| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495233 | A. Building<br>B. Wing | 05/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Poplar Hill Health and Rehab | 360 Hospital Drive<br>Warrenton, VA 20186 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to notify the medical provider of changes in condition one of eight residents in the survey sample, Resident #1. The findings include:For Resident #1 (R1), the facility staff failed to notify the medical provider of change in condition on 3/26/2026.On the most recent minimum data set (MDS), quarterly assessment with an assessment reference date (ARD) of 1/8/2026, the patient's BIMS (brief interview for mental status) score was assessed at 15, indicating the resident was cognitively intact for making daily decisions.The resident admission demographic information documented R1 being their own responsible party and two alternates as emergency contacts. R1 diagnoses include but are not limited to hypertension (1), peripheral vascular disease (2) and diabetes mellitus (3). The progress notes for R1 documented in part, -A review of the Attending Physician's note on 3/16/2026 at 6:43 PM, the resident's BP (blood pressure) was 120/74. -A review of the NP's (nurse practitioner) notes on 3/24/2026 at 12:37 PM, documents the resident's blood pressure:110/68. -A review of a late entry note entered by LPN #4, for 3/25/2026 at 15:30 (3:30PM), documents: OT (occupational therapist) reported that the client was observed lowering herself to the ground and complained of dizziness. Upon assessment client denied hitting her head and was alert and responsive. No visible injuries noted on examination. Vital signs were obtained and blood pressure was noted to be low. (bp-95/54, hr (heartrate)-69, rr (respiration rate)-16, temp (temperature)-97.9, pain -0/10). Assistance was provided with another nurse to get her back in bed. Encouraged fluids to client and Patient refused oral intake. Patient did not eat breakfast or lunch either. Will continue to encourage fluids, reassess vital signs every hour, and reassess safety status. -Neuro Check Assessment Form documented in part, 3/25/2026 at 1:15 AM, BP- 81/50; at 3:45 PM, BP -100/63; at 5:15 PM, BP-100/61; 3/26/2026 at 5:15 AM, BP- 80/51. The assessment failed to evidence notification of the physician of the blood pressure. On 5/13/2026 at 8:17 AM, an interview was conducted with the Attending Physician. When asked what nursing should have done about R1 complaint of not feeling well, dizziness along with the decrease in her blood pressure, he stated the NP should have been contacted for any alarming signs or symptoms. He stated alarming signs would be anything that is not baseline, which include loss of consciousness, drop in blood pressure or severe fever and with a decrease in blood pressure it should be repeated in ten minutes until it is at baseline. A review of the facility's Notification of Changes policy, revised 1/26, revealed the policy purpose is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Circumstances requiring notification include: significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: life-threatening conditions. 5/13/2026 at 10:10 AM, Administrator and Director of Nursing were made aware of the concern for R1. No further information was provided prior to exit. References: Hypertension- Blood pressure is the force of your blood pushing against the walls of your arteries. https://medlineplus.gov/highbloodpressure.htmlPeripheral Vascular Disease- Is a condition of the blood vessels that supply the legs and feet. It occurs due to narrowing of the arteries<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | in the legs. This causes decreased blood flow, which can injure skin, muscles, nerves and other tissues heart. https://medlineplus.gov/ency/article/000170.htmDiabetes Mellitus- Diabetes, also known as diabetes mellitus, is a disease in which your blood glucose, or blood sugar, levels are too high. https://medlineplus.gov/diabetes.html |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide care and services to meet professional standards for one of eight residents, Resident #4.The findings include: The facility staff failed to meet professional standards by administering medications as ordered for Resident #4 (R4).R4 was admitted to the facility on [DATE] with diagnosis that included but were not limited to paroxysmal atrial fibrillation (A-fib), HTN (hypertension), CHF (congestive heart failure) and DM (diabetes mellitus).The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/14/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for transfer, hygiene, bathing/dressing and set up for eating. A review of the comprehensive care plan dated 9/8/23 revealed, FOCUS: Resident has decreased Cardiac Output due to A-fib and HTN. Resident is at risk for is for unstable Blood Glucose Level due to Diabetes. INTERVENTIONS: Administer cardiac medications per MD (physician) order. Administer medications as prescribed.A review of the physician orders dated 7/14/24 revealed, Apixaban Oral Tablet (1) 5 MG (Apixaban) Give 1 tablet by mouth two times a day. Metoprolol Tablet (2) 25 MG, Give 1 tablet by mouth two times a day. Ordered to be administered at 9:00 AM.A review of the physician orders dated 10/11/24 revealed, Cartia XT Oral Capsule Extended Release 24 Hour 180 MG (Diltiazem HCl Coated Beads) (3) Give 1 capsule by mouth one time a day. Ordered to be administered at 9:00 AM.A review of the physician orders dated 3/4/25 revealed, Furosemide Tablet (4) 20 MG Give 1 tablet by mouth one time a day. Ordered to be administered at 8:00 AM.A review of the physician orders dated 12/16/25 revealed, ?Metformin HCl Oral Tablet (5)500 MG, Give 1 tablet by mouth two times a day. Ordered to be administered at 9:00 AM.A review of the medication time audit report for 2/3/26 revealed these medications (Apixaban, Metoprolol, Cartia, Furosemide and Metformin) were administered on 2/3/26 at 3:24 PM.There was no progress note documenting delay in administration.The LPN (licensed practical nurse) who administered the medications on 2/3/26, is no longer employed at the facility.Medication Administration was observed on 5/13/26 at 7:45 AM with LPN (licensed practical nurse) #1. Asked the process for medication administration, LPN #1 stated, check the order, right patient, drug, dose, route, time and then document it.An interview was conducted on 5/13/26 at 11:30 AM, an interview was conducted with the DON (director of nursing). When asked about the process for administration of medications, the DON stated, the medications are to be administered within one hour before or after the administration time and documented in PCC (point click care) MAR (medication administration record). Asked about the delay in medications administered on 2/3/26 for R4, the DON stated that this LPN was giving the medications on time and waiting until the end of his shift to document. He was not following the facility standard of care. Asked what is the process if medications are administered outside the time frame, the DON stated, there should be a written progress note explaining that the medications were given on time and he did not document them as administered until the end of his shift. Asked if this LPN's medication administration on 2/3/26 was following the standard of practice, the DON stated, no this was not following standards of practice.On 5/13/26 at 2:00 PM, the regional administrator and the director of nursing were made aware of the findings. A review of the facility's Lippincott Manual of Nursing Practice policy revealed, Departure from Standard of Care- Failure to administer medications properly and in a timely fashion or to report and administer omitted doses appropriately. (6)No further information was provided prior to exit. References:Apixaban-anticoagulant and thrombin inhibitor. [NAME] 2019 Drug Guide for Nurses, page 25.Metoprolol-antihypertensive. [NAME] 2019 Drug Guide for Nurses, page 243.Diltiazem-antianginal, antihypertensive. [NAME] 2019 Drug Guide for Nurses, page 112.Lasix-loop diuretic. [NAME] 2019 Drug Guide for Nurses, page<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 167.Metformin-antidiabetic. [NAME] 2019 Drug Guide for Nurses, page 235.Lippincott Manual of Nursing Practice 12th Edition-page 15. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident/staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide ADL (activities of daily living) care for dependent residents for one of eight residents, Resident #4.The findings include: The facility staff failed to provide ADL specifically incontinence care for a dependent resident, Resident #4 (R4).R4 was admitted to the facility on [DATE] with diagnosis that included but were not limited to paroxysmal atrial fibrillation, HTN (hypertension), CHF (congestive heart failure) and DM (diabetes mellitus).The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/14/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for transfer, hygiene, bathing/dressing and set up for eating. A review of the comprehensive care plan dated 9/8/23 revealed, FOCUS: Resident has an alteration in self-care related to Co-morbidities. She frequently refuses showers, to get out of bed and at times refuses to be changed. INTERVENTIONS: Assist with dressing, bathing, incontinent care, bed mobility and transfers. Educate resident on the risks vs benefits of not being changed timely.A review of the ADL reveals missing evidence of incontinence care being provided on following shifts and dates: Day shift: 1/15, 1/16, 1/17, 1/18, 1/19, 1/20, 1/22, 1/23, 1/25, 1/26, 1/29, 2/5, 2/15, 3/3, 3/5, 3/10, 3/11, 3/12, 3/20, 3/26, 4/9, 4/30 and Evening shift: 1/14, 1/18, 1/23, 1/24, 1/25, 2/3, 3/16, 5/4; night shift: 1/14, 1/15, 1/16, 1/17, 1/31, 2/11, 2/19, 2/28, 3/7, 3/25, 3/31, 4/8 and 4/30.An interview was conducted on 5/13/26 at 7:20 AM with CNA (certified nursing assistant) #1. Asked about the incontinence care rounding process, CNA #1 stated, resident rounding is every one-two hour to provide incontinence care and reposition the residents. Ask if there is evidence of this care, CNA #1 stated, there is documentation in the ADL form. Asked if there was no documentation, is there evidence the care was provided, CNA #1 stated, no, there is not. 5/13/26 at 9:40 AM an interview was conducted with CNA #2, who stated, the resident is on my assignment most days. Incontinence care is documented every shift in PCC (point click care). Asked if there is no evidence of incontinence care, CNA #2 stated, if it is not documented, it is not done. There is work being done to reduce call bell response time and to make sure care is documented.On 5/13/26, at 11:30 AM, an interview was conducted with the DON (director of nursing). When asked about the incontinence care being provided, the director of nursing stated, there is a performance improvement plan (PIP) on call bells and incontinence care. DON was asked to provide the PIP.The PIP dated 4/6/2026 documented the following: Timely call bell response with incontinent care. Providing timely call bell response with incontinent care and general care services. Other residents could be affected by this practice.All licensed nursing staff were re-educated by the SDC on timely call bell response and timely incontinent care.The Supervisors/Designees will randomly audit call bell response and incontinent care for (4) weeks. The results of these reviews will be presented to QAPI (Quality Assurance Performance Improvement) for review and recommendations. Completion date:5/6/2026.Review of staff educational sign-in sheets for the call bells and incontinence care in-services dated 4/6/26 through 4/8/26 documented 59 staff members educated. The facility Incontinence policy was attached to the education sign-in sheets. Education and training were reviewed and verified by multiple staff interviews. Implementation of the education was verified with resident interviews and observations. No concerns were identified.A review of the facility's Incontinence policy revealed, Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.On 5/13/26 at 2:00 PM, the regional administrator and the director of nursing were made aware of the findings of past non-compliance. No further information was provided prior to exit. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility document review, the facility staff failed to follow professional standards of care for one of eight residents in the survey sample, Resident #1. The findings include:For Resident #1 (R1), the facility staff failed to follow standard of care for resident with persistent complaints of decreased blood pressure (BP), dizziness, and gastrointestinal (GI) (1) symptoms and little to no improvement in symptoms and no evidence of discussion or implementation of an alternative plan of care. On the most recent minimum data set (MDS), quarterly assessment with an assessment reference date (ARD) of 1/8/2026, the patient's BIMS (brief interview for mental status) score was assessed at 15, indicating the resident was cognitively intact for making daily decisions. The resident admission demographic information documented R1 being their own responsible party and two alternates as emergency contacts. -A review of Attending Physician's notes on 3/6/2026 at 17:15 (5:15 PM), documents in part, Patient is seen today for a medical exam. Repeat labs (laboratory tests) in approximately 20 days (around 3/26) to include CBC (2) and iron panel for anemia follow-up -A review of NP (nurse practitioner)'s note on 3/9/2026 at 11:45 AM, documents in part, Patient is seen today for evaluation of nausea and vomiting. Gastroparesis (3): Diabetic gastroparesis evaluated today. Abdominal ultrasound ordered to rule out gastric outlet obstruction. Nausea with vomiting, unspecified: Continue with Ondansetron (4) HCl 4 mg by mouth every 6 hours as needed for nausea/vomiting. -A review of the NP's note on 3/10/2026 at 11:19 AM, documents in part, Pt (patient) reports still feeling nauseous (no emesis), but slight improvement from yesterday. Pt reports Zofran (5) helps when taken, but it has only been administered once so far. c/w (continue with) Zofran for symptom management. f/u (follow up) on abd(abdominal) US (ultrasound). VS (vital signs) ordered BID (twice a day) x2 days. START CBC/BMP (basic metabolic panel) (6) to r/o (rule out) active infection or electrolyte imbalance. - 3/15/2026 at 15:17 (3:17 PM), Nursing Note: she has low BP (blood pressure) which was mentioned on TAR/MAR (treatment administration record/medication administration record), encouraged to drink more fluid, she rested on bed whole time, let the next upcoming nurse to continue monitor and update. Review of the TAR/[DATE]/15/2026 does not document a BP. - 3/15/2026 at 22:30 (10:30 PM), Nursing Note: patient complained of nausea and dizziness during the shift. -A review of the Attending Physician's note on 3/16/2026 at 6:43 PM, the resident's BP was 120/74. The note also documents the additional following blood pressures:On 3/3/2026- BP 138/92; On 3/4/2026- BP 126/84; On 3/5/2026- BP 125/72; On 3/6/2026, BP 120/74. -A review of the NP's note on 3/24/2026 at 12:37 PM, documents the resident's blood pressure: 110/68. Patient was seen per nursing request for coughing and lab orders. Nausea with vomiting, unspecified: Zofran has not been effective. Ordered abdominal ultrasound to rule out cholecystitis (7) and biliary tract obstruction (8).-abd (abdominal) US (ultrasound) w/no acute findings. Pt (patient) reports N/V (nausea/vomiting) has been going on for a few weeks now. Would like to do labs including CBC (complete blood count), CMP (comprehensive metabolic panel) (9), lipase (10), and TSH (thyroid stimulating hormone) (11), however, pt refused labs even after education.-HOLD iron (new med and pt denies being on it before) and START Pepcid-if no relief, will need GI (gastrointestinal) appt.(appointment)-3/24 pt reports some improvement today but gave limited details. -A review of the NP's note on 3/26/2026 at 8:30 AM, documents in part, Persistent nausea and vomiting. Nausea with vomiting, unspecified: Zofran has not been effective. Ordered abdominal ultrasound to rule out cholecystitis and biliary tract obstruction. -A review of a late entry note entered by LPN #4, for 3/25/2026 at 15:30 (3:30PM), documents: OT (occupational therapist) reported that the client was observed lowering herself to the ground and complained of dizziness. Upon assessment client denied hitting her head and was alert and responsive. No visible injuries noted on examination. Vital signs were obtained and blood pressure was noted to be low. (bp-95/54, hr (heartrate)-69, rr (respiration rate)-16, temp (temperature)-97.9, pain -0/10). Assistance (continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | was provided with another nurse to get her back in bed. Encouraged fluids to client and Patient refused oral intake. Patient did not eat breakfast or lunch either. Will continue to encourage fluids, reassess vital signs every hour, and reassess safety status. At approximately 1615 (4:15 PM), I checked on resident's roommate; resident was observed in bed sleeping at that time. At approximately 1640 (4:40 PM) I returned to the room to perform treatment on roommate and notes residents' bed was empty. Resident was then observed lying on the floor. I immediately sought assistance from another nurse. Upon initial assessment residents lower extremities appeared pale and scaly, and skin was cold to touch with lips having a bluish tent.At 1645 (4:45 PM) I called 911 while additional nursing staff arrived and initiated CPR (cardiopulmonary resuscitation) (10). I retrieved crash cart and oxygen; oxygen therapy and chest compressions were started immediately. At approximately 1650 (4:50 PM) EMS (emergency medical service) arrived and continued CPR efforts. At 1712 (5:12 PM) I called and notified the Director of Nursing. At 1717 (5:17PM) time of death was pronounced by EMS 1101 via phone with Dr. [doctor's name]. Family was then notified of time of death. -Additionally, a review of the blood pressure graphing documents an ongoing decrease in R1's systolic blood pressure beginning on 3/1/2026. -A review of the physician's orders documented three orders for abdominal ultrasounds ordered on the 3/10/2026, 3/16/2026 and 3/18/2026. Review of the clinical record failed to evidence completion of an abdominal ultrasound on 3/12/2026 and failed to evidence completion or refusal of the additional ultrasounds ordered. -Neuro Check Assessment Form documented in part, 3/26/2026 at 1:15 AM, BP- 81/50; 3/26/2026 at 5:15 AM, BP- 80/51. The assessment failed to evidence notification of the physician of the blood pressure. -Review of R1's comprehensive care plan failed to evidence documentation of R1 refusing care or treatments. Review of the clinical record failed to evidence that alternatives to treatment were discussed with R1, regarding the lack of improvement in symptoms or options available for interventions outside of the facility. There was no evidence of the additional ultrasounds being completed or refused and no evidence of referral to GI that was documented in the NP notes frequently. On 5/12/2026 at 1:15 PM, an interview was conducted with LPN (license practical nurse) #4 . When asked what do you remember about R1 symptoms on 3/25/2026, the nurse stated, R1 had a recent room change, and staff on that unit had worked with her for three days. He stated she had been refusing meals, not drinking a lot. He stated she was just lying in bed and had always been in bed since working with her. On 5/12/2026 at 1:37 PM, an interview was conducted with the NP. When asked, what was the POC (plan of care) for R1 due to her persistent symptoms, not responding to treatment and refusing care? The NP stated R1could make her own decision. She stated R1 had been nauseated and was being seen for that. NP stated I wanted to do blood work but she was refusing despite educating her. The NP further stated that the goal was to send her to a (GI) gastrointestinal doctor but R1 would only agree to think about it and the GI appointment was never scheduled. The NP stated one ultrasound was ordered and it was negative for acute findings. The NP stated that the criteria to send R1 to a GI doctor were negative labs but R1 refused the blood work. When asked if there was a discussion about IV (intravenous) (12) fluids, the NP stated there was no indication to give IV fluids. NP states R1 was being encouraged to take in more fluids and that day she was drinking. When asked, the NP stated that she did not have any discussions with the family about refusals of treatment or encouraging R1 to accept care. The NP was asked to describe the timeline of R1's decline; the NP stated that R1 was first seen in 2/2026. The NP stated that they didn't expect her to pass despite having a lot of comorbidities. The NP stated the biggest problem was R1 refusing treatment. She stated that her nausea was improving, and the diabetes was fairly controlled. The NP stated that R1 seemed pretty much the same during the time that she worked with her. On 5/12/2026 at 2:17 PM, an interview was conducted with the DON (director of nursing). When asked if there were any changes in R1's symptoms on 3/25/2026 or 3/26/2026, the DON stated, not that she is aware of. She stated she knew the R1 was having belly issues and was getting an ultrasound and taking Zofran for it. On 5/13/2026 at 8:17 AM, an interview was conducted with the Attending Physician. He stated that R1 was alert<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and oriented, her vital signs were stable, she was not cooperative and refused bloodwork. When asked what would the bloodwork shown, He stated that could not be predicted but what was needed was a baseline. When asked what should nursing have done about R1's complaint of not feeling well, dizziness along with the decrease in her blood pressure, he stated the NP should have been contacted for any alarming signs or symptoms. He stated alarming signs would be anything that is not baseline, which include loss of consciousness, drop in blood pressure or severe fever and with a decrease in blood pressure it should be repeated in ten minutes until it is at baseline. On 5/13/2026 at 8:40 AM, an interview was conducted with the Medical Director (MD). When asked if there is a resident who is refusing the POC (plan of care) for treatment and has a blood pressure that is decreasing for two weeks, what intervention should be taken? The MD stated, talk to them and explain the risk of not adhering to POC. When asked, would you discuss code status or end of life? The MD stated if they are declining I would discuss code status but if a resident is alert and oriented, they can make their own decision, and you cannot force the patient. The MD stated those types of conversations would be in the provider's note. 5/13/2026 at 10:10 AM, Administrator and Director of Nursing were made aware of the concern for R1. No further information was provided prior to exit. References:1. Gastrointestinal- Your digestive or gastrointestinal (GI) tract includes the esophagus, stomach, small intestine, large intestine or colon, rectum, and anus. https://medlineplus.gov/gastrointestinalbleeding.html2. CBC- A complete blood count (CBC) is a blood test that measures amounts and sizes of your red blood cells, hemoglobin, white blood cells and platelets.3. Gastroparesis- is a condition that reduces the ability of the stomach to empty its solid contents. https://medlineplus.gov/ency/article/000297.htm4.Ondansetron-https://medlineplus.gov/druginfo/meds/a601209.html5. Zofran-https://my.clevelandclinic.org/health/drugs/18477-ondansetron-solution6. BMP- A basic metabolic panel (BMP) measures eight different substances in your blood. It provides important information about your body's fluid balance, your metabolism (the process your body uses to make energy from food you eat), and how well your kidneys are working. https://medlineplus.gov/lab-tests/basic-metabolic-panel-bmp/7.Cholecystitis-Acute cholecystitis is sudden swelling and irritation of the gallbladder. Chronic cholecystitis is swelling and irritation of the gallbladder that continues over time. https://medlineplus.gov/ency/article/000264.htm; https://medlineplus.gov/ency/article/000217.htm8. Biliary tract obstruction-A bile duct obstruction occurs when a blockage or narrowing in your bile ducts prevents bile from flowing as it should. https://my.clevelandclinic.org/health/diseases/bile-duct-obstruction9. CMP- A comprehensive metabolic panel (CMP) is a routine blood test that measures 14 different substances in a sample of your blood. https://medlineplus.gov/lab-tests/comprehensive-metabolic-panel-cmp/10. Lipase- A lipase blood test shows how much of the pancreatic enzyme lipase you have in your blood. https://my.clevelandclinic.org/health/diagnostics/lipase-blood-test11. TSH- A TSH test is a blood test that measures this hormone. https://medlineplus.gov/lab-tests/tsh-thyroid-stimulating-hormone-test/12. IV- means giving medicines or fluids through a needle or tube (catheter) that goes into a vein. https://medlineplus.gov/ency/patientinstructions/000496.htm |

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| | 495233 | A. Building<br>B. Wing | 05/13/2026 |

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| Poplar Hill Health and Rehab | 360 Hospital Drive<br>Warrenton, VA 20186 |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to assist in arrangement of follow up vision services for one of eight residents in the survey sample, Resident #5. The findings include:For Resident #5 (R5), the facility staff failed to evidence arrangement of a follow-up ophthalmology (1) appointment. On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 4/8/26, R5 scored two out of 15 on the brief interview for mental status (BIMS) assessment, indicating they were severely impaired for making daily decisions. The assessment further documented R5 having diagnoses that included but were not limited to aphasia (2) and cerebral infarction (3). The progress notes for R5 documented in part,- Effective Date: 03/31/2026 23:19 (11:19 PM) Type: [Name of wound care practice] skin and wound note . Per nursing anf [sic] primary NP (nurse practitioner) request, wound team consult to new skin rash to face. Upon assessment, Pt noted to have Herpes Zoster (4) (shingels) [sic] rash on left forehead, left face, and left nose bridge, and left eye, herpes zoster ophthalmicus (HZO) with Viral Conjunctivitis (5). Please initiate the wound treatment plan listed in the wound plan section. Calamine zinc 8-8% external lotion (6) to left forehead, leave open to air, avoid putting in the eye. ophthalmologist consult STAT (now), PO (by mouth) Valacyclovir (7) 7 days. Discussed with primary NP for POC (plan of care). Also, pt needs to be on isolation r/t (related to) drainage. Shingles is contagious until the blisters have completely dried and scabbed over. Direct contact with the fluid can spread the virus .- Effective Date: 03/31/2026 14:38 (2:38 PM) Type: Health Status Note. Note Text: spoke w/resident's daughter and she is going to schedule eye appt/transport for resident- resident has shingles on his face, possibly in eye. Was seen by NP and Wound NP and orders placed. resident moved to isolation room.- Effective Date: 04/09/2026 17:03 (5:03 PM) Type: Follow Up Visit - [Name of nurse practitioner] .shingles treatment discussed w/ ID (infectious disease). No further medications necessary. Rash has resolved. PERRLA (pupils equal, round, reactive to light and accommodation) (8) noted. unclear how his vision is at this time . Review of the visit summary note from the retina specialist who examined R5 on 4/1/2026 documented in part, .Imp/Plan (impression/plan): 1. Herpes Zoster Ophthalmicus OS (left eye), oral acyclovir and lubrication- refer to [Name of ophthalmologist] . Review of the clinical record failed to evidence a follow up appointment set up, offered or discussed with R5's family for R5 to see the ophthalmologist that they were referred to on 4/1/2026. On 5/13/2026 at 9:20 AM, an interview was conducted with licensed practical nurse (LPN) #2 who stated that R5's eye had started by being pinkish red with clear drainage and they were treated with eye drops. She stated that R5 had been rubbing the eye and when the rash developed started scratching the rash which caused the blisters to break open and crust over. LPN #2 stated that the nurse practitioner and the wound nurse practitioner had both assessed R5 on 3/31/2026 and diagnosed shingles at that time. She stated that they had started medication, put R5 on contact isolation and R5's family had taken them to the eye doctor the next day. LPN #2 stated that normally family members scheduled appointments for the residents, but she assisted as needed. She stated that R5 had not been back to the eye doctor for follow up and normally she would get a copy of the physician's note from the office and coordinate with the family to set up the appointment needed. On 5/13/2026 at 11:18 AM, an interview was conducted with the Director of Nursing who stated that they had not set up a follow up appointment with the ophthalmologist because the nurse practitioner had said that R5 did not need it. She stated that she was not sure why the nurse practitioner did not think R5 needed the follow up appointment. On 5/13/2026 at 12:00 PM, an interview was conducted with the nurse practitioner who stated that when she saw R5 her priority was getting them to the eye doctor right away. She stated that she did not think it was dire for R5 to follow up because she had been checking his eyes and the resident reports that he has vision in the eye. She stated that if the family wanted R5 to go they would send him but typically the family sets up appointments. She stated that when she examines a resident's eyes, she makes sure that a<br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident is reporting no changes in their vision and she is checking the pupils for equal size, reaction to light and accommodation. She stated that R5 could nod yes or no to answer some questions and had nodded appropriately to some questions, but she could not say that the resident was 100% cognitively intact. The facility provided letter to residents and families dated 2/25/2025 documented in part, . Appointments & Transportation. All appointments should be scheduled by yourself or a family member. [Name of facility] is not responsible for transportation. If you have questions, concerns or need assistance, please contact your Unit Manager or Social Services. We understand that appointments and outings are an important part of maintaining quality of life, and we are always happy to support you and your loved ones . On 5/13/2026 at 1:53 PM, the Regional Administrator and the Director of Nursing were made aware of the concern. No further information was provided prior to exit. Reference:(1) Ophthalmologists are medical doctors. They are the only eye doctors with medical degrees, either MD or DO (doctors of osteopathic medicine) . Ophthalmologists must complete many more years of medical training than optometrists and opticians . As a result, an ophthalmologist is the most qualified among eye care professionals to diagnose and treat a wide range of eye diseases, beyond the routine eye and vision care provided by an optometrist . This information was obtained from the website: https://www.aao.org/eye-health/tips-prevention/what-is-ophthalmologist(2) 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 . This information was obtained from the website: Aphasia \| MedlinePlus(3) A stroke occurs when blood flow to a part of the brain stops. A stroke is sometimes called a brain attack.If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. A stroke can also occur if a blood vessel inside the brain bursts, leading to bleeding inside the head . This information was obtained from the website: Stroke: MedlinePlus Medical Encyclopedia(4) Shingles (herpes zoster) is an infection that causes a painful rash. It is caused by the varicella-zoster virus (VZV). This is the same virus that causes chickenpox. After you have chickenpox, the virus stays in your body. It may not cause problems for many years. But as you get older, the virus may become active again and cause shingles . This information was obtained from the website: Shingles \| Herpes Zoster \| MedlinePlus(5) Conjunctivitis is the medical name for pink eye. It involves inflammation of the outer layer of the eye and inside of the eyelid. It can cause swelling, itching, burning, discharge, and redness. Causes include:Bacterial or viral infectionAllergiesSubstances that cause irritationContact lens products, eye drops, or eye ointmentsPink eye usually does not affect vision. Infectious pink eye can easily spread from one person to another. The infection will clear in most cases without medical care, but bacterial pink eye needs treatment with antibiotic eye drops or ointment . This information was obtained from the website: Conjunctivitis \| Pink Eye \| MedlinePlus(6) What are the treatments for shingles? There is no cure for shingles. Antiviral medicines may help to make the attack shorter and less severe. They may also help prevent PHN. The medicines are most effective if you can take them within 3 days after the rash appears. So if you think you might have shingles, contact your provider as soon as possible. Pain relievers may also help with the pain. A cool washcloth, calamine lotion, and oatmeal baths may help relieve some of the itching . This information was obtained from the website: https://medlineplus.gov/shingles.html(7) Valacyclovir is used to treat certain viral infections including, It is in a class of medications called antivirals. It works by stopping the spread of the herpes virus in the body.herpes labialis (cold sores)varicella infections including herpes zoster (shingles) and chicken pox)genital herpes (a sexually transmitted infection)Valacyclovir helps treat and control outbreaks of genital herpes but should be used with safe sexual practices. Valacyclovir will not cure genital herpes . This information was obtained from the website: Valacyclovir: MedlinePlus Drug Information(8) Clinicians need to check the pupils during the physical assessment to evaluate cranial nerves II and III. Cranial nerve II (optic) controls visual acuity/afferent input, while Cranial nerve III (oculomotor) controls pupil constriction and dilation. The (continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PERRLA test is used to examine the pupils: Pupils, Equal, Round, Reactive to, Light, Accommodation . This information was obtained from the website: How to Do A Neurological Assessment: 5-Step Neuro Exam |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide pharmacy services for two of eight residents in the survey sample, Residents #3, and #5. The findings include:1. For Resident #3 (R3), the facility staff failed to ensure the medication Ciprofloxacin (an antibiotic) was available for administration 3/23/26 through 3/25/26.<br><br>A review of R3's clinical record revealed a physician's order dated 3/23/26 for Ciprofloxacin 500mg (milligrams)- one tablet two times a day for five days for a urinary tract infection. R3's March 2026 MAR (medication administration record) documented the same physician's order.<br><br>A nurse's note dated 3/23/26 documented, Ciprofloxacin Oral Tablet 500 MG (milligrams). Give 1 tablet by mouth two times a day for UTI (Urinary Tract Infection) for 5 Days. Waiting for pharmacy to deliver medication.<br><br>A nurse's note dated 3/24/26 documented, Cipro not available. Mistakenly signed it. Pharmacy will deliver later.<br><br>A nurse's note dated 3/25/26 documented, Ciprofloxacin Oral Tablet 500 MG. Give 1 tablet by mouth two times a day for UTI for 5 Days. Checked med (medication) bank, med not available, notified unit manager.<br><br>A nurse's note dated 3/25/26 documented, Ciprofloxacin Oral Tablet 500 MG. Give 1 tablet by mouth two times a day for UTI for 5 Days. Pharmacy called and they said they sent medication but medication not on hand, unit manager notified.<br><br>A nurse's note dated 3/26/26 documented, Complete antibiotic timeout under assessment one time only for Antibiotic timeout for 1 Day. RESIDENT RECEIVED FIRST DOSE TODAY.<br><br>The med bank was a machine in the facility that contained various medications. A review of the med bank list revealed the machine should have contained at least ten tablets of Ciprofloxacin 250mg.<br><br>On 5/13/26 at 9:48 a.m. an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated that if a medication is not available, the nurse should obtain the medication from the med bank and call the pharmacy. LPN #1 stated that if the medication is not in the med bank, the nurse should call the pharmacy and have them deliver the mediation stat on a delivery separate from the two routine daily deliveries.<br><br>On 5/13/26 at 2:00 p.m. the Administrator and Director of Nursing were made aware of the above concern.<br><br>The facility policy titled, Medication Administration failed to document the facility process for obtaining medications that are not available.<br><br>The facility Corrective Action Plan dated 4/8/26 documented, Problem Identified: Medication not available. Address how corrective action will be accomplished for resident(s) found to have been affected: Notification to provider when medication is not available and the process of obtaining<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medication when it is not available. Address how corrective action will be accomplished for resident (s) having potential to be affected by the same issue needing to be addressed: Other residents could be affected by this practice. Address what measures will be put in place or system changes made to ensure that the identified issue does not occur in the future: All licensed nurses were re-educated by the SDC (Staff Development Coordinator) on proper method of following up on medications not available and notifying provider/RP (Responsible Party). Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The Unit Managers will run missed medication and not available medication reports, follow up until resolved for 5x week for (4) weeks. The results of these reviews will be presented to QAPI (Quality Assurance Performance Improvement) for review and recommendation. The documented completion dated was 5/6/26. All credible evidence was reviewed and verified during the survey.<br><br>PAST NON-COMPLIANCE<br><br>2. For Resident #5 (R5), the facility staff failed to ensure medication was available for administration.<br><br>The physician orders for R5 documented in part, Erythromycin Ophthalmic Ointment 5 MG/GM (milligram/gram) (Erythromycin (Ophth)) (1), Instill 1 centimeter in left eye, four times a day for Shingles for 7 Days. Order Date: 4/1/2026.<br><br>Review of the eMAR (electronic medication administration record) for R5 dated 4/1-4/30/2026 documented the Erythromycin ophthalmic ointment started on 4/1/2026 with missed doses on 4/3/2026 at 9:00 AM and 12:00 PM. The eMAR documented the medication not available for those doses.<br><br>The progress notes for R5 documented in part,<br><br>- Effective Date: 03/31/2026 23:19 (11:19 PM) Type: [Name of wound care practice] skin and wound note . Upon assessment, Pt noted to have Herpes Zoster (2) (shingels) [sic] rash on left forehead, left face, and left nose bridge, and left eye, herpes zoster ophthalmicus (HZO) with Viral Conjunctivitis (3) . ophthalmologist consult STAT (now) .<br><br>- Effective Date: 03/31/2026 14:38 (2:38 PM) Type: Health Status Note. Note Text: spoke w/resident's daughter and she is going to schedule eye appt/transport for resident- resident has shingles on his face, possibly in eye. Was seen by NP and Wound NP and orders placed. resident moved to isolation room.<br><br>- Effective Date: 04/01/2026 12:56 (PM) Type: Pharmacy Note Text: Call placed to pharmacy to have the Erythromycin ointment sent STAT (now). Pharmacy stataed [sic] it will be sent stat .<br><br>- Effective Date: 04/03/2026 09:00 (9:00 AM) Type: eMAR - Administration Note. Note Text: Erythromycin Ophthalmic Ointment 5 MG/GM. Instill 1 centimeter in left eye four times a day for Shingles for 7 Days. Medication on order, not administered. NP (nurse practitioner) & RP (responsible party) notified.<br><br>- Effective Date: 04/03/2026 14:04 (2:04 PM) Type: eMAR (electronic medication administration record)- Administration Note. Note Text: Erythromycin Ophthalmic Ointment 5 MG/GM. Instill 1<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | centimeter in left eye four times a day for Shingles for 7 Days. Medication on order, not administered. NP & RP notified.<br><br>Review of the visit summary note from the retina specialist who examined R5 on 4/1/2026 documented a copy of a prescription for Erythromycin ointment into the left eye, four times a day.<br><br>On 5/12/2026 at 1:38 PM, an interview was conducted with the nurse practitioner who stated that the erythromycin eye ointment was ordered by the eye doctor for R5. She stated that it was an eye antibiotic used to reduce the risk of infection due to R5 having drainage to the eye and they were doing everything they could to preserve vision in the eye. She stated that her expectation would be for R5 to receive the full dosing of the medication.<br><br>On 5/13/2026 at 9:20 AM, an interview was conducted with licensed practical nurse (LPN) #2 who stated that after the nurse practitioner had diagnosed R5 with shingles he had gone to the eye doctor the next day who had ordered the erythromycin ointment. She stated that she was not aware of any problems getting the medication to the facility and was not sure why R5 missed the 9:00 AM and 12:00 PM doses of the medication on 4/3/2026 but it came in a small tube, and they may have run out. LPN #2 stated that when medications were not available, staff were to check the cart twice, then check the pyxis (back up medication system) for availability and notify the pharmacy. She stated that they also notified the nurse practitioner and the responsible party.<br><br>On 5/13/2026 at 11:18 AM, an interview was conducted with the Director of Nursing who stated that she had to clarify the erythromycin ointment order when it first came back from the eye doctors office because it was missing some details, but she was not aware of any delays getting the medication started. She stated that the pharmacy came in twice a day to deliver medications and medications were delivered that evening if entered by 12:00 PM and they could also order the medication stat.<br><br>On 5/13/2026 at 1:53 PM, the Regional Administrator and the Director of Nursing were made aware of the concern.<br><br>No further information was provided prior to exit.<br><br>Past non-compliance<br><br>Reference:<br><br>(1) Ophthalmic erythromycin is used to treat bacterial infections of the eye. This medication is also used to prevent bacterial infections of the eye in newborn babies. Erythromycin is in a class of medications called macrolide antibiotics. It works by killing bacteria that cause infections . This information was obtained from the website: Erythromycin Ophthalmic: MedlinePlus Drug Information<br><br>(2) Shingles (herpes zoster) is an infection that causes a painful rash. It is caused by the varicella-zoster virus (VZV). This is the same virus that causes chickenpox. After you have chickenpox, the virus stays in your body. It may not cause problems for many years. But as you get older, the virus may become active again and cause shingles . This information was obtained from the website: Shingles \| Herpes Zoster \| MedlinePlus<br><br>(3) Conjunctivitis is the medical name for pink eye. It involves inflammation of the outer layer of the eye and inside of the eyelid. It can cause swelling, itching, burning, discharge, and redness. Causes (continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | include:<br><br>Bacterial or viral infection<br><br>Allergies<br><br>Substances that cause irritation<br><br>Contact lens products, eye drops, or eye ointments<br><br>Pink eye usually does not affect vision. Infectious pink eye can easily spread from one person to another. The infection will clear in most cases without medical care, but bacterial pink eye needs treatment with antibiotic eye drops or ointment . This information was obtained from the website: Conjunctivitis \| Pink Eye \| MedlinePlus |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to follow medication orders for administration for one of eight residents in the survey sample, Resident #5. The findings include:For Resident #5 (R5), the facility staff failed to hold medication according to the ordered parameters. The physician orders for R5 documented in part, Metoprolol Succinate ER (extended release) (1) Oral Tablet Extended Release 24 Hour 25 MG (milligram) (Metoprolol Succinate) Give 1 tablet by mouth one time a day for HTN (hypertension) hold for SBP (systolic blood pressure) <100 or HR (heart rate) <60. Start Date: 04/24/2026. Review of the eMAR (electronic medication administration record) for R5 dated 4/1-4/30/2026 documented the Metoprolol Succinate ER administered on 4/25/2026 at 9:00 AM with a heart rate documented at 55. On 5/13/2026 at 9:20 AM, an interview was conducted with licensed practical nurse (LPN) #2 who stated that when administering medication that contained administration parameters they checked the vital signs first and then went to the order to review if the medication needed to be held or given. She reviewed the eMAR for R5 and stated that according to the order for the Metoprolol it should have been held on 4/25/2026 because the heart rate was below 60 which was in the order. LPN #2 stated that the nurse should have documented that the medication was held and notified the nurse practitioner. The facility policy Medication Administration revised 9/25, documented in part, .Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters . On 5/13/2026 at 1:53 PM, the Regional Administrator and the Director of Nursing were made aware of the concern. No further information was provided prior to exit. Reference:(1) 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 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495233 | A. Building<br>B. Wing | 05/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Poplar Hill Health and Rehab | 360 Hospital Drive<br>Warrenton, VA 20186 |

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 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>Based on observation, staff interview and facility document review, facility staff failed to provide residents with the correct amount of food according to the facility's menu in one of one facility kitchens.The findings include:On 05/12/2026 at approximately 12:00 p.m. an observation in the facility's kitchen revealed Dietary Manager plating lunch for the residents. The lunch menu consisted of whole chicken leg quarters, whole mixed vegetables, cubed potatoes, chopped chicken, pureed chicken, mash potatoes and pureed mixed vegetables. Observations of the serving utensils being used by the Dietary Manager to plate the food revealed she was using a green handle scoop for whole mixed vegetables, cubed potatoes, chopped chicken, ground chicken, pureed chicken, mash potatoes and pureed mixed vegetables. Continued observations revealed the Dietary Manager placed one scoop of each of the food items list above on each of the residents' lunch plates.The facility's Diet Spreadsheet for lunch on 05/12/2026 documented in part, Week 3. Tuesday. Regular. Lunch. Seasoned diced potatoes. Portion Size: 4 oz (four ounce) spdl (spoodle - type of portion control serving spoon), Four Way Mixed Vegetables. Portion Size: 4 oz spdl. Ground Baked Chicken Breast w/(with) Thick Gravy. Portion Size: #8 (number eight) scp (scoop). Pureed Baked Chicken Quarter. Portion Size: #8 scp., Mashed Potatoes & (and) Gravy. Portion Size: #8 scp.The kitchen's Scoop Size Chart reference sheet revealed pictures of different colored scoop handles indicating the following: [NAME] handle Scoop #6 - 5 ˆ OZ, Grey handle Scoop #8 - 4 OZ, Beige handle Scoop #10 - 31/4 OZ, [NAME] handle Scoop #12 - 2ˆ OZ, Blue handle Scoop #16 - 2OZ.On 05/13/2026 at approximately 9:19 a.m. an interview was conducted with the facility's Dietary Manager regarding portion control. She was asked to describe the procedure for ensuring residents receives the correct portion of food for each meal. She stated the Scoop Size Chart that is posted above the steam table is referred to make sure the residents receive the correct portion according to the Diet Spreadsheet. She further stated the correct size scoops were not used for the resident's lunch on 05/12/2026 and the residents did not receive the correct portion of food.The (Name of Dietary and Healthcare Food Services Company) policy Portion Control documented in part, Policy: Portion size is determined by the nutritional needs of the residents, federal and state regulations that specify the food groups, and portion sizes that must be served according to the facility menu. Procedure: 2. Serve portions according to the menu spreadsheet.On 05/13/2026 at approximately 1:57 p.m. the Administrator and Director of Nursing were made aware of the above findings.No further information was provided prior to exit. |

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| | 495233 | A. Building<br>B. Wing | 05/13/2026 |

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| Poplar Hill Health and Rehab | 360 Hospital Drive<br>Warrenton, VA 20186 |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation and staff interview, it was determined that the facility staff failed to serve palatable food on one of four facility units, the 400 Unit.The findings include:On 05/12/2026 at 12:00 p.m. the holding temperatures for the resident's food for lunch were obtained by the Dietary Manager in the facility's kitchen at steam table with the following results: whole chicken leg quarter-168 F (degrees Fahrenheit), whole mixed vegatables-187 F, diced potatoes- 159 F, Chopped chicken-160 F, ground chicken-166 F, pureed chicken-158 F, mashed potatoes-177 F, pureed mixed vegatables-172 F. On 05/12/2026 at 12:48 p.m., a test tray consisting of all the food item listed below was placed on a cart with other meal trays for residents and taken to the 400 Unit. At 1:10 p.m., the last lunch tray was served to a resident on the 400 Unit. The Dietary Manager was then asked to remove the covers from the two test plates and proceeded to take the temperatures of the food. Two surveyors observed Dietary Manager obtaining the food temperatures. The whole chicken leg quarter-127 F, whole mixed vegatables-112 F, diced potatoes- 123 F, pureed chicken-127 F, mashed potatoes-118 F, pureed mixed vegatables-122 F. The test tray was sampled by two surveyors and the Dietary Manager for appropriate holding temperatures and palatable taste. When asked to describe the taste of the food she stated the whole mixed vegetables and cubed potatoes were cold and not palatable.The (Name of Dietary and Healthcare Food Services Company) policy Safe Food Handling Practices documented in part, Policy: All food must be purchased, prepared and distributed in a clean, safe manner while promoting safe food handling in compliance with state and federal guidelines. Procedure: Hot foods are served at 135 degrees or higher and cold foods are served at 41 degrees or lower.On 05/13/2026 at approximately 1:57 p.m. the Administrator and Director of Nursing were made aware of the above findings.No further information was provided prior to exit. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations and staff interviews, the facility staff failed to prepare food in a sanitary manner in one of one facility kitchens.The findings include:On 05/12/2026 at approximately 11:30 an observation of OSM (other staff member) #3 kitchen aide in the facility's kitchen revealed she was placing covers on approximately 20 cups of a beverage for the resident's lunch. Further observations of OSM #3 failed to evidence she was wearing a hairnet.On 05/12/2026 at approximately 11:30 an observation of a ladder cart in the facility's kitchen revealed trays of approximately 12 plated slices of cake on each tray next to the kitchen steamer and in front of a food preparation table. Further observation of the cart failed to evidence covering over the cart of the individual slices of cake.On 5/12/26 at approximately 12:34 p.m. an observation of lunch trays being delivered to resident rooms on the 200 unit revealed the trays served with cake were uncovered, at approximately 12:45 p.m. an observation of lunch trays being delivered to resident rooms on the 300 unit revealed the trays served with cake were uncovered and at approximately 12:53 p.m. an observation of lunch trays being delivered to resident rooms on the 400 unit revealed the trays served with cake were uncovered.On 05/13/2026 at approximately 9:19 a.m. an interview was conducted with the facility's Dietary Manager regarding the observation stated above of OSM #3 not wearing a hair net and the cake not being covered. She stated the use of hair nets is to prevent hair from falling into the food and contamination of the residents' food. She further stated OSM #3 should have been wearing a hairnet. Regarding the cake not being covered she stated it should have been covered to prevent contamination.On 05/13/2026 at approximately 11:13 a.m. an interview was conducted with OSM #3 regarding the observation of not wearing a hairnet. She stated the purpose for the hair net to hair from falling into the food and contaminating the food. She stated that she forgot to put one on when she entered the kitchen.The (Name of Dietary and Healthcare Food Services Company) policy Dress Code documented in part, 7. Dietary employees should wear a hairnet covering that covers all hair completely.The (Name of Dietary and Healthcare Food Services Company) policy Handling, Serving and Transporting Foods documented in part, Procedure: 7.When serving room trays, every food item must be covered until it reaches the resident (i.e drinks, desserts, salads).On 05/13/2026 at approximately 1:57 p.m. the Administrator and Director of Nursing were made aware of the above findings.No further information was provided prior to exit. |