part, .Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . 2. Training: . c. Facility employees will be required to complete the comprehensive oritation program that includes the following information at a minimum: . iv. What constitues abuse, neglect, mistreatment of and misappropriation of resident's property . 3. Prevention: . f. A comprehensive assessment and individualized care plan will be developed for each resident to assist staff in providing effective interventions to prevent abuse, meet the resident's needs and promote quality of life for the resident . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/29/25 at 12:15 p.m., a meeting was conducted with the administrator, the DON and the RDCS. During this meeting they were made aware of the above concerns regarding R4's wound being identified at an advanced stage that required sharp debridement, the lack of treatment measures being implemented when the wound was identified, the delay in implementing treatment and x-ray orders from the provider as well as the concerns with the QAPI plan being submitted without evidence that it had been completed in full prior to the survey team's arrival on-site. No additional information was provided prior to the exit conference.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. For R2, the facility staff failed to follow professional standards of nurse practice by failing to administer physician ordered medications within an hour of the scheduled time. On 4/28/25, an interview was conducted with R2. R2 denied any concerns about medications when asked. On 4/28/25, a clinical record review was conducted of R2's chart. According to the medication administration records, R2 had medications scheduled to be administered at 9 a.m., 5 p.m., 7 p.m., and 9 p.m. According to the physician orders, medication administration record and Medication Admin Audit Report, R2 had Valsartan, Hydrochlorothiazide, Quetiapine Fumarate, Pantoprazole Sodium, Clopidogrel Bisulfate, and Metoprolol Succinate ER [Extended release] scheduled to be administered at 9 a.m., and they were not given until 12:43 p.m. On 4/17/25 R2's morning medications scheduled for administration at 9 a.m., were not administered until 11:38 a.m. and on 4/18/25, the medications were not given until 10:41 p.m. On 4/20/25, the scheduled medications for 9 a.m., were not administered until 10:38 a.m. On 4/22/25, R2's morning medications, noted above, were scheduled to be given at 9 a.m., and were not administered until 4:54 p.m. R2 had Mirtazapine and melatonin scheduled to be administered at 7 p.m. and Quetiapine Fumarate and Metoprolol Succinate ER to be given at 9 p.m., On 4/2/25 the 7 p.m., scheduled medications were not administered until 11:45 p.m. and the 9 p.m. medications were given at 10:34 p.m. On 4/3/25, 7 p.m. and 9 p. m. medications were given together at 10:52 p.m. On 4/5/25, the 7 p.m. medications were given at 10:10 p. m. and the 9 p.m. medications were given at 8:35 p.m. On 4/7/25 the 7 p.m. and 9 p.m. medications were given together at 11:35 p.m. On 4/8/25, the melatonin was given with Quetiapine and Metoprolol Succinate ER at 1:31 a.m. on 4/9/25. The Quetiapine Fumarate scheduled for 7 p.m. on 4/8/25 was given on 4/9/25 at 3:28 a.m. On 4/9/25, the 7 p.m. medications were administered at 10:42 p.m. after the 9 p.m. medications were given at 10:12 p.m. From 4/10/25-4/26/25, R2's medications scheduled for 7 p.m., were given outside of the professional standard to give within 1 hour of the scheduled time on 14 occasions. There was no evidence within R2's clinical record to indicate that the ordering provider or attending physician was made aware of the instances that R2's medications were not administered timely. No additional information was provided prior to exit. Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to follow professional standards of nursing practice with regards to the management of an advanced pressure wound for one resident (Resident #4-R4), constituting harm, and the timeliness of medication administration for three residents (Resident #2 -R2, Resident #3-R3, and Resident #4-R4), in a survey sample of six residents. (continued on next page)

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	495230	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhurst Health & Rehabilitation	4238 James Madson Highway Fork Union, VA 23055

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The findings included: 1. For R4, the facility failed to provide appropriate management of an advanced pressure wound per professional standards of care, subsequently resulting in further wound deterioration, which contstituted harm. On 4/29/25 at 10:00 a.m., an interview was conducted with the director of nursing (DON). The DON said, A blank on the MAR means it wasn't given and, on the TAR, means it wasn't done. The DON stated, When the nurse found a new wound, that it was to be reported to me and the unit manager, cleaned with soap and water, nurse practitioner notified, treatment orders obtained until the wound provider evaluated the wound, and the responsible party notified of the findings. The DON stated that weekly skin sweeps were completed by 2 nurses, and that one must be a registered nurse (RN). When questioned about evidence of repositioning, the DON stated that there was no documentation for the repositioning of R4 every two hours and that the nurses talk with the aides to make sure it was done. The DON stated that she checked every morning that xray's and labs were obtained when ordered and results were received in a timely manner. The DON said, I review the wound specialist nurse practioner's documentation. The wound provider recommendations are put in as orders and reviewed by our in-house NP. The NP agrees with the wound providers' recommendations. The DON said, Wound care provider orders and recommendations are put into the system the next business day, within 24 hours. If an order is obtained on the 28th the treatment should begin on the 28th. On 4/29/25 at 10:15 a.m., a review of R4's clinical record was conducted. A progress note written by RN#1 was reviewed. On 3/22/25 RN# found a pressure ulcer on R4's sacral area. RN#1 wrote a progress note that read, Patient brief changed after bm, noted an unstageable pressure ulcer to sacrum/coccyx. Wound bed >70% slough 25% beefy red granulating tissue. Dark red bruising to peri wound. Wound measures 2 cm x 2 cm x 0.2 cm. This RN#1, using aseptic technique cleansed with wound cleanser, patted dry with 4x4, applied Medi honey to wound bed, covered with silver alginate and bordered sacral foam dressing. Patient tolerated well. There were no physician orders for this treatment, nor were any wound care orders obtained to continue this treatment order. On 4/29/25 at 10:30 a.m., a comprehensive review of the TAR was conducted. Following the identification of the sacral/coccyx pressure wound on 3/22/25, there were no treatment orders or evidence that any sacral wound treatment was provided from 3/23/25 through 3/29/25. The first treatment order was written on 3/27/25 but was not implemented until 3/30/25. On 3/27/25, the wound specialist also recommended that R4 be positioned side-lying to offload pressure to the sacral/coccyx wound. On 3/31/25, the wound specialist recommended the use of zinc to the periwound, which was not implemented until 4/27/25. On 4/10/25, the wound specialist recommended an xray, given the documented findings of the wound deterioration with visible bone exposure, but the xray was not obtained until 4/29/25. On 4/10/25, the wound specialist also recommended new treatment with Dakin's solution, which was not started until 4/14/25. On 4/24/25, the wound specialist recommended a change in wound treatment that was not started until 4/27/25. Further review revealed that no treatment was documented on 4/21/25, 4/23/25, 4/25/25, and 4/26/25 to R4's sacral wound, which had been determined to be a Stage 4 - the most severe type. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/25 at 11:15 a.m., the DON was interviewed about R4's xray not being otained timely. The DON was asked why there were repeated recommendations by the wound specialist on 4/10/25, 4/17/25 and 4/24/25, which was not ordered until 4/25/25, but the xray was not obtained until 4/29/25. The DON said, Our in-house NP did not agree with doing the xray, thought it was too early to obtain an Xray. The DON stated that she texted the in-house nurse practitioner and would find the documentation about the in-house NP not agreeing with the recommendation for R4's xray. When not able to provide any documentation by the in-house NP's not wanting the xray obtained, the DON said, That was a miss on my behalf, usually they [mobile xray] don't take that long to come. They were here over the weekend getting chest x-rays on two residents and we questioned why it was not done. They came and it resulted this morning. On 4/29/25 at 10:40 p.m., a review of the facility document titled, Pressure Injury Prevention and Management, was reviewed and read in part, .develop and maintain systems and processes to ensure that the resident does not develop pressure ulcers/injuries (PU/PIs) 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 (including prevention of infection to the extent possible); and prevent development of additional pressure ulcer/injury. 2. For R3, the facility staff failed to follow professional standards of nurse practice to ensure medications were administered within an hour of the scheduled time. On 4/28/25 a clinical record review was conducted. R3's medication administration record (MAR) indicated that medications were ordered to be administered at 7:00 a.m., 9:00 a.m., 7:00 p.m., and 9:00p.m. According to the Medication Admin Audit Report, R3 was scheduled Tums, Thiamine, Divalproex Sodium, Levetiracetam, Vitamin D3, Folic Acid, Multiple Vitamins-Minerals, Aspirin, Fluoxetine, and Gabapentin for 9:00 a.m., but was administered at 11:37 a.m on 4/9/25. R3's Baclofen was scheduled at 7:00 a.m., but was administered at 12:59 p.m. on 4/10/25, administered at 12:21 p.m. on 4/11/25, administered at 9:07 a.m. on 4/12/25, administered at 8:49 a.m. on 4/14/25, and administered at 1:44 p.m. on 4/15/25. Documentation also revealed that R3 was scheduled Thiamine, Divalproex Sodium, Levetiracetam, Vitamin D3, Folic Acid, Multiple Vitamins-Minerals, Aspirin, Fluoxetine, Ciprofloxacin, Lactobacillus and Gabapentin for 9:00 a.m., but was administered on 4/15/25 at 10:22 a.m., on 4/16/25 at 10:32 a.m., on 4/17/25 at 10:40 a.m., and on 4/18/25 at 10:15 a.m. R3's 7:00 a.m. dose of Baclofen, was administered on 4/17/25 at 12:40 p.m., on 4/18/25 at 1:16 p.m., on 4/19/25 at 12:12 p.m., on 4/20/25 at 9:19 a.m., on 4/21/25 at 9:21 a.m., and on 4/22/25 at 11:56 a.m. R3's was scheduled Thiamine, Divalproex Sodium, Levetiracetam, Vitamin D3, Folic Acid, Multiple Vitamins-Minerals, Aspirin, Fluoxetine, Gabapentin and Calcium + Vitamin D3 was administered on 4/22/25 at 11:55 a.m., on 4/23/25 at 10:12 a.m., on 4/24/25 at 10:39 a.m., on 4/26/25 at 1:39 p.m., on 4/27/25 at 11:09 a.m., and on 4/28/25 at 10:45 a.m. R3's was scheduled Baclofen at 7:00 a.m., was administered on 4/23/25 at 10:12 a.m., on 4/24/25 at 11:56 a.m., on 4/25/25 at 9:47 a.m., and on 4/26/25 at 1:39 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3 was scheduled Atorvastatin and Baclofen at 7:00 p.m. and was administered at 9:24 p.m. on 4/5/25. On 4/6/25 R3 was scheduled Zonisamide, Baclofen, and Atorvastatin at 7:00 p.m., and was administered at 9:11 p.m. On 4/7/25 R3 was scheduled Zonisamide, Baclofen, Ciprofloxacin and Atorvastatin were administered at 9:31 p.m. On 4/8/25 Atorvastatin, Zonisamide, Baclofen and Melatonin were scheduled at 7:00 p.m., and was administered at 8:40 p.m., on 4/9/25 at 8:37 p.m., and on 4/10/25 at 8:36 p.m. On 4/9/25 Divalproex Sodium was scheduled at 5:00 p.m., and was administered at 6:26 p.m. On 4/10/25 R3 had ciprofloxacin scheduled at 7:00 p.m., and was administered at 7:03 p.m. On 4/11/25 R3 had Baclofen, Zonisamide, and Melatonin scheduled at 7:00 p.m., and administered at 10:21 p.m. On 4/11/25 R3 had Atorvastatin scheduled at 7:00 p.m., and was administered at 11:00 p.m., and Levetiracetam was scheduled for 9:00 p.m., and administered at 10:21 p.m. R3 had scheduled Atorvastatin, Zonisamide, Baclofen, and Melatonin at 7:00 p.m., was administered at 9:50 p.m., on 4/13/25, administered at 8:49 p.m., on 4/14/25, administered at 9:17 p.m., on 4/15/25, administered at 9:14 p.m., on 4/16/25, administered at 9:40 p.m., on 4/18/25, administered at 9:58 p.m. on 4/19/25, administered at 9:15 p.m., on 4/20/25, administered at 12:16 a.m., on 4/22/25. R3's Levetiracetam was scheduled for 9:00 p.m., and was administered at 12:16 a.m., on 4/22/25. R3 had scheduled Atorvastatin, Zonisamide, Baclofen, and Melatonin at 7:00 p.m., was administered at 10:17 p.m., on 4/22/25, administered at 11:36 p.m., on 4/23/25, administered at 10:01 p.m., on 4/24/25, administered at 8:59 p.m., on 4/25/25, administered at 10:01 p.m., on 4/26/25, and administered at 11:57 p.m., on 4/27/25.On 4/29/25 at 9:40 a.m., an interview was conducted with LPN. LPN#1 said, A hole in the MAR or TAR means it wasn't done. When a wound is found, we report it to the doctor, complete a change in condition, report to the unit manager and director of nursing, and obtain a treatment order from the doctor. On 4/29/25 at 9:50 a.m., an interview was conducted with LPN#2. LPN#2 said, Holes in the treatment and med record means it was not done. On 4/29/25 at 10:00 a.m., an interview was conducted with the director of nursing (DON). The DON said, A blank on the MAR [medication administration record] means it wasn't given and on the TAR [treatment administration record] means it wasn't done. The DON said, If an order is obtained on the 28th the treatment should begin on the 28th. The DON stated, When the nurse found a new wound that it was to be reported to me and the unit manager, cleaned with soap and water, nurse practitioner notified and obtained treatment until the wound specialist evaluated the wound and the responsible party notified of the findings. On 4/29/25 at 11:30 a.m., an interview was conducted with R3. R3 said, I missed some medications in the beginning of my stay, and I don't refuse any of my medications. 3. For R4, the facility staff repeatedly failed to administer the physician ordered medications within an hour of the scheduled time. On 4/28/25, a clinical record review was conducted. R4's medication administration record indicated that medications were to be administered at 6:00 a.m., 9:00 a.m., 12:00 p.m., 6:00 p.m., and 12:00 a.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Medication Admin Audit Report, R4 was scheduled to receive Baclofen, Senna-S, Eliquis, Theradex M, and Cymbalta at 9:00 a.m., but they was administered at 12:43 p.m. on 4/3/25. R4 was scheduled to receive Oxycodone at 12:00 p.m., but it was administered at 1:42 p.m. on 4/17/25, and at 1:14 p.m. on 4/24/25. R4 was scheduled for Senna-S and Eliquis at 9:00 p.m., but they were administered at 11:46 p.m. on 4/2/25, was administered at 10:28 p.m. on 4/3/25, and was administered at 11:37 p.m. on 4/3/25. R4 was scheduled for Eliquis at 9:00 p.m., which was administered at 1:14 a.m. on 4/8/25. R4 was scheduled for Senna-s at 9:00 p.m. on 4/8/25, but it was administered at 3:28 a.m. on 4/9/25. R4 was scheduled Oxycodone at 12:00 a.m. on 4/9/25, but it was administered at 1:14 a.m. R4 was scheduled Senna-S and Eliquis at 9:00 p.m., and it was administered at 10:12 p.m., on 4/9/25, was administered at 11:03 p.m. on 4/16/25, and at 4:56 a.m. on 4/18/25. R4 was scheduled Oxycodone at 12:00 a.m., but it was administered at 4:56 a.m. on 4/18/25. On 4/28/25 at 1:00 p.m., a tour of the nursing unit on the 400 wing was conducted. R4 was non-verbal and not interviewable. On 4/28/25 at 4:32 p.m., an interview was conducted with a register nurse, RN#2. RN#2 stated that the medications were administered according to the physician orders. RN#2 said, If meds are ordered at 9 in the morning, then you can give one hour before or one hour after schedule time. If a med isn't given timely, then you notify your manager and call the doctor if important like IV's. On 4/28/25 at 4:40 p.m., an interview was conducted with a licensed practical nurse, LPN#1. LPN#1 said, If a med is ordered at 9 a.m., it should be given between 8 and 10. If giving too late, call the doctor to get an order for different time or hold it for the doctor notification. On 4/28/25 at 4:50 a.m., an interview was conducted with the unit manager, LPN#3. LPN#3 said, Meds ordered at 9 a.m. should be given between 8 a.m., and 10 a.m. Notify the doctor if late and a nursing note should have if the doctor was notified. On 4/28/25 at 5:00 p.m., a review of a facility document was conducted. The policy titled, General Guidelines for Medication Administration, read in part, .medications are administered as prescribed in accordance with good nursing principles and practices and only by legally authorized to administer. A facility document titled, Medication Orders, was reviewed and read in part, .the purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. The facility cited [NAME] as the resource used for professional nursing standards. Guidance was given by [NAME], Fundamentals of Nursing, which reads: To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. The right time 6. The right documentation According to [NAME]'s Manual of Nursing Practice, the Eighth Edition, on page 18, the following was noted, Common Legal Claims for Departure from Standards of Care . Failure to administer medications properly and in a timely fashion, or to report and administer omitted doses appropriately . On 4/28/25 at 5:45 p.m., an end of day meeting was conducted with the administrator, the director of nursing and the corporate staff. They were informed of the above concerns. No additional information was provided.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, staff interview, resident interview, clinical record review, and facility documentation review, the facility staff failed to identify a pressure ulcer until it was at an advanced stage, implement and treat a pressure ulcer for one resident, Resident #4 (R4) in a survey sample of six residents which resulted in harm for R4. The findings included: For Resident #4 (R4), the facility staff discovered an in-house acquired pressure wound, which was at an advanced stage upon discovery, as evidenced by having greater than 70% slough (dead tissue). Upon identification, the facility staff initiated a one-time treatment without a physician order and failed to obtain treatment orders for ongoing treatment of the wound. When the resident was seen five days later by a wound specialist provider, the wound required sharps debridement (surgical removal of the dead tissue). Approximately one month from discovery, R4's wound had 10% exposed bone, after the facility repeatedly delayed implementing orders for sacral wound care, repeatedly omitted the provision of wound treatment, and failed to obtain an x-ray that was ordered to rule out osteomyelitis for 18 days, all of which constituted harm. On 4/28/25 a tour of the nursing unit, 400 wing, was conducted. R4 was observed lying in bed on her back, with an alternating pressure mattress in place. R4 was observed to not have her feet/heels floated nor any pressure reducing boots in place on her feet. R4 was non-verbal and therefore uninterviewable. On 4/29/25 at 9:30 a.m., an observation of R4's sacral wound treatment was requested, but Licensed practical nurse LPN#1 said, All of R4's treatments were already done. On 4/29/25 at 9:30 a.m., R4 was observed laying on her back with her heel protectors on and chewing on the corner of a sheet. LPN#1 stated that R4 would chew on her sheets and that R4 has a diagnosis of pica. On 4/29/25 at 11:50 a.m., an observation of R4 was conducted. R4 was still in the same position on her back, heel protectors on but heels were not floating or off loaded from the bed surface. R4 was again observed chewing on the corner of her sheet. R4's certified nursing assistant was in the room assisting R4's roommate and stated that she would be over to provide care to R4 shortly. On 4/28/25-4/29/25, a review of R4's clinical record was conducted and revealed that on 3/22/25, there was documentation that R4 had been noted with a facility acquired pressure wound to the sacral/coccyx area that day. The 3/22/25 progress note written by RN#1 read, Patient brief changed after bm [bowel movement], noted an unstageable pressure ulcer to sacrum/coccyx. Wound bed >70% slough 25% beefy red granulating tissue. Dark red bruising to peri wound. Wound measures 2 cm x 2 cm x 0.2 cm. This RN#1, using aseptic technique cleansed with wound cleanser, patted dry with 4x4, applied Medi honey to wound bed, covered with silver alginate and bordered sacral foam dressing. Patient tolerated well. Review of the physician orders and TAR [treatment administration record] revealed no physician order for the wound care treatment performed by RN #1 on 3/22/25 or physician notification of the new sacral wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	According to the progress notes, assessment tab and documents tab of R4's clinical record revealed no further documentation regarding the sacral wound following the identification on 3/22/25 by RN #1, until 3/27/25. According to the provider's progress note dated 3/27/25, R4 was seen by a wound specialist nurse practitioner, who documented the following, . Staff have asked this writer to evaluate new concern for injury to pt's [patients] sacrum . Staff report the new injury to sacrum was noted this past weekend while staff were completing routine care and deny any changes to pt's elimination routine. Staff note applying foam dressing since injury first noted .Sacrum/coccyx: full thickness ulceration that measures 5.0 x 3.5 x 0.2 cm. Wound base 80% slough, 20% granular prior to debridement, 50% adherent slough, 50% granular after. Edges adherent to wound base, moderate non-odorous serous drainage, peri wound without erythema, no induration, no cellulitis. Patient does not demonstrate evidence of pain when area is palpated. (Please note, when debridement is completed, measurements are always taken post debridement.) Plan: SACRUM/COCCYX - unstageable PI contributing factors to dx: poor mobility, type 2 DM, dementia, LE contractions, malnutrition, dysphagia, LTC, incontinence Wound care to SACRUM/COCCYX as follows:- Cleanse site with normal saline or sterile water (Do not use wound cleanser, this may decrease effectiveness of Santyl (collagenase).- Apply Santyl (collagenase) ointment (nickel thickness) to wound base- (tx [treatment] for enzymatic debridement).- Apply alginate. - Cover with foam dressing. - Provide this care daily and as needed for saturation or soilage . As patient allows and tolerates, recommend the following interventions: Turn/reposition at least every 2 hours . PROCEDURE: Performed excisional debridement of COCCYX wound(s) consisted of: Ulceration site(s) was/were prepped, and conservative sharp debridement was performed. Depth of debridement was at level of subcutaneous tissue, and within wound margins. Removal of devitalized necrotic [dead] tissue with a 5mm curette [scalpal]. There was scant bleeding that quickly subsided with light pressure and cleansing. Patient appeared to tolerate procedure without pain or signs of discomfort. On 3/31/25, the wound specialist nurse practitioner documented the following note in R4's chart, . On exam, wound to COCCYX is enlarged compared to last week. Staff report pt frequently prefers to remain in her wheelchair. Wheelchair is reclinable with pressure redistribution mattress to support offloading. Still recommend side lying placement in bed routinely throughout the day to offload SACRUM . SACRUM/COCCYX (+) full thickness ulceration that measures 7.0 x 4.0 x 0.2 cm. Wound base 30% intact deep maroon and purple intact, with two open areas consisting of 50% slough, 20% granular prior to debridement, 30% intact, 50% thinner adherent slough, 20% granular after. Edges adherent to wound base, moderate non-odorous serous drainage, peri wound without erythema, no induration, no cellulitis. Patient does not demonstrate evidence of pain when area is palpated . PLAN: Wound care to SACRUM/COCCYX as follows:- Cleanse site with normal saline or sterile water (Do not use wound cleanser, this may decrease effectiveness of Santyl (collagenase).- Apply Santyl (collagenase) ointment (nickel thickness) to wound base- (tx for enzymatic debridement).- Apply zinc to peri wound.- Apply alginate. - Cover with foam dressing. - Provide this care daily and as needed for saturation or soilage . As patient allows and tolerates, recommend the following interventions: Turn/reposition at least every 2 hours . PROCEDURE: Performed excisional debridement of COCCYX wound(s) consisted of: Ulceration site(s) was/were prepped, and conservative sharp debridement was performed. Depth of debridement was at level of subcutaneous tissue, and within wound margins. Removal of devitalized necrotic tissue with a 5mm curette. There was scant bleeding that quickly subsided with light pressure and cleansing. Patient appeared to tolerate procedure without pain or signs of discomfort According to the physician orders and treatment administration record, there was no documented change in orders to reflect the wound specialist's new treatment that included the zinc regimen. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/10/25, R4's wound was evaluated and treated by the wound specialist nurse practitioner. The note documented the following, which read in part, . On exam, wound to coccyx is slightly enlarged, but intact skin no longer with maroon and purple. Recommend x-ray to sacrum to r/u OM [rule out osteomyelitis] . SACRUM/COCCYX (+) full thickness ulceration that measures 9.0 x 6.0 x 0.2 cm. Wound base 30% intact, 20% eschar, 50% adherent yellow slough prior to debridement, 30% intact, 15% eschar, 55% adherent slough after. Edges adherent to wound base, moderate non-odorous serous drainage, peri wound without erythema, no induration, no cellulitis . Plan: Recommend x-ray to rule out OM. Site declined, CHANGE care- Wound care to SACRUM/COCCYX as follows: - Cleanse with NS or wound cleanser, pat dry. - Apply 1/4 strength Dakin's moistened gauze to wound bed. - Cover with foam dressing. - Provide this care daily and as needed for saturation or soilage . PROCEDURE: Performed excisional debridement of COCCYX wound(s) consisted of: Ulceration site(s) was/were prepped, and conservative sharp debridement was performed. Depth of debridement was at level of subcutaneous tissue, and within wound margins. Removal of devitalized necrotic tissue with a #10 scalpel. There was scant bleeding that quickly subsided with light pressure and cleansing. Patient appeared to tolerate procedure without pain or signs of discomfort. This note documented that the wound deteriorated, as evidenced by the increased wound size and the concerns suspecting an emerging bone infection. R4's clinical record revealed no evidence the facility obtained a physician's order to refelct the recommended xray to rule out the suspected bone infection. On 4/17/25, R4 was again treated by the wound specialist. The note documented the following findings, . SACRUM/COCCYX (+) full thickness ulceration that measures 6.5 x 6.0 x 1.5 cm. Wound base 100% thick slough prior to debridement, 100% thinner slough after. Edges adherent to wound base, moderate mildly malodorous serous drainage, peri wound without erythema, no induration, no cellulitis . Recommend x-ray to rule out OM. Site improved, depth increased d/t removal of necrotic tissue, wound is cleaner with decreased length, continue care- Wound care to SACRUM/COCCYX as follows: - Cleanse with NS or wound cleanser, pat dry. - Apply 1/4 strength Dakin's moistened gauze to wound bed. - Cover with foam dressing. - Provide this care daily and as needed for saturation or soilage This evaluation determined wound deterioration, as evidenced by the findings of 100% slough. On 4/24/25, R4's wound was evaluated and treated by the wound specialist. The note documented the following, .Of note, wound base is now visible and can now be staged as stage 4 PI [Pressure Injury] d/t the presence of exposed bone. Recommend a 21-day course of Doxycycline 100 mg BID d/t dusky color and mild malodor noted to the wound bed, and increased peri wound erythema. Also recommend an XRAY to rule out OM . SACRUM/COCCYX (+) full thickness ulceration that measures 6.2 x 6.5 x 3.5 cm. Wound base 15% eschar, 85% slough prior to debridement, 5% eschar, 15% thinner slough, 70% dusky granular, 10% exposed bone after. Edges adherent to wound base, moderate mildly malodorous serous drainage, peri wound erythema, no induration, no cellulitis . PLAN: Please treat empirically for wound infection with Doxycycline 100mg PO BID x 21 days. Recommend x ray to rule out OM. Site declined, increased depth related to removal of necrotic tissue, d/t malodor and peri wound erythema, CHANGE care- Wound care to SACRUM/COCCYX as follows: - Cleanse with NS or wound cleanser, pat dry. - LIGHTLY PACK silver alginate to wound bed. - Apply zinc to peri wound. - Cover with foam dressing. - Provide this care daily and as needed for saturation or soilage . On 4/25/25, R4's physician orders for treatment of the sacrum/coccyx pressure ulcer were discontinued prior to the treatment being done that day, and no new treatment was ordered/provided until 4/27/25, leaving R4's pressure ulcer with exposed bone without any form of wound treatment since 4/24/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	According to R4's clinical record, the x-ray recommended by the wound specialist on 4/10/25, 4/17/25, and 4/24/25, was never ordered until 4/25/25, and read, X ray of patient with sacral pressure wound with concerns for osteo. Please perform x-ray of sacrum and coccyx one time only for sacral wound for 16 days. According to R4's TAR, this order for the sacral/coccyx xray was signed off as completed on 4/26/25. There was no other evidence within the clinical record that the x-ray had been completed, nor were any x-ray results on file. There was a progress note dated 4/24/25 that read, : DON [director of nursing] spoke to patients POA [power of attorney], [POA's name redacted], on Wednesday afternoon. [POA's name redacted] is aware that the sacral wound is not improving [sic]. Per IDT [interdisciplinary team] discussion .will place pt on abx [antibiotic], place foley, culture wound, CBC [complete blood count- a lab test], BMP [basic metabolic panel- a lab test] and sacral xray to assess for osteo have been ordered . On 4/28/25, there was another progress note that read, Called [contracted mobile x-ray company name redacted] regarding X-ray, will call facility on expected date and time. On 4/29/25 at 9:40 a.m., an interview was conducted with LPN#1. LPN#1 said, A hole in the MAR [medication administration record] or TAR [treatment administration record] means it wasn't done. When a wound is found, we report it to the doctor, complete a change in condition, report to the unit manager and director of nursing, and obtain a treatment order from the doctor. We are to put the information in the wound provider book to schedule evaluation with wound provider. LPN#1 stated that the mobile xray company comes to the facility timely but sometimes it was taking long periods of time. LPN#1 stated that xray results were received in the same day, if obtained early morning but at least within 24 hours. LPN#1 stated that orders were put into the system by the provider. LPN#1 stated that the wound provider recommendations were reviewed by the in-house nurse practitioner (NP) and if they agree, an order was written. On 4/29/25 at 9:50 a.m., an interview was conducted with LPN#2. LPN#2 said, Holes in the treatment and med record means it was not done. LPN#2 stated that the wound care provider was coming to the facility weekly. She stated that the wound care provider was uploading her orders as a document and the nurses were to follow up and put the orders into the resident's record/chart. LPN#2 stated that when a xray was ordered that it would be obtained within one hour if stat, but non-stat orders were taking up to one to two days to be obtained. LPN#2 stated that if results were not received within 24 hours the nurses would follow up with the results being sent to the facility. LPN#2 stated that R4 had an order for repositioning every 2 hours, which was being monitored by the unit manager and the charge nurses. LPN#2 stated that there was no documentation about R4's repositioning being completed every two hours. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/29/25 at 10:00 a.m., an interview was conducted with the director of nursing (DON). The DON said, A blank on the MAR means it wasn't given and, on the TAR, means it wasn't done. The DON stated that when the nurse found a new wound, that it was to be reported to me and the unit manager, cleaned with soap and water, nurse practitioner notified, treatment orders obtained until the wound provider evaluated the wound, and the responsible party notified of the findings. The DON stated that weekly skin sweeps were completed by 2 nurses, and that one must be a registered nurse (RN). When questioned about evidence of repositioning, the DON stated that there was no documentation for the repositioning of R4 every two hours and that the nurses talk with the aides to make sure it was done. The DON stated that she checked every morning that xray's and labs were obtained when ordered and results were received in a timely manner. The DON said, I review the wound specialist nurse practioner's documentation. The wound provider recommendations are put in as orders and reviewed by our in-house NP. The NP agrees with the wound providers' recommendations. The DON said, Wound care provider orders and recommendations are put into the system the next business day, within 24 hours. If an order is obtained on the 28th the treatment should begin on the 28th. On 4/29/25 at 10:45 a.m., a meeting was conducted with the administrator, the DON and corporate staff. During this meeting, they were informed of the above findings, including the failure to identify the sacral wound until late, and the failure to manage R4's wound management timely, may be considered harm. The regional director of clinical services (RDCS), who was present in the meeting, stated that the facility was working on a QAPI (Quality Assurance Performance Improvement) Action Plan for wounds. The RDCS and facility staff were then asked to present all the evidence and any new information that they had to provide. The RDCS then stated that R4's xray was obtained that morning at 5:00 a.m. and subsequently provided a copy of the xray report, which indicated that it was obtained on 4/29/25 at 5 a.m. On 4/29/25 at 10:50 a.m., the RDCS presented a form that was titled, QAPI Action Plan. The form was dated 3/15/25, but notably the issue/concern area was blank, the root cause analysis/related factors area was blank, there was no responsible person listed to perform the tasks, there was no projected completion date listed, and the section with the review (date and status report) was blank. The RDCS was informed that the provided form appeared to be a blank template, with the only information completed being the date. On 4/29/25 at 10:55 a.m., the administrator provided a second QAPI form for review that had the persons responsible section filled out, along with one projected date of 3/30/25 for skin sweeps, noting that an audit would be performed to check that each identified impairment has a current, appropriate treatment order and/or interventions, and that an audit for each resident with skin impairment has a corresponding care plan. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/29/25 at 11:00 a.m., the DON, who was assigned as the responsible person for the submitted QAPI action plan, was asked if she had completed the indicated audits. In response, the DON shrugged her shoulders and stated that she would check at the nurse's station in the wound notebook. At 11:10 a.m., the DON stated that she was not able to find any audits that she completed. The DON went on to show the survey team in a skin/wound book, containing weekly skin sheets listing residents with wounds, that she was signing and dating those sheets that she reviewed weekly. Upon reviewing the skin impairment weekly report, the DON had signed off on only one form with the findings of skin impairment, but there was nothing submitted to indicate root cause analysis, appropriate treatment orders had been completed, or that care plan measures had been implemented. The DON also provided evidence of a skin sweep that was conducted on 4/28/25, which was not included on the provided QAPI form and did not include any of the areas indicated on the QAPI. On 4/29/25 at 11:15 a.m., the DON was interviewed about R4's xray not being otained timely. The DON was asked why there were repeated recommendations by the wound specialist on 4/10/25, 4/17/25 and 4/24/25, which was not ordered until 4/25/25, but the xray was not obtained until 4/29/25. The DON said, Our in-house NP did not agree with doing the xray, thought it was too early to obtain an Xray. The DON stated that she texted the in-house nurse practitioner and would find the documentation about the in-house NP not agreeing with the recommendation for R4's xray. When not able to provide any documentation by the in-house NP's not wanting the xray obtained, the DON said, That was a miss on my behalf, usually they [mobile xray] don't take that long to come. They were here over the weekend getting chest x-rays on two residents and we questioned why it was not done. They came and it resulted this morning. The DON was interviewed about the QAPI Action Plan that was provided for review and was asked what specific area had been identified as the issue. The DON first stated, When we noticed R4's wound getting worse was when we QAPI'ed that. Then the DON stated that R4 . was the only one we had with a pressure ulcer. When again asked what the identified issue was since that area was blank on the submitted QAPI form, the DON said, Lack of documentation and poor documentation was the issue. The DON stated that education was being provided to the nursing staff. The DON said, A lot was wrapped around agency staff saying they did not know who to call but our numbers are posted at the desk, the unit managers and mine. The DON was asked to provide evidence of education. The DON provided an in-service sheet, without a topic listed, no date on the sheet, which read, See attached but no attachment was included. When asked about the education given, the DON said, We weren't getting any documentation done or any change in condition. No paper, just verbalized about the change in condition; didn't give a policy or anything, just verbalized about change in condition. The in-service sheet indicated that only six staff had signed and one of those was a certified nursing assistant. The DON also provided evidence of a skin sweep, which was not signed by who completed the audit or dated as to when it was completed. A Midnight Census report dated 4/27/25, with a print date of 4/28/25 at 7:27 p.m., that was color coded to indicate if a resident had refused the skin evaluation, had wounds or no skin impairments. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/29/25 at 11:45 a.m., the RDCS provided a medical progress note to be reviewed. The progress note read in part, .Being seen per nursing request for high risk for skin breakdown. High risk for skin breakdown - Severe protein/calorie malnutrition- significant weight loss- c/w [continue with] Prostat- follow wound team recommendations for sacral/coccyx wound-LTC [long term care] supportive care, assistance with ADL's [activities of daily living] DNR [do not resuscitate] Rehab potential: fair. When asked if she expected a wound to be found at the advanced stage that it needed debridement (removal of dead tissue by scalpal), the RDCS said, I would not necessarily expect a wound to be found at needing debridement for the wound. The RDCS stated that the staff was working with her family to get R4 on hospice because of her condition and has not been able to get that started due to the responsible party issues the family was having. The RDCS was informed that there was no evidence in R4's clinical record of hospice care being discussed. No additional information was offered at that time. On 4/29/25 at 12:00 p.m., a review of the facility document titled, Pressure Injury Prevention and Management, included, .develop and maintain systems and processes to ensure that the resident does not develop pressure ulcers/injuries (PU/PIs) 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 (including prevention of infection to the extent possible); and prevent development of additional pressure ulcer/injury. On 4/29/25 at 12:10 p.m., a review of the facility document titled, Skin and Wound Guidelines, included, .the purpose to the pressure injury/skin breakdown clinical protocol is to assist facilities to implement interventions to prevent pressure ulcers and/or enhance the wound healing process, to accurately assess/monitor a residents risk for alteration in skin integrity, to maintain and promote healthy skin integrity of residents and to establish guidelines for the prevention and treatment of pressure sores/alterations in skin integrity. On 4/29/25 at 12:15 p.m., a meeting was conducted with the administrator, the DON and the RDCS. During this meeting, the facility was again informed of the above indications of harm regarding R4's sacral wound being identified at such an advanced stage that it required sharp debridement (removal of dead tissue by scalpal), the lack of treatment orders being implemented when the wound was identified, the delay in implementing treatment and x-ray orders from the wound specialist, as well as the concerns with missing treatments and the inadeqacies of the submitted QAPI plan, particularly that it had not been filled out or completed in full prior to the survey team's arrival on-site. No additional information was provided prior to the exit conference.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, staff interview, and facility documentation review, the facility staff failed to serve meals at a temperature that was palatable to multiple residents eating in their rooms on 4 of 4 wings. The findings included: On 4/28/25, a review of the resident council minutes and grievance logs from June 2024-April 2025 were reviewed and noted that in September 2024, November 2024, and February 2025, concerns were shared about food being cold when served in resident rooms. On 4/28/25, observations were conducted in the kitchen of the evening meal. The meal service began at 4:35 p.m. Residents eating in the dining room were served first and then trays for the residents eating in their rooms were prepared and placed in a transport cart. A test tray was prepared and placed on the cart. It was observed that the facility used insulated plate bottoms and lids but were not using the heated pellets under the plates to hold temperatures. When asked why pellets were not being used, said, They have thick insulated bottoms that hold heat and don't use the pellets. When they run out of the thick insulated bottoms, they will use pellets. Trays were observed being prepared with plates placed in both style bottoms without any heated pellets being used. When asked if the insulated bottoms are heated, the dietary manager said, No. The surveyor explained that she had seen both pellets used at other facilities and the thick insulated bottoms are heated and when the thinner bottom is used there is a metal pellet that goes inside which is heated. The dietary manager confirmed they don't do that. On 4/28/25 at 5:12 p.m., the last tray was placed in the transport cart and the cart exited the kitchen. At 5:14 p.m., the meal trays arrived on the unit. Multiple staff to include managers, began distributing trays to the residents. At 5:24 p.m., the last resident tray was removed from the cart and taken to a resident. On 4/28/25 at 5:24 p.m., as the last resident tray was being served, the dietary manager removed the test tray from the cart, and he obtained the temperature of the foods on the tray. They were as follows: the Swedish meatballs were 123.2 degrees Fahrenheit (F), rice 116 degrees F, green beans 114.6 degrees F, and the fruit dessert was 52.8 degrees F. The surveyor and dietary manager both sampled each of the food items and both agreed that the hot foods were lukewarm and not very appetizing in temperature, but the flavor was acceptable. The dietary manager stated that he likes his food hot and would not be satisfied with the food temperature served. According to the facility policy titled, Food and Nutrition Services, that read in part, . 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature . On 4/28/25 at 5:45 p.m., during an end of day meeting with the facility administrator, director of nursing and corporate nurse, the above findings were reviewed. On 4/29/25, the corporate nurse notified the survey team that the pellets were being used that day. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 documentation review, the facility staff failed to ensure food was distributed in a manner to prevent contamination in the main kitchen. The findings included: In the main kitchen, the facility staff failed to ensure that hair restraints were worn by all staff in the food preparation and distribution areas. On 6/10/25 at 12:02 p.m., observations were conducted in the main kitchen of the lunch meal's plating of food and distribution. While the facility's dietary staff were plating food on the serving line, at 12:21 p.m., the facility's maintenance director entered the kitchen and walked over to the serving line without donning a hair net or beard guard. The dietary aide immediately said, Hey, you need a hair net. To which the maintenance director did not respond. The maintenance director went behind the serving line where the cook was plating food, and pulled out a cell phone. The dietary manager then approached the maintenance director and took the cell phone from the maintenance director, who then stepped away from the serving line. The dietary manager took a photo of the labels on the hood system and returned the phone to the maintenance director. The maintenance director then exited the kitchen. On 6/10/25 at 12:30 p.m., an interview was conducted with the dietary manager. The manager was asked if the maintenance director usually enters the kitchen without a hair net and the dietary manager said, Usually the staff stop at the door, I guess he was gung [NAME] on seeing when they [the hood inspectors] come back. The dietary manager confirmed that all persons entering the kitchen are to have hair coverings on. On 6/10/25 at 3:13 p.m., an interview was conducted with the facility's maintenance director. When asked about the purpose of his visit to the kitchen during the lunch meal service, he reported he needed the phone number of who inspects the hood system because the number he had was not correct. When asked if he frequents the kitchen often and if he puts on a hairnet, the maintenance director said, Like yesterday, I ran in there with the plumber to work on the sink. We just run in there and don't wear hairnets. I always just run in and out of there all the time. They always have stuff that needs to be fixed. I wasn't aware I needed a hair net; no one ever told me. I know now but they need to have them for me to get to. The surveyor explained where the hairnets are located, which was just inside the door. The surveyor explained that since he had a beard, he would also need a beard guard, while the surveyor saw dietary staff wearing beard guards and knows they are available, she did not know the location of them, and he would need to inquire about that. The maintenance director thanked the surveyor and said, Now I know, thank you for telling me. Review of the facility policy titled, Prevention of Infection- Dietary Department with a date of 10/1/21 was reviewed. The policy read in part, . 7. Dietary staff will wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495230	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhurst Health & Rehabilitation	4238 James Madson Highway Fork Union, VA 23055

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25, during an end of day meeting, the facility administrator and regional nurse was made aware of the above findings. No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to implement their infection prevention and control program by failure to implement precautions to prevent the transmission of diseases and infections in accordance with accepted national standards from the Centers for Disease Control and Prevention (CDC) for one resident (Resident #101-R101) in a survey sample of five residents. The findings included: For R101, who had multiple open wounds, the facility staff failed to implement and adhere to enhanced barrier precautions in accordance with their policy and nationally accepted standards from CDC. On 6/10/25 at 11:33 a.m., during a tour of the facility, two certified nursing assistants were observed to enter R101's room, without donning any PPE (personal protective equipment). Observations noted there was no signage on R101's room door to indicate she was on any type of precautions. On 6/10/25 at approximately 11:45 a.m., the certified nursing assistants exited R101's room, and one pushed the resident in a wheelchair to the dining room, at which time, the surveyor observed R101 had both feet wrapped with cling. On 6/10/25, a clinical record review was conducted of R101's chart. This review revealed that R101 had multiple wounds, which included but were not limited to a stage IV pressure ulcer to the sacrum and three stage III pressure ulcers to the right foot. Review of the physician orders revealed that R101 had orders for Catheter Care: change foley cath as needed for blockage, leaking or malfunctioning. According to the nursing notes, an entry on 6/6/25, noted that R101 had wounds and a foley catheter. There were no physician orders for enhanced barrier precautions. Review of R101's care plan revealed focus areas to include pressure ulcers and skin impairments and the foley catheter. There was no indication that R101 was on enhanced barrier precautions within the care plan. On 6/11/25 at 9:25 a.m., the surveyor noted R101's door closed, there was no signage to indicate the resident was on any precautions or notification to staff that PPE was to be worn during direct care activities. The surveyor knocked on the door and facility staff were providing care. On 6/11/25 at 9:30 a.m., an interview was conducted with a certified nursing assistant (CNA #1). CNA #1 stated that residents on precautions have signs on the door. CNA #1 reported that they currently had no one on precautions in the facility. On 6/11/25 at 9:35 a.m., an interview was conducted with certified nursing assistant #2 (CNA #2). When asked about precautions, CNA #2 explained that if a resident is on precautions or PPE is needed a sign is on their room door and in their care plan, which she stated everyone has access to. When asked about enhanced barrier precautions, CNA #2 explained that it is to protect residents from any possible exposure as well as protect yourself. Right now, the precautions for enhanced barrier precautions are due to tubing, like a foley, nephrology tubes, and such. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 9:40 a.m., while the surveyor was in R101's room, licensed practical nurse #1 (LPN #1) entered the room. LPN #1 confirmed she was R101's assigned nurse and said, I just did wound care, and the CNA was helping me with her. When asked if she wore any PPE during that process/wound care, LPN #1 confirmed she had only worn gloves. When asked if PPE has to be worn during care of R101, LPN #1 went on to state, As far as I've been told we use PPE with colostomies, for basic wound care there are no special instructions. When asked about enhanced barrier precautions, LPN #1 said, That is something new to me, her [R101's] wound doesn't have MRSA [Methicillin-resistant Staphylococcus aureus, a type of bacteria], it is just basic wound care so just wear gloves. On 6/11/25 at 9:45 a.m., an interview was conducted with the facility's director of nursing (DON), who is also the facility's designated infection preventionist. The surveyor asked the DON to explain enhanced barrier precautions (EBP), when they are used, the purpose, and so forth. The DON said, EBP is to protect patients with compromising skin issues, medical ports, foleys, etc. We don't want infections to happen. Or people with a history of MDRO's [multi-drug-resistant organisms]. Staff wear a gown and gloves during care, it is a protective process. When the surveyor discussed that R101 had multiple wounds and asked if she should be on EBP, the DON said, Yes, she should be on EBP. When asked if she was aware that R101 is not on EBP, the DON stated she was not aware as she had only started at the facility mid-day on Monday [2 days ago] and explained that she didn't have anyone doing infection control and that was one of the programs/processes she was working on. The DON said, I'm going to do a lot of education, there is a lot of agency staff that don't know. On 6/11/25 at 10 a.m., the facility administrator and regional nurse were made aware of the above findings. According to the Centers for Disease Prevention and Control (CDC), there is a guidance document titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) dated 4/2/24. The document read in part, .Updates as of July 12, 2022. Key Points:1: Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. 2. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. 3. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status Infection or colonization with an MDRO. 4. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care . Accessed online at: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility administration provided a facility policy titled, Enhanced Barrier Precautions (EBP) Policy dated 3/28/24. According to the policy, which read in part, . 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: EBP should be utilized during the following activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care . 6. Duration of EBP Usage: EBP should remain in place for the duration of a resident's say in the facility or until the resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk . No further information was provided prior to the conclusion of the survey.