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	07/02/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify the physician or responsible party of a change in condition and/or need to alter treatment for two of seven residents, Residents #1 and #2. The findings include: 1. For Resident #1 (R1) the facility staff failed to notify the responsible party of change in condition. R1 diagnoses include but were not limited to Alzheimer's disease (1), aphasia (2) dysphagia (3), and protein-calorie malnutrition (4). On the most recent minimum data set (MDS), nursing home discharge of 6/6/2026, the resident's BIMS (brief interview for mental status) score was not entered. Section C-Cognitive Patterns documented the resident's daily decision making as moderately impaired-decisions poor; cues/supervision required. It further documented R1 having a weight loss of 5% or more in the last month or loss of 10% or more in last six months. Additionally, Section M-Skin Conditions documented the resident with unhealed pressure injuries. The progress notes for R1 documented in part, -6/3/2026 13:40 (1:40 PM), Note: seen today for follow-up and review of laboratory results obtained on 06/01/2026 for monitoring of cirrhosis. The patient was admitted to the skilled nursing facility following hospitalization on 05/19/2026 for acute clinical deterioration. Since his return to the SNF (skilled nursing facility), vital signs have been stabilizing with blood pressure improving from 90/52 mmHg at the time of hospitalization to the 120s/70s range, most recently 128/70 mmHg on 06/01/2026. Heart rate has remained stable in the 80s. Oxygen saturations have improved from the 80s on room air during the hospitalization to 94-98% on current monitoring. Weight was documented at 141.5lbs on 06/01/2026, decreased from 161.5lbs on 04/02/2026, likely reflecting diuresis achieved during and after hospitalization. Liver function panel obtained on 06/01/2026 demonstrates worsening hepatic function compared to prior values. ALT(5) (alanine aminotransferase) has increased to 166. At the SNF initial visit on 05/28/2026, the patient remained lethargic with decreased alertness from baseline, with +1 pitting edema bilateral feet. GENERAL- Lethargy, Change in alertness from baseline, No weight changes, No fatigue, No fever, No night sweats, No chills, No dizziness. RESPIRATORY- No shortness of breath, No cough, No wheezing, No chest pain with breathing, No sputum, No blood in sputum. NEUROLOGICAL- Decreased alertness from baseline, non-verbal. Lethargy and decreased alertness from baseline noted on today's examination; no acute agitation or behavioral changes reported. Nursing staff to monitor for agitation or behavioral changes and document triggers or safety concerns, and to notify provider if symptoms worsen. Follow-up chest x-ray to document resolution of left lower lobe pneumonia (recommended 02/2026, remains outstanding)- Continue monitoring bilateral foot edema and right lower extremity petechiae(6); report worsening swelling, new (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	petechiae, or signs of bleeding - Continue nutritional monitoring with periodic albumin and weight assessments; albumin decreased from 3.2 to 3.0 to 2.9 g/dL - Continue monitoring LFTs (liver function test) and platelet counts per facility schedule - Monitor for changes in alertness and lethargy following hospitalization. -6/4/2026 19:22 (9:22 PM), Note: seen today for general decline. Collateral information was obtained from nursing staff, as the patient is aphasic and non-verbal at baseline. His functional status has declined since re-admission to the facility following recent hospitalization. Nursing reports the patient is intaking less than 25% of meals, pocketing food at the lowest gradable diet consistency, and pocketing medications. Nutritional parameters reflect progressive decline. Weight has decreased from 161.5lbs on 04/02/2026 to 141.5lbs on 06/01/2026. Serum albumin has trended downward from 3.2 g/dL on 02/18/2026 to 3.0 g/dL on 05/19/2026 to 2.9 g/dL on 06/01/2026, consistent with ongoing protein-calorie malnutrition. Liver function panel obtained on 06/01/2026 demonstrates worsening hepatic function: ALT 166 U/L, AST (aspartate aminotransferase) 136 U/L, alkaline phosphatase 248 U/L, total bilirubin 1.4 mg/dL, direct bilirubin 0.85 mg/dL, GGT (gamma-glutamyl transferase) 287 U/L, and albumin 2.9 g/dL. These values represent continued upward trending of transaminases, alkaline phosphatase, bilirubin, and GGT, with progressive decline in albumin, reflecting ongoing hepatic inflammation and progressive synthetic dysfunction in the setting of cirrhosis. Given the patient's overall clinical decline with progressive functional deterioration, poor nutritional status, and worsening hepatic synthetic dysfunction, the responsible party will be notified to discuss goals of care, with recommendations for palliative care consultation and hospice transition. -6/5/2026 20:51 (8:00 PM), Note: Notified RP; [RP's name] regarding clinical concerns regarding overall physiological decline. VM (voice message) left. On 7/2/2026 at 2:23PM, an interview was conducted with Nurse Practitioner (NP). NP stated there was nutritional declined. NP stated they left a voice message for the RP (responsible party) to recommend transference to hospice for palliative care. NP stated that the RP didn't contact them back and that they never got a chance to discuss end of life planning. On 7/2/2026 at 2:50 PM, an interview was conducted with the Attending Physician (AP). AP stated that they usually try to talk with the RP about a change of condition but because R1 was doing better they did not speak with the RP about end-of-life planning. When the AP was asked who is responsible for discussion of end-of-life planning such as hospice/PEG (percutaneous endoscopic gastrostomy) tubes and IV (intravenous) fluids, the AP stated themself as the admitting physician or the NP. The facility's policy Change in a Resident's Condition documented in part, The facility will promptly notify the representative of changes in resident's medical/mental condition and /or status.except in medical emergencies, notification will be made within twenty-four hours of a change occurring in the resident's medical condition. On 7/2/2026 at 9:30 AM, Administrator, Regional Clinical Services Director and the Director of Nursing were notified of the findings. No further information was provided prior to exit. References: 1. Alzheimer's Disease-Alzheimer's disease (AD) is the most common form of dementia among older (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	people. Dementia is a brain disorder that seriously affects thinking and memory skills. https://medlineplus.gov/alzheimersdisease.html 2. Aphasia-Aphasia is a language disorder that makes it hard for you to read, write, and say what you mean to say. Sometimes it makes it hard to understand what other people are saying, too. Aphasia is not a disease. It's a symptom of damage to the parts of the brain that control language. https://medlineplus.gov/aphasia.html 3. Dysphagia- a swallowing disorder, you may have difficulty or pain when swallowing. https://medlineplus.gov/swallowingdisorders.html 4. Protein-Calorie Malnutrition-is a condition caused by a lack of adequate dietary intake of protein, calories (energy), or both. It leads to poor growth, weight loss, muscle wasting, diminished immunity, and impaired organ function. https://my.clevelandclinic.org/health/diseases/22987-malnutrition 5.ALT (aspartate aminotransferase)- The aspartate aminotransferase (AST) blood test measures the level of the enzyme AST in the blood. https://medlineplus.gov/ency/article/003472.htm 6.Petechiae- tiny, pinpoint red, purple, or brown spots caused by minor bleeding under the skin or mucous membranes. https://www.ncbi.nlm.nih.gov/books/NBK482331/ 2. For Resident #2 (R2), the facility staff failed to notify the physician of medications not administered when the resident was out of the facility for scheduled appointments on multiple dates reviewed in May and June 2026. On the most recent minimum data set (MDS), a significant change assessment with an assessment reference date (ARD) of 5/22/2026, the resident was assessed as receiving dialysis while a resident. It further documented R2 receiving scheduled pain medication, an antipsychotic, antidepressant, opioid and anticonvulsant medication. Review of the physician orders documented the following orders: - Acetaminophen Oral Tablet (1) 500 MG (Acetaminophen) Give 2 tablet by mouth three times a day for pain. Order Date: 12/11/2025. - Amlodipine Besylate (2) Oral Tablet 10 MG (milligram) (Amlodipine Besylate) Give 1 tablet by mouth in the morning for HTN (hypertension). Order Date: 04/15/2026. - Calcium Acetate (Phos Binder) (3) Oral Capsule 667 MG (Calcium Acetate (Phosphate Binder)) Give 2 capsule by mouth three times a day for ESRD. Order Date: 12/11/2025. - Cetirizine HCl (4) Tablet 10 MG Give 0.5 tablet by mouth one time a day every Mon, Wed, Fri for Allergy symptoms Total dose: 5mg. Order Date: 12/12/2025. - Docusate Sodium (5) Oral Capsule 100 MG (Docusate Sodium) Give 1 capsule by mouth one time a day for constipation. Order Date: 12/11/2025. - Eliquis (6) Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day related to acute on chronic diastolic (congestive heart failure); acute embolism and thrombosis of left popliteal vein; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	acute embolism and thrombus of right popliteal vein. Order Date: 12/11/2025. - Ipratropium-Albuterol Solution 0.5-2.5 (7) MG/3ML 3 ml inhale orally via nebulizer three times a day related to Chronic obstructive pulmonary disease, unspecified. Order Date: 12/11/2025. - Lactobacillus (8) Oral Tablet 0.05-0.05 MG (Lactobacillus) Give 1 tablet by mouth one time a day for constipation. Order Date: 12/11/2025. - Lidocaine Pain Relief External Patch (9) 4 % (Lidocaine) Apply to Shoulders bilaterally topically one time a day for Pain On in the morning. Order Date: 12/11/2025. - Lurasidone HCl (10) Oral Tablet 40 MG (Lurasidone HCl) Give 1 tablet by mouth in the morning for Schizophrenia . Order Date: 4/24/2026. - Methocarbamol (11) Oral Tablet 750 MG (Methocarbamol) Give 1 tablet by mouth three times a day for Chronic pain. Order Date: 12/11/2025. - Metoprolol Succinate ER (extended release) (12) Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate) Give 1 tablet enterally one time a day related to Essential (primary) Hypertension. Order Date: 01/25/2026. - Midodrine HCl (13) Oral Tablet 5 MG (Midodrine HCl) Give 5 mg by mouth two times a day for symptomatic hypotension symptomatic hypotension (SBP <90); hold if SBP >110 or DBP>70; check BP prior to each dose and 1 hour post-dose; do not administer within 4 hours of bedtime; notify provider if SBP <80, persistent symptoms after 2 doses. Order Date: 04/24/2026. - Revatio (14) Oral Tablet 20 MG (Sildenafil Citrate (Pulmonary Hypertension)) Give 2 tablet by mouth one time a day related to Pulmonary Hypertension, Unspecified. Order Date: 12/11/2025. - Renal Oral Capsule (15) 1 MG (B-Complex w/ C &Folic Acid) Give 1 capsule by mouth one time a day for Supplement. Order Date: 12/12/2025. - Sertraline HCl (16) Oral Tablet 25 MG (Sertraline HCl) Give 3 tablet by mouth one time a day for Depression related to Depression, Unspecified. Order Date: 12/11/2025. Review of the eMAR (electronic medication administration record) for R2 dated 5/1-5/31/2026 documented the resident missing nine doses of the Docusate and Metoprolol,10 doses of the Amlodipine, Lactobacillus, Revatio, Eliquis and Calcium acetate, 11 doses of the Cetirizine, Lurasidone, Renal capsule, Sertraline, Midodrine and Methocarbamol, 12 doses of the Lidocaine patch and Ipratropium-Albuterol nebulizer and 13 doses of the Tylenol during the month at scheduled morning doses. The eMAR notes documented the resident was out at dialysis or out of the facility and failed to evidence notification of the physician of the multiple missed medications. Review of the eMAR for R2 dated 6/1-6/30/2026 documented the resident missing 10 doses of the Amlodipine, Lactobacillus, Lurasidone, Metoprolol, Sertraline, 11 doses of the Cetirizine, Docusate, Renal capsule, Eliquis, Midodrine, 12 doses of the Revatio, Tylenol, Methocarbamol, 13 doses of the Lidocaine patch, 14 doses of the calcium acetate and 15 doses of the Ipratropium-Albuterol nebulizer. The eMAR notes documented the resident was out at dialysis or out of the facility and failed to evidence notification of the physician of the multiple missed medications. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/2026 at 2:02 PM, an interview was conducted with registered nurse (RN) #2 who stated that R2 left for dialysis early and was not given any medications from the day shift before leaving. She stated that the medication administration times were 7-11 AM and it was out of the timeframe when R2 got back which was usually a little after 1:00 PM. She stated that the physicians and nurse practitioner were already aware of R2 not getting the medications on dialysis days, so they just wrote notes that the resident was out. She stated that the nurse practitioner had told them in the past that the medications would be dialyzed out of the resident anyway. On 7/1/2026 at 2:29 PM, an interview was conducted with the nurse practitioner who stated that R2 should be getting the medications ordered prior to dialysis before she left the building and if the others were scheduled while she were at dialysis she would expect them to be given when the resident returned. The facility policy Change in a Resident's Condition documented in part, .The nurse will notify the resident's Attending Physician/practitioner or physician on call when there has been a(an): .need to alter the resident's medical treatment significantly; refusal of treatment or medications two (2) or more consecutive times . On 7/1/2026 at approximately 5:06 PM, the interim Administrator, the Administrator in training, the Director of Nursing and the Regional Director of Clinical Services were made aware of the concern. No further information was provided prior to exit. Reference: (1) Acetaminophen is used to relieve mild to moderate pain and to reduce fever. Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body . This information was obtained from the website: Acetaminophen: MedlinePlus Drug Information (2) Amlodipine is used to treat high blood pressure . Amlodipine: MedlinePlus Drug Information (3) Calcium acetate is used to control high blood levels of phosphorus in people with kidney disease who are on dialysis (medical treatment to clean the blood when the kidneys are not working properly). Calcium acetate is in a class of medications called phosphate binders. It binds phosphorus that you get from foods in your diet and prevents it from being absorbed into your blood stream . This information was obtained from the website: Calcium Acetate: MedlinePlus Drug Information (4) Cetirizine is used to treat allergy symptoms . Cetirizine: MedlinePlus Drug Information (5) Docusate Sodium- Stool softeners are used on a short-term basis to relieve constipation . Stool Softeners: MedlinePlus Drug Information (6) (Eliquis)Apixaban is used to: prevent strokes or blood clots in people who have atrial fibrillation (a condition where the heart beats irregularly and can lead to clots and stroke) in adults. prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in certain situations. treat DVT and PE . Apixaban: MedlinePlus Drug Information (7) The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD . Albuterol and Ipratropium Oral Inhalation: MedlinePlus Drug Information (8) Lactobacillus (probiotic) . This information was obtained from the website: Dietary Supplement Fact Sheets (9) Prescription lidocaine transdermal (Dermalid, Lidoderm, Ztildo) is used to relieve the pain of post-herpetic neuralgia (PHN; burning, stabbing pains, or aches that may last for months or years after a shingles infection) . This information was obtained from the website: Lidocaine Transdermal Patch: MedlinePlus Drug Information (10) Lurasidone is used to treat the symptoms of schizophrenia . Lurasidone: MedlinePlus Drug Information (11) Methocarbamol is used with rest, physical therapy, and other measures to relax muscles and relieve pain and discomfort caused by strains, sprains, and other muscle injuries. Methocarbamol is in a class of medications called muscle relaxants. It works by slowing activity in the nervous system to allow the body to relax . This information was obtained from the website: Methocarbamol: MedlinePlus Drug Information (12) Metoprolol is used to treat high blood pressure, angina (chest pain) and heart failure. Metoprolol also is used to improve survival after a heart attack . Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure . This information was obtained from the website: Metoprolol: MedlinePlus Drug Information (13) Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine is in a class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure . This information was obtained from the website: Midodrine: MedlinePlus Drug Information (14) Sildenafil (Liqrev, Revatio) is used to improve the ability to exercise in adults (Liqrev, Revatio) and children 1 year of age and older (Revatio) with pulmonary arterial hypertension (PAH; high blood pressure in the vessels carrying blood to the lungs, causing shortness of breath, dizziness, and tiredness). Sildenafil is in a class of medications called phosphodiesterase (PDE) inhibitors . This information was obtained from the website: Sildenafil: MedlinePlus Drug Information (15) Renal Caps is indicated in the wasting syndrome of chronic renal failure; uremia and impaired metabolic functions of the kidney. Renal Caps is also highly effective as a stress vitamin . This information was obtained from the website: Renal Caps: Package Insert / Prescribing Information (16) Sertraline is used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life) . This information was obtained from the website: Sertraline: MedlinePlus Drug Information

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain a homelike environment on one of four unit hallways, the 300's hallway.The findings include:On 6/30/2026 at 11:39 AM, an observation of the lower portion of the 300's hallway between rooms 303-306 revealed a strong stale urine odor in the hallway.Additional observations on 6/30/2026 at 12:21 PM and 2:45 PM revealed the same strong stale urine odor in the same area. At 2:45 PM, a wet floor sign was observed in the hallway and a faint deodorizing scent was noted however the stale urine odor scent remained.On 7/1/2026 at 8:16 AM the hallway between rooms 303-306 was noted to have the stale urine odor. On 7/1/2026 at 4:18 PM, an interview was conducted with the director of housekeeping (DOH) who stated that they were new to the facility and still learning the processes there. She stated that to control odors in the facility the housekeeping staff used Virex disinfectant, Odoban odor eliminiator and a spray air freshener. She stated that they tried to identify any hot spot rooms from the staff so they could take care of any odors right away. The DOH stated that she was aware of problem areas down the 300 hallway at the end and they had changed a mattress in one resident room with urine saturation from a leaking urine collection bag. She stated that the odor lingered, and they could not seem to detect where it was coming from. An observation was made of the 300's hallway with the director who stated that she had recently ordered a new enzymatic product adn was hopeful that it would help to remove the stale urine odor on the hallway but the smell was better now than when she first started working there.The facilit policy Homelike Environment documented in part, .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment; b. comfortable (minimum glare) yet adequate (suitable to the task) lighting; c. inviting colors and decor .On 7/1/2026 at 5:06 PM, the interim Administrator, the Administrator in training, the Director of Nursing and the Regional Director of Clinical Services were made aware of the concern. 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 - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on staff interview, clinical record review, and facility document review, the facility staff failed to promote a resident's highest level of well-being for two of seven residents, Residents #1and #2.The findings include:1. For Resident #1 (R1) the facility staff failed to promote a resident's highest level of well-being by delaying transition of care. R1 diagnoses include but were not limited to Alzheimer's disease (1), aphasia (2) dysphagia (3), and protein-calorie malnutrition (4).On the most recent minimum data set (MDS), nursing home discharge of 6/6/2026, the resident's BIMS (brief interview for mental status) score was not entered. Section C-Cognitive Patterns documented the resident's daily decision making as moderately impaired-decisions poor; cues/supervision required. It further documented R1 having a weight loss of 5% or more in the last month or loss of 10% or more in last six months. Additionally, Section M-Skin Conditions documented the resident with unhealed pressure injuries.-6/6/2026 17:47 (5:47PM), Third Eye Note: Primary Chief Complaint: Respiratory: Hypoxia(5) History Present Illness: Consult received for hypoxemia. Patient is aphasic and nonverbal at baseline, limiting symptom assessment. Nursing noted oxygen saturation of 88% on room air. Patient was placed on 2 liters per minute of supplemental oxygen with improvement in oxygen saturation to 92%. Nursing reports mild expiratory wheezing. Patient is currently receiving nebulizer treatments. No fever, tachycardia (6), or hypotension (7) has been observed. Due to the patient's baseline nonverbal status, subjective symptoms such as shortness of breath cannot be reliably assessed. Pt is aphasic and nonverbal at baseline. Per nurse and/or patientVital Signs: T (temperature): 97.7 (F); HR (heart rate): 95 (bpm) (beats per minute); BP (blood pressure) Sys (systolic): 125 (mm/Hg)/Dia (diastolic): 88 (mm/Hg); RR: 25 (rpm); SpO2: 88(%); Sp02 Levels: Room Air. Physical Exam: Exam findings per nurse and video observation Physical Exam - Notes: Gen (general): not in distress, non verbal, with NC (nasal canula) oxygen, no abdominal breathing. Diagnosis, Assessment/Plan : J9601 - Acute respiratory failure with hypoxia (Primary) Condition is stable 1. Hypoxemia.- Oxygen saturation 88% on room air.- Improved to 92% on 2 L (liter) supplemental oxygen. Monitor oxygen saturation, respiratory effort, and vital signs. Notify provider for worsening hypoxemia, respiratory distress, fever, or acute clinical changes. -6/6/2026 21:44 (9:44 PM), Nursing Note: at 1350hrs resident had shortness of breath, SPO2 (peripheral oxygen saturation) checked, it was 88%; placed in a high Fowler's position; vital signs, checked: BP (blood pressure)-125/86, PR (pulse rate)-96, RR (respiration rate)-25. T (temperature)-97.7, oxygen instilled at 2LPM (liters per minute) via nasal cannula; Ipratropium-albuterol nebulization, given as PRN (as needed) medication q4; Third Eye (on-call physician services), informed and gave order to notify a clinician of any change in condition, continue oxygen therapy and nebulization as ordered, obtain cxry (chest x-ray), CBC (cell blood count) , CMP (comprehensive metabolic panel) and Urinalysis and to monitor the resident; 2 doses of nebulization given at 2pm and 6pm; monitored for signs of desaturation and respiratory distress; SPO2 reached 91-92% and the resident still with shortness of breath; Third Eye, updated but no reply; family, informed and responsible person decided to send the resident to the hospital; EMS (emergency medical services) arrived at 2020hrs and accompanied the resident to (initials of hospital).On 7/2/2026 at 2:23PM, an interview was conducted with Nurse Practitioner (NP). When asked what can you tell me about R1's decline, NP stated R1 was last seen on 6/4/2026 by them. R1 couldn't communicate their needs, there was functional decline and quite a bit of weight loss. NP stated ultimately that R1 was sent out to the emergency department (ED) and transitioned to hospice from the hospital. When asked if a nurse calls a doctor twice about a change in condition with additional changes what would be your recommendation? NP stated, send the resident out to the ED without question. On 7/2/2026 at 2:50 PM, an interview was conducted with the Attending Physician (AP). When asked what can you tell me about R1's decline, AP stated that they saw the resident twice for HNP (history and physical) and follow-up acute visit. R1, was sitting with a blank stare and the LE were not very swollen. Labs were reviewed on 6/7/2026 and were abnormal. When asked (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what are some causes for hypernatremia, AP stated not drinking enough water, some medication, cirrhosis of the liver and hepatic renal syndrome. When asked were you notified that R1 was not taking in PO (by mouth) starting on 6/2/2026, AP answered, no the resident was last seen on 6/3/2026. When asked if a nurse calls a doctor twice about a change in condition with additional changes what would be your recommendation? AP stated, send the resident to the emergency department. On 7/2/2026 at 3:00PM, an interview was conducted with the DON (Director of Nursing). When asked what they remembered about R1, they stated that the resident went to the hospital twice between May and June. They stated regarding the first admission there was general decline that the staff noticed. DON stated R1's family was offered hospice but declined. DON stated that when R1 returned to the facility R1 continued to decline and was admitted to the hospital a second time and discharged from there to home with hospice. When asked who is responsible for reporting to the RP about a resident's decline the DON stated the DON/ADON (assistant director of nursing) is responsible. A facility policy was not provided. On 7/2/2026 at 9:30 AM, Administrator, Regional Clinical Services Director and the Director of Nursing were notified of the findings.No further information was provided prior to exit.References:1. Alzheimer's Disease-Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects thinking and memory skills. https://medlineplus.gov/alzheimersdisease.html2. Aphasia-Aphasia is a language disorder that makes it hard for you to read, write, and say what you mean to say. Sometimes it makes it hard to understand what other people are saying, too. Aphasia is not a disease. It's a symptom of damage to the parts of the brain that control language. https://medlineplus.gov/aphasia.html3. Dysphagia- a swallowing disorder, you may have difficulty or pain when swallowing. https://medlineplus.gov/swallowingdisorders.html4. Protein-Calorie Malnutrition-is a condition caused by a lack of adequate dietary intake of protein, calories (energy), or both. It leads to poor growth, weight loss, muscle wasting, diminished immunity, and impaired organ function. https://my.clevelandclinic.org/health/diseases/22987-malnutrition5. Hypoxia-Hypoxia-Hypoxia occurs when there is not enough oxygen getting to the brain. https://medlineplus.gov/ency/article/001435.htm6. Tachycardia- When your heart beats faster than normal, it's called tachycardia. https://medlineplus.gov/arrhythmia.html7. Hypotension- Low blood pressure occurs when blood pressure is below normal. This means the heart, brain, and other parts of the body may not get enough blood. In adults, the normal blood pressure is between 90/60 mmHg and 120/80 mmHg. https://medlineplus.gov/ency/article/007278.htm 2. For Resident #2 (R2), the facility staff failed to evidence monitoring of the blood pressure prior to administration and one hour after administration of Midodrine (1) per the physicians order. Review of the physician orders documented the following orders Midodrine HCl Oral Tablet 5 MG (Midodrine HCl) Give 5 mg by mouth two times a day for symptomatic hypotension, symptomatic hypotension (SBP <90) (systolic blood pressure); hold if SBP >110 or DBP>70 (diastolic blood pressure); check BP (blood pressure) prior to each dose and 1 hour post-dose; do not administer within 4 hours of bedtime; notify provider if SBP <80, persistent symptoms after 2 doses. Order Date: 04/24/2026. Review of the eMAR (electronic medication administration record) for R2 dated 5/1-5/31/2026 and 6/1-6/30/2026 failed to evidence documentation of the blood pressure readings prior to administration of the Midodrine or one hour post administration of the medication. On 7/1/2026 at 2:02 PM, an interview was conducted with registered nurse (RN) #2 who stated that when she administered R2's Midodrine she checked the blood pressure to ensure it was in the parameters for administration prior to giving the medication. She stated that she went back and rechecked the blood pressure after administration following the order but was not sure if it was documented. RN #2 stated that there should be a note that popped up for them to enter the blood pressure prior to administration and the one hour follow up blood pressure that would show on the eMAR and progress notes, but she was not sure if it showed for R2 or not. On 7/1/2026 at approximately 3:29 PM, the regional director of clinical services stated that they did not have any evidence of the blood pressure readings prior to administration of the Midodrine or one hour (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	post administration to provide. The facility policy [Name of facility corporation] Medication Administration Policy documented in part, .Before removing the medication package/container from the cart/drawer . Review necessary vital signs or tests required before administration . Obtain and document any necessary vital signs or monitoring parameters before administration . On 7/1/2026 at approximately 5:06 PM, the interim Administrator, the Administrator in training, the Director of Nursing and the Regional Director of Clinical Services were made aware of the concern. No further information was provided prior to exit. Reference:(1) Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine is in a class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure . This information was obtained from the website: Midodrine: MedlinePlus Drug Information

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, resident interview, clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to provide care and services to promote healing of a pressure injury (1) for one of seven residents in the survey sample, Resident #2. The findings include: Based on observation, resident interview, clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to provide care and services to promote healing of a pressure injury (1) for one of seven residents in the survey sample, Resident #2. The findings include: For Resident #2 (R2), the facility staff failed to A) clean an unstageable DTI (deep tissue injury) pressure injury prior to applying treatment during wound care observation on 6/30/2026 and B) evidence weekly monitoring of the unstageable DTI wound including location, staging, sizing, and description of the wound. On the most recent minimum data set (MDS), a significant change assessment with an assessment reference date (ARD) of 5/22/2026, R2 was assessed as scoring 14 out of 15 on the BIMS (brief interview for mental status) indicating they were cognitively intact for short term recall and oriented to year, month and day. The assessment documented no rejection of care behaviors and R2 having one unstageable deep tissue injury that was not present on admission. On 6/30/2026 at approximately 12:21 PM, an interview was conducted with R2 who stated that she had a diaper rash wound on her buttocks and staff put cream on it and told her that it was getting better. R2 stated that it had been there for a little while but could not recall when the wound developed. Review of the physician orders documented the following orders - Stage Unstageable DTI- wound, Right, Ischium; 1- Alginate Calcium w/silver/Once Daily 2- Superabsorbent Gelling Fiber w/Silicone Border; Faced/Once Daily one time a day for wound care. Order Date: 06/01/2026.- Peri: Skin Prep / Once Daily one time a day for wound care. Order Date: 06/01/2026. The most recent wound physician note dated 6/18/2026 documented in part, .DRESSING TREATMENT PLAN, Primary Dressing(s): Alginate calcium w/silver apply once daily and as needed: if saturated, soiled, or dislodged. For 23 days. Secondary Dressing(s): Superabsorbent gelling fiber w/ silicone bdr & faced apply once daily and as needed: if saturated, soiled, or dislodged. For 23 days. Peri Wound Treatment: Skin prep apply once daily and as needed: if saturated, soiled, or dislodged . The comprehensive care plan for R2 documented in part, SKIN IMPAIRMENT: the resident has a skin impairment of DTI to right ischium. Date Initiated: 05/08/2026. A) On 6/30/2026 at 3:40 PM, an observation was made of the Director of Nursing (DON) performing wound care to R2's right ischium DTI pressure injury. R2 was observed laying on the bed on her side and was assisted by the Director of Nursing and Assistant Director of Nursing to pull her pants down and undo an adult brief to expose the DTI wound which was not dressed at that time. The Director of Nursing was observed to apply a skin prep wipe to the area surrounding the wound and then placed a bordered gauze with a calcium alginate pad onto the wound area. The wound area was not cleaned prior to placement of the dressing. On 6/30/2026 at approximately 4:00 PM, the DON stated that she did not clean the pressure injury because the physician's order does not say to clean it with anything. She stated that if it said to clean it with normal saline or wound cleanser then she would have used one of those. On 7/1/2026 at 12:13 PM, an interview was conducted with the wound physician who stated that the nursing staff should use their judgement for cleaning the pressure injury and in general they could use either wound cleanser or house stock saline. On 7/1/2026 at 2:02 PM, an interview was conducted with registered nurse (RN) #2 who stated that when she performed wound care to R2's pressure injury she cleans it with normal saline or wound cleanser. She stated that she cleaned the wound due to infection control because you always cleaned a wound prior to treatment and did not want to stick something new on something that is dirty. B) Review of the wound physician evaluations for R2 documented the wound assessed on the following dates, 5/7/2026, 6/11/2026, 6/18/2026. The wound physician notes documented a refusal to be assessed on 5/29/2026. The wound physician notes also documented the following on the following dates:- 5/22/2026: .The patient's visit has been rescheduled as she had (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gone to a Dialysis appointment .- 6/5/2026: .The patient's visit has been rescheduled. Pt is at dialysis .- 6/26/2026: . The patient's visit has been rescheduled as she was out of the facility . The clinical record failed to evidence additional assessments or refusals of assessments to the right ischium DTI. On 6/30/2026 at 1:58PM, a request was made to the Administrator in Training for evidence of weekly assessment of the pressure injury for R2 from first discovery to the present. At approximately 3:00 PM, the wound physician notes listed above were provided. On 6/30/2026 at 4:10 PM, the DON stated that the weekly wound assessments were the responsibility of the assistant director of nursing and were previously done by the director of nursing. She stated that the weekly monitoring was completed to make sure the wounds were progressing and not deteriorating. On 6/30/2026 at 4:55 PM, the Administrator in Training stated that they did not have any more assessments to provide and they relied solely on the wound physician for the assessments of wounds at the facility. On 7/1/2026 at 12:13 PM, an interview was conducted with the wound physician who stated that when he could not see R2 because they were out at dialysis appointments he saw them the next week. He stated that he expected the nursing staff to assess and measure the wound when he could not see it that week. The facility policy Pressure Injury Prevention and Management documented 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 (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 . Evaluation/assessment of pressure ulcer/injury will be completed weekly and with significant change in condition of the ulcer/injury by a licensed nurse and/or practitioner. 2. Documentation of the evaluations/assessment of the pressure ulcer/injury will [sic] maintained in the resident's medical record. Documentation may include: a. Location of ulcer/injury b. Date that the ulcer/injury was acquired [when known] c. Description of the ulcer/injury to include stage, measurements [length, width, depth], presence/absence of any tunneling or undermining, type of tissue [epithelial, granulation, slough, necrosis, etc.], presence/absence and type of drainage, surrounding tissue description, and presence/absence of pain with the ulcer/injury. d. Treatment and interventions to promote healing . On 7/1/2026 at approximately 5:06 PM, the interim Administrator, the Administrator in training, the Director of Nursing and the Regional Director of Clinical Services were made aware of the concern. No further information was provided prior to exit. Reference:(1) A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Causes: Pressure sores occur when there is too much pressure on the skin for too long. This reduces blood flow to the area. Without enough blood to nourish the skin, the skin can die and a sore may form . Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst.Stage I: A reddened, painful area on the skin that does not turn white (blanch) when pressed. This is a sign that a pressure ulcer may be forming. The skin may be warm or cool, firm or soft.Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated.Stage III: The skin now develops an open, sunken hole called a crater or ulcer. The tissue below the skin is damaged. You may be able to see body fat in the ulcer.Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints.There are two other types of pressure sores that don't fit into the stages.Sores covered in dead skin that is yellow, tan, green, or brown. The dead skin makes it hard to tell how deep the sore is. This type of sore is unstageable.Pressure sores that develop in the tissue deep below the skin. This is called a deep tissue injury. The area may be dark purple or maroon. There may be a blood-filled blister under the skin. This type of skin injury can quickly become a stage III or IV pressure sore . This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on staff interview, clinical record review, and facility document review, the facility staff failed to implement dietician recommendations for one of 7 residents in the survey sample, Residents #1. The findings include:For Resident #1 (R1) the facility staff failed to implement dietician's recommendations. R1 diagnoses include but were not limited to Alzheimer's disease (1), aphasia (2) dysphagia (3), and protein-calorie malnutrition (4).On the most recent minimum data set (MDS), nursing home discharge of 6/6/2026, the resident's BIMS (brief interview for mental status) score was not entered. Section C-Cognitive Patterns documented the resident's daily decision making as moderately impaired-decisions poor; cues/supervision required. It further documented R1 having a weight loss of 5% or more in the last month or loss of 10% or more in last six months. Additionally, Section M-Skin Conditions documented the resident with unhealed pressure injuries (5).The comprehensive care plan for R1 documented in part, resident is at risk for dehydration, weight loss, or malnutrition related to advanced age, chronic disease. Date Initiated: 4/29/2025. Revision on 6/10/2026.Physician orders documented an order for resident to eat with maroon spoon for all meals to control PO intake on 3/24/2025 and an order on 2/23/2026, for mechanical diet soft texture, regular/thin consistencyA nutritional assessment for R1 dated 5/24/2026 documented in part, weekly weights times four to re-establish a baseline weight on 5/24/2026. Re-admit. CBW(current base weight): 171lbs (5.4.26). BMI: 23.8, WNL. Wt (weight) is up 5.6% over the past month. Diet: Regular diet, mechanical soft texture, thin consistency. Intakes: 100% (2126 kcal, 84 g PRO). Appears to not meet est energy needs of 2330 kcal/day (30kcal/kg/day), 77 g PRO daily (1 g/kg/day), 2330 mL fluid daily (30 mL/kg/day). Despite not meeting needs wt is up over the past month.Review of R1's monthly weight documented in part, on 1/6/2026, the resident weighed 156.5lbs (wheelchair); on 2/5/2026, the resident weighed 156.5 (wheelchair); on 3/4/2026, the resident weighed 158.5 (wheelchair); on 4/2/2026, the resident weighed 161.5 (wheelchair); on 5/4/2026, the resident weighed 171.0 (mechanical lift); on 6/1/2026, the resident weighed 141.5 (wheelchair). A review of the weight summary revealed, weekly weights times four to re-establish a baseline weight were not done. Review of the ADL (activities of daily living) documentation for R1 documented that May 29th-31st, R1 was dependent with eating, June 2nd R1 required maximum assistant with eating and June 3rd-6th R1 was dependent with eating. R1 ate 26-50% of meals May 29th-31st and June 2nd-3rd 25 of meals.The progress notes for R1 documented in part, -6/1/2026 at 12:15 PM Note: Intaking less than 25% of meals; pocketing foods at the lowest gradable diet as well as medications.-6/3/3026 at 13:40 (1:40 PM) Note: Weight was documented at 141.5lbs on 06/01/2026, decreased from 161.5lbs on 04/02/2026, likely reflecting diuresis achieved during and after hospitalization.-6/4/2026 at 19:22 (9:22 PM) Note: Weight decreased from 161.5lbs to 141.5 lbs. Escalate nutritional interventions and continue close monitoring. Escalate nutritional support given oral intake below 25% of meals - Monitor medication administration given pocketing of medications and food at lowest gradable diet.On 7/1/2026 at 10:10 AM, an interview was conducted with certified nursing assistant (CNA) #8, who stated: when R1 returned from the hospital, the resident was weak and not feeding himself. The resident was pocketing food. Some days R1 would have energy to feed themself. R1 required supervision and redirection.On 7/1/2026 at 11:56 AM, an interview was conducted with CNA #3, who stated R1 required help with feeding and drinking. CNA #3 stated that they took care of R1once or twice during day shift. CNA #3 stated that when R1 came back from the hospital, R1 looked bad and it looked like R1 was about to die. CNA #3 stated that previously R1 wasn't like that and R1 went quick. After R1's hospitalization CNA #3 further stated the resident required more care and wasn't eating.On 7/1/2026 at 12:22 PM, an interview was conducted with CNA #6, who stated they took care of R1 a lot and when R1 came back from the hospital R1 wasn't eating or holding their head up and that R1 was lethargic. CNA #6 stated R1 had lost a lot of weight. CNA stated R1 required prompting for taking in water. CNA #6 further stated they could get the resident to eat 25-30% of R1's food.On 7/1/2026 at (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:40 PM, an interview was conducted with CNA #5, who stated they didn't work with R1 a lot. CNA #5 stated they remembered a lot of decline in R1 not eating. CNA #5 stated when they would feed R1 the resident would hold food in his mouth or it would come out of R1's mouth.On 7/1/2026 at 3:29 PM, the Regional Director of Clinical Services (RDCS) informed the surveyor that they do not have any weights per the dietician recommendations. On 7/2/2026 at 9:15AM, an interview was conducted with the dietician, who stated that on 5/24/2026, R1 was trending upward and there wasn't any weight loss, so no changes were made. When asked why were weekly weights times four ordered to establish a baseline weight, they stated because R1 had been readmitted to the facility and they wanted to track and trend his weight for a baseline. The dietician stated that they communicate their recommendations to the facility via a portal system and the facility receives a notification that they have sent the recommendation.The facility's policy Weight Assessment and Intervention document in part, The interdisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. Weights will be recorded in the resident's medical record. The designated dietary staff will review the weight records [based on frequency of weights] to follow individual weight trends over time. (a). The treatment team will evaluate negative trends whether or not the criteria for significant weight change has been met.On 7/2/2026 at 9:30 AM, Administrator, Regional Clinical Services Director and the Director of Nursing were notified of the findings.No further information was provided prior to exit.References:1. Alzheimer's Disease-Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects thinking and memory skills. https://medlineplus.gov/alzheimersdisease.html2. Aphasia-Aphasia is a language disorder that makes it hard for you to read, write, and say what you mean to say. Sometimes it makes it hard to understand what other people are saying, too. Aphasia is not a disease. It's a symptom of damage to the parts of the brain that control language. https://medlineplus.gov/aphasia.html3. Dysphagia- a swallowing disorder, you may have difficulty or pain when swallowing. https://medlineplus.gov/swallowingdisorders.html4. Protein-Calorie Malnutrition-is a condition caused by a lack of adequate dietary intake of protein, calories (energy), or both. It leads to poor growth, weight loss, muscle wasting, diminished immunity, and impaired organ function. https://my.clevelandclinic.org/health/diseases/22987-malnutrition5. Pressure Injuries-Bedsores, also known as pressure ulcers, pressure injuries, pressure sores, and decubitus ulcers, result from prolonged pressure that cuts off the blood supply to the skin, causing the skin and other tissue to die. https://skinsight.com/skin-conditions/pressure-ulcer-decubitus-ulcer/?Imiw9cApl=1