STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, resident interview, and facility document review, it was determined that facility staff failed to promote resident's dignity for one of 10 residents in the survey sample, Resident #8 (R8). The findings include:For R8, the facility staff failed to provide privacy for the catheter collection bag. R8 was admitted to the facility with diagnoses that included but were not limited to urinary retention (1). The admission MDS (minimum data set) was not due at the time of the survey. The facility's Clinical Admission assessment for R8 dated 08/14/2025 documented in part, Level of cognitive impairment: b. alert (some forgetfulness). On 08/25/2025 at approximately 3:47 p.m. observation of the catheter collection bag hanging on lower portion of bed uncovered. Further observation revealed the contents of the collection bag could clearly be seen. On 08/27/2025 at approximately 7:45 p.m. observation of the catheter collection bag hanging on lower portion of bed uncovered. Further observation revealed the contents of the collection bag could clearly be seen. The physician's order for R8 documented, Indwelling catheter 16FR (French) with 10cc (cubic centimeter) balloon to bedside straight drainage for diagnosis/Hx (history) of urinary retention. Order Date Date:8/14/2025. On 08/27/2025 at approximately 9:15 a.m. an interview was conducted with R8. When asked how he felt about the catheter collect bag not being covered and that the urine could be seen by anyone walking into his room, he stated that it bothered him that the urine could be seen by anyone coming into his room. The facility's policy Resident Rights Under Federal Law documented in part, 1. Resident Rights. The resident has a right to a dignified existence, self-determination, andcommunication with and access to persons and services inside and outside the facility:1.1. The facility must treat each resident with respect and dignity and care for each residentin a manner and in an environment that promotes maintenance or enhancement of his/herquality of life, recognizing each resident's individuality. On 08/27/2025 at approximately 3:10 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, interim director of nursing, were made aware of the above findings. No further information was provided prior to exit. References:(1) A condition where your bladder doesn't empty all the way or at all when you urinate. This information was obtained from the website: https://my.clevelandclinic.org/health/disease/15427-urinary-retention.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, resident interview, and staff interview, the facility staff failed to provide accommodation of needs for one of ten residents in the survey sample, Resident #6 (R6). The findings include:For Resident #6 (R6), the facility staff failed to maintain the resident's call bell within reach. On 8/25/25 at 3:37 p.m., R6 was observed lying in bed. The resident stated staff answer the call bell, but this can only happen when the call bell is within reach. R6 further stated the call bell is not always within her reach. At this time, R6's call bell was observed on the floor, out of the resident's reach. On 8/25/25 at 3:41 p. m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that when a resident is in bed, the call bell should be placed next to him or her or clipped on him or her, so the call bell is within the resident's reach. R6's call bell was observed with LPN #1. LPN #1 stated the call bell was not within R6's reach. On 8/26/25 at 4:08 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the interim director of nursing) were made aware of the above concern. No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on staff interview, clinical record review and facility document review, the facility staff failed to notify the responsible party as required for one of 10 current residents in the survey sample, Resident #8 (R8). The findings include:The findings include: For R8, facility staff failed to notify the responsible party (RP) that medication, Daptomycin (1), was not available for administration on 08/15/2025. R8 was admitted to the facility with diagnoses that included but were not limited to left foot infection. The admission MDS (minimum data set) was not due at the time of the survey. The facility's Clinical Admission assessment for R8 dated 08/14/2025 documented in part, Level of cognitive impairment: b. alert (some forgetfulness). The physician's order for R8 documented in part, Daptomycin Intravenous Solution Reconstituted 500 MG (milligram) (Daptomycin). Use 10 ml (milliliter) intravenously (into a vein) one time a day every other day for left foot gangreen [sic] (2) for 23 Days. Order Date Date:8/15/2025. The EMAR (electronic medication administration record) for R8 dated August 2025 documented the physician's order as stated above. Further review of the eMAR revealed it was coded HD on 08/15/2025 for Daptomycin. The Chart Codes / Follow Up Codes on the eMAR documented in part, HD=Hold/See Nurse Note. The facility's nurse's note for R8 dated 08/15/2025 documented, Daptomycin Intravenous Solution Reconstituted 500 MG. Use 10 ml intravenously one time a day every other day for left foot gangreen [sic] for 23 days, per pharmacy it will be delivered next run np (nurse practitioner) (Name of NP) aware. Review of the facility's nurse's notes for R8 dated 08/15/2025 through 08/16/2025 failed to evidence documentation of R8's responsible party being notified of the Daptomycin not being available on 08/15/2025. Review of the facility back up pharmacy system inventory list failed to evidence Daptomycin. On 08/26/2025 at approximately 1:54 p.m. LPN (licensed practical nurse) #1. When asked to describe the procedure when a physician ordered medication is not available for a resident she stated that the pharmacy is called to find out the status of the medication such as a problem with the scrip or a delay in sending the medication, notify the nurse practitioner or physician regarding the status of the medication and notify the responsible party. She further stated that the status of the medication and notification to the nurse practitioner or physician and responsible party it is documented in the progress notes. After reviewing the nursing progress notes for R8 regarding the daptomycin she stated she could not locate the documentation. The facility's policy Change in Condition: Notification of. Documented in part, A Center must immediately inform the patient, consult with the patient's physician, and notify,consistent with their authority, the patient's representative, where there is: A need to alter treatment significantly (that is, a need to discontinue or change an existing formof treatment due to adverse consequences, or to commence a new form of treatment) On 08/27/2025 at approximately 3:10 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, interim director of nursing, were made aware of the above findings. No further information was provided prior to exit. References:(1) Used to treat certain blood infections or serious skin infections caused by bacteria. This information was obtained from the website: https://medlineplus.gov/druginofo/meds/a608045.html. (2) The death of tissues in your body. This information was obtained from the website: https://medlineplus.gov/gangrene.html.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, facility document review, the facility staff failed to maintain a clean and comfortable environment for one of ten residents in the survey sample, Resident #4 The findings include: For Resident #4 (R4), the facility staff failed to maintain the resident's fall mats and floors in a clean and comfortable environment. Observation was made of R4's room on 8/25/25 at 4:02 p.m. The resident was in bed; there were fall mats on both sides of the bed. The fall mats had evidence of liquids having been spilled and the surveyor's shoes stuck to the fall mats. There were bits of paper on both sides of the bed. There were dirt and debris behind the bed and nightstand. On 8/26/25 at 10:59 a.m., an interview was conducted with OSM (other staff member) #5 (the director of environmental services). OSM #5 stated all resident rooms are cleaned every day. OSM #5 stated that in the morning, the cleaning consists of pulling the trash, cleaning surfaces, sweeping, moping, cleaning the bathroom, and replacing toiletries. OSM #5 stated that later in the day, the housekeeping staff completes a walk through and the walk through consists of pulling the trash, cleaning debris on the floor, wiping the bedside tables, pulling the trash, and replacing toiletries. OSM #5 stated fall mats should be lifted up, pulled away from the bed, and cleaned every day.A second observation was made on 8/26/25 at 2:00 p.m. The resident was not in bed but both fall mats were down. There was evidence of spills on the fall mats. An interview was conducted with OSM (other staff member) #9, environmental services, on 8/26/25 at 2:03 p.m. OSM #9 observed the fall mats and stated there were in need of cleaning. The facility policy, Accommodation of Needs, documented in part, The resident/patient (hereinafter patient) has the right to a safe, clean, comfortable, and homelike environment including, but not limited to, receiving treatment and support for daily living safely.ASM (administrative staff member) #1, the administrator, and ASM #2, the acting director of nursing, were made aware of the above concern on 8/27/25 at 3:11 p.m. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to evidence efforts to resolve a grievance for one of ten residents in the survey sample, Resident #1.The findings include: For Resident #1 (R1), the facility staff failed to evidence efforts to resolve a written grievance sent to the former administrator by R1's responsible party in November 2024. This is cited as past non-compliance with a date of compliance of 5/10/2025.A review of the facility grievances from 1/1/2024 to the present documented one grievance dated 4/13/2024 for care concerns. The grievances failed to evidence any concerns from November 2024.On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/9/2025 the resident was assessed as being severely impaired for making daily decisions. The resident was assessed as being dependent on staff for ADLs (activities of daily living).The resident demographic information documented a family member as the responsible party and health care representative.On 8/25/2025 at 2:56 p.m., a telephone interview was conducted with R1's responsible party who stated that they had sent a written complaint to the former administrator back in November 2024 regarding concerns regarding wound care procedures and other care concerns. R1's responsible party stated that they were told that the administration was looking into her concerns, but she never received any follow up or resolution on the concerns.On 8/26/2025 at 1:22 p.m., an interview was conducted with ASM (administrative staff member) #3, former director of nursing. ASM #3 stated that she recalled ASM #6 receiving a letter from R1's responsible party and she was pretty sure that the former administrator had investigated the situation and followed up with the family member.On 8/27/2025 at 9:47 a.m., an interview was conducted with ASM #6, former administrator. ASM #6 stated that she remembered R1's responsible party emailing something to her with something about wounds in it. She stated that if she remembered correctly she thought that the former director of nursing had investigated it and discussed the concerns thoroughly with R1's responsible party. ASM #6 stated that she was not sure if an official grievance was completed but it probably should have been since it was sent in an email. She stated that she did recall that an investigation was completed and a timeline was done and discussion completed with the responsible party. ASM #6 stated that R1's responsible party came in frequently and had concerns often which were all addressed directly.On 8/27/2025 at 12:27 p.m., an interview was conducted with ASM #1, the current administrator. ASM #1 stated that grievances could come from residents or family and came in writing or verbally. She stated that when a family had a concern they tried to have a meeting within 72 hours to discuss any concerns and a resolution. She stated that when she started working at the facility they had identified a gap in the grievance procedure and had implemented a performance improvement project for identification and resolution of grievances. ASM #1 stated that now they had a whiteboard that they documented the grievances on, came up with a response within two days and the manager followed up with the family member to make sure the issue was resolved. She stated that she could not find any documentation of the concern sent in by R1's responsible party in November 2024.On 8/27/2025 at 1:08 p.m. , ASM #1 provided evidence of the performance improvement project for grievances with a date of compliance of 5/10/2025.Review of the plan of correction for Grievances included an assessment of the current problem, a root cause analysis of the identified problem, a plan to correct the problem and the team responsible for implementing the plan of correction. Review of the plan of correction documented an audit of the 2023 and 2024 grievances, education provided to all department heads on the grievance procedure, implementation of new processes, and audits of grievances. Review of the education, audits and tracking from 5/10/2025 to the present documented resolution of concerns. Implementation of the plan of correction was verified by resident and staff interviews. There were no current concerns regarding grievance resolution or follow-up during the survey dates.The facility policy Grievance/Concern revised 10/15/24 documented in part, .The Administrator will serve as the Grievance Officer who is responsible for overseeing the grievance process, including Civil Rights grievances/concerns, receiving and tracking grievances through to their conclusion, leading any necessary investigations by the facility, maintaining the confidentiality of all information associated with grievances, for example, the identity of the patient for those grievances submitted anonymously, issuing written grievance decisions to the patient, and coordinating with state and federal agencies, in consultation with the National Law Department, as necessary in light of specific allegations.On 8/27/2025 at 3:11 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the interim director of nursing were made aware of the findings cited as past non-compliance No further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to submit an MDS (minimum data set) assessment in the required timeframe for one of ten residents in the survey sample, Resident #7.The findings include:For Resident #7 (R7), the facility staff failed to submit the admission MDS assessment within fourteen days of admission.Review of the facesheet for R7 documented an admission date of 8/9/2025.Review of the MDS assessments for R7 documented an admission assessment with an ARD (assessment reference date) of 8/15/25 in progress. The assessment failed to show a completion or submission date.On 8/26/2025 at 2:33 p.m., an interview was conducted with LPN (licensed practical nurse) #8, MDS coordinator. LPN #8 stated that the admission MDS was completed and submitted before the fourteenth day after admission. She stated that some of the MDS assessments had gotten behind due to staffing issues.According to the RAI (Resident Assessment Instrument) 3.0 User's Manual Version 1.19.1 October 2024, documented in part, .OBRA-Required Tracking Records and Assessments are Federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include: Tracking records: Entry, Death in facility. Assessments: admission (comprehensive). Assessment Type/Item Set- admission (Comprehensive) - Assessment Reference Date (ARD) (Item A2300) No Later Than: 14th calendar day of the resident's admission (admission date + 13 calendar days).On 8/27/2025 at 3:11 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the acting director of nursing were made aware of the findings.No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **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 develop and implement a baseline care plan for two of 10 residents in the survey sample, Resident #2 (R2) and R7. The findings include:1. For R2, facility staff failed to develop a baseline care plan for oral hygiene. R2 was admitted to the facility with diagnoses that included but were not limited to muscle weakness. On the most recent MDS (minimum data set), a 5 (five)-Day assessment with an ARD (assessment reference date) of 02/12/2024, R2 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. The baseline care plan for R2 dated 02/09/2024 documented, “Focus: Resident has COVID 19 (coronavirus disease 2019) infection. Date Initiated: 02/09/2024. Created on: 02/09/2024.; Resident/Patient requires assistance/is dependent for mobility related to: Date Initiated: 02/09/2024. Created on: 02/09/2024. ” On 08/27/2025 at approximately 2:30 p.m. an interview was conducted with LPN (licensed practical nurse) #8, MDS coordinator. When asked how and when a resident’s baseline care plan is developed She stated that it is developed on the day of admission and they gather information from the resident’s record, care concerns, physician’s orders and diagnoses. LPN #8 was asked to review R2’s baseline care plan dated 02/09/2024 as described above. She further stated that a baseline care plan for R2 was not developed. The facility’s policy “Person-Centered Care Plan” documented in part, The Center must develop and implement a baseline person-centered care plan within 48 hours of admission/readmission for each patient/resident (hereinafter “patient”) that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care. The baseline care plan will ensure that patients who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for patients’ experiences and preferences.” On 08/27/2025 at approximately 3:10 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, interim director of nursing, were made aware of the above findings. No further information was provided prior to exit. 2. For Resident #7 (R7), the facility staff failed to implement the baseline care plan to provide pressure injury treatment as ordered on 8/15/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS (minimum data set) assessment was not completed at the time of the survey. The nursing admission assessment dated [DATE] documented no skin issues. The baseline care plan for R7 documented in part, “Resident at risk for skin breakdown related to actual pressure ulcer, Advanced age(greater than 75 years), impaired cognition, incontinence, shear/friction risks. Resident has actual skin impairment: bruises to right outer forearm, right outer wrist, right and left antecubital space and left dorsum hand, and stage 2 to right Ischial Tuberosity. Date Initiated: 08/11/2025. ” Under “Interventions” it documented in part, “…Provide wound treatment as ordered. Date Initiated: 08/11/2025…” The physician orders for R7 documented in part, “Clean area to right Ischial tuberosity with NS (normal saline), pat dry, apply calcium alginate and cover with dressing. Every day shift for wound care. Order Date: 08/11/2025.” Review of the eTAR (electronic treatment administration record) for R7 dated 8/1/25-8/31/25 failed to evidence treatment to the right ischial tuberosity wound completed on 8/15/2025. The progress notes for R7 failed to evidence refusal of the wound treatment on 8/15/2025. On 8/26/2025 at 2:55 p.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that wound care was completed by the wound nurse during the weekdays and by the floor nursing staff when she was not there and on weekends. She stated that the staff evidenced the treatments being done by dating the dressings before they applied them and by signing them off on the eTAR when done. LPN #4 stated that the purpose of the care plan was to document the things that they identified and put in place for goals and to prevent anything from happening. She stated that the care plan should be implemented for resident safety. On 8/27/2025 at 3:11 p.m., ASM (administrative staff member) #1 and ASM #2, the interim director of nursing were made aware of the concern. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to develop and/or implement the comprehensive care plan for three of ten residents in the survey sample, Resident #3, Resident #1, and Resident #8. The findings include: 1. For Resident #3, the facility staff failed to implement the comprehensive care plan to utilize two persons for bed mobility, resulting in the resident falling out of the bed and suffering a fracture of the distal right femur of the right below the knee amputation. The comprehensive care plan dated, 9/15/23, and with a readmission date of 9/23/23, documented in part, “Focus: Resident/Patient requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to: Amputation of R (right) BKA (below the knee amputation).” The interventions documented in part, “8/17/23 - Provide resident/patient with extensive assist of 2 for bed mobility.” The CNA Kardex dated, 8/25/25, documented in part, “Ambulation/Mobility/Transfers - Provide - resident/patient with extensive assist of 2 for bed mobility.” The admission nurse’s note dated, 9/23/23 at 2300 (11:00 p.m.), documented in part, “She is 2 person assist for her ADLs. Incontinence for her bowel and bladder.” The nurse’s note dated, 9/24/23 at 3:16 a.m. documented, “Resident had a fall at 0200 (2:00 a.m.). When the aide was changing her, she rolled over and slipped out of bed. She had a small skin tear on her right stump. Writer put a dressing on her right stump. Vitals are wnl (within normal limit). Resident complained for pain 10/10. Called 911 at 0245 (2:45 a.m.) Resident left the building at 0300 (3:00 a.m.). ” An interview was conducted with LPN #6 on 8/26/25b at 10:10 a.m. LPN #6 reviewed the care plan and stated the admission date is on the care plan so that it was in effect at the time of the fall. The Kardex was reviewed with LPN #6. LPN#6 stated even though it was dated 8/25/23, it was still in effect until any changes are made. An interview was conducted with LPN #3 on 8/26/25 at 10:46 a.m. LPN #3 stated the purpose of the care plan is to provide adequate care for the well-being of the residents. She stated it should be followed. The above care plan was reviewed with LPN #6. LPN #6 stated if the care plan says two person assist then there should be two people in the room while providing care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, “Person Centered Care Plan,” documented in part, “The Center must develop and implement a baseline person-centered care plan within 48 hours of admission/readmission for each patient/resident (hereinafter “patient”) that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care… A comprehensive, individualized care plan will be developed within seven days after completion of the comprehensive assessment (admission, annual or significant change in status) and review and revise the care plan after each assessment. After each assessment means after each assessment known as the Resident Assessment Instrument (RAI) or Minimum Data Set (MDS). Care plan includes measurable objectives and timetables to meet a patient’s medical, nursing, nutrition, and mental and psychosocial needs that are identified in the comprehensive assessments. For newly admitted patients, the comprehensive care plan must be completed within seven days of the completion of the comprehensive assessment and no more than 21 days after admission.” ASM (administrative staff member) #1, the administrator and ASM #2, the acting director of nursing, were made aware of the above concern on 8/26/25 at 4:04 p.m. No further information was provided prior to exit. 2. For Resident #1 (R1), the facility staff failed to A) implement the comprehensive care plan to provide incontinence care/toileting assistance on multiple dates in 12/2024, 1/2025 and 2/2025, B) implement the comprehensive care plan to provide pressure injury treatment as ordered for dates in January and February 2025 and C) develop the comprehensive care plan to address contracture management. On the most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 1/9/2025, the resident was assessed as being severely impaired for making daily decisions. R1 was assessed as always being incontinent of bowel and bladder and being dependent on staff for toileting hygiene. It documented R1 having functional limitation in range of motion to both upper and lower extremities with no splint or brace assistance use. The assessment further documented R1 having one Stage II pressure injury and two unstageable pressure injuries. The comprehensive care plan for R1 documented in part, - “Resident is incontinent of bowel and bladder and is unable to cognitively or physically participate in a retraining program. Date Initiated: 03/29/2024.” Under “Interventions” it documented in part, “Provide incontinence care to maintain dignity and comfort and to prevent incontinence related complications… Date Initiated: 03/29/2024.” - “Wound Management. Date Initiated: 03/18/2024.” Under “Interventions” it documented in part, “…Provide wound care per treatment order. Date Initiated: 03/18/2024. ” The care plan failed to evidence documentation regarding management of R1’s contracture of the lower leg. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A) Review of the ADL (activities of daily living) documentation for R1 from 12/1/2024-12/31/2024 failed to evidence incontinence care provided on day shift on 12/20/24, 12/23/24, and 12/31/24, on evening shift on 12/12/24, 12/18/24, 12/20/24, and 12/23/24 and on night shift on 12/15/24 and 12/31/24. The dates were blank or documented with “-97” with the documentation key showing “-97-not applicable. ” Review of the ADL documentation for R1 from 1/1/2025-1/31/2025 failed to evidence incontinence care provided on day shift on 1/9/25, 1/13/25, 1/20/25, 1/24/25, 1/25/25, 1/28/15, and 1/29/25, on evening shift on 1/3/25, 1/5/25, 1/7/25, 1/9/25, 1/18/25, 1/20/25, 1/24/25, 1/27/25, and 1/30/25. The dates were blank or documented with “-97” with the documentation key showing “-97-not applicable.” Review of the ADL documentation for R1 from 2/1/2025-2/28/2025 failed to evidence incontinence care provided on day shift on 2/3/25 and 2/15/25, on evening shift on 2/11/25, 2/15/25, 2/16/25 and 2/19/25. The dates were blank or documented with “-97” with the documentation key showing “-97-not applicable.” On 8/27/2025 at 11:30 a.m., an interview was conducted with CNA (certified nursing assistant) #4 who stated that incontinence care was provided every two hours and as needed during the shift. She stated that the care provided to residents was evidenced by their documentation in the electronic medical record. CNA #4 stated that there should be no blanks or “97” on the documentation because it meant “not applicable.” She stated that if a resident was always incontinent it should never be “not applicable” for incontinence care, and it should be dependent and 1- or 2-person assistance for each shift. On 8/26/2025 at 2:55 p.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that the purpose of the care plan was to document the things that they identified and put in place for goals and to prevent anything from happening. She stated that the care plan should be implemented for resident safety. B) The physician orders for R1 documented in part, - “Venelex External Ointment (Balsam Peru Castor Oil) Apply to sacrum topically every day and evening shift for wound to sacrum. Start Date: 11/22/2024.” - “Calcium Alginate-Silver External Pad 4 (Calcium Alginate-Silver) Apply to Left Gluteus topically every day shift for Wound. Cleanse left Gluteus wound with NS (normal saline), pat dry, skin prep wound edges, apply calcium alginate - silver to wound bed and cover with dry dressing daily. Start Date: 12/28/2024. ” - “Desitin Maximum Strength External Paste 40 % (Zinc Oxide (Topical)) Apply to sacrum topically every shift for MASD (moisture associated skin damage). Start Date: 12/27/2024.” - “Povidone-Iodine External Solution 10 % (Povidone-Iodine) Apply to right heel topically every day shift for wound care. Clean right heel with NS, pat dry, apply gauze soaked in Povidine and then dry gauze, wrap with Kling and ace bandage. Start Date: 01/15/2025.” (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the eTAR (electronic treatment administration record) for R1 dated 12/1-12/31/24 failed to evidence treatment to the sacrum on 12/24/24 evening shift. Review of the eTAR for R1 dated 1/1-1/31/25 failed to evidence treatment to the Left gluteus wound on 1/17/25, 1/19/25, 1/27/25, and 1/31/25, the sacrum on day shift on 1/17/25, and 1/19/25, and the right heel on 1/17/25, 1/19/25, 1/27/25, and 1/31/25. The progress notes for R1 failed to evidence refusal of the wound treatment on the dates listed above. On 8/26/2025 at 2:55 p.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that wound care was completed by the wound nurse during the weekdays and by the floor nursing staff when she was not there and on weekends. She stated that the staff evidenced the treatments being done by dating the dressings before they applied them and by signing them off on the eTAR when done. LPN #4 stated that the purpose of the care plan was to document the things that they identified and put in place for goals and to prevent anything from happening. She stated that the care plan should be implemented for resident safety. C) Review of the diagnosis information for R1 documented a diagnosis of contracture of muscle, unspecified lower leg dated 11/21/2024. The progress notes for R1 documented in part, - “09/11/2024 physiatry progress note… PRIOR FUNCTIONAL STATUS: Patient resides in a long term care facility. Patient is a long-term care resident of the facility who was max dependent for transfers to wheelchair or geriatric chair depending on the day. Patient has a knee brace to prevent contractures. Patient uses a manual wheelchair and a mechanical lift for transfers…” The physician orders documented in part, - “Resident to wear right hand splint for 3-6(hrs.)on and as tolerated at night with skin checks as well as tolerated check skin pre/post application. Hand wash and leave to dry as needed for hygiene purposes. Order Date: 08/02/2024. End Date: 09/05/2024.” - “Resident to wear Left leg brace for >6(hrs.)on and as tolerated at night with skin checks as well as tolerated check skin pre/post application. Hand wash and leave to dry as needed for hygiene purposes. Order Date: 08/02/2024. End Date: 09/06/2024.” Review of the physical therapy discharge summaries for R1 documented services provided between 3/18-4/10/24, 6/19-8/2/24, 9/9-10/24/24, 11/22-12/10/24, and 1/6-2/4/25. The PT (physical therapy) Discharge summary dated [DATE] documented in part, “…Discharge recommendations: wear knee flexion brace to L knee 7x a week 6hrs daily with occasional skin checks performed. Can wear over night to patients tolerance .” (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The PT Discharge summary dated [DATE] documented in part, “…Discharge Recommendations: donn [sic] knee flexion contracture brace every day in gerichair unit manager has video demonstration for reference…” The PT Discharge summary dated [DATE] documented in part, “…Discharge recommendations. 24-hour care, Splint/brace and home exercise program for ROM (range of motion)/Contracture management. ” On 8/27/2025 at 9:25 a.m., an interview was conducted with OSM (other staff member) #6 who stated that R1 was treated by therapy off and on during their stay at the facility for contracture management. She stated that R1 wore the knee brace as tolerated and would often refuse to wear it. She stated that when they discharged R1 they would train the nursing staff and the family on application of the brace and expected the brace to be applied as tolerated throughout R1’s stay at the facility. She stated that R1 was still able to use the knee brace until around January 2025 when there was a steady decline and she went to the hospital. She stated that R1 used the knee brace for contracture management since she was first admitted to the facility. On 8/27/2025 at 10:58 a.m., an interview was conducted with LPN (licensed practical nurse) #9 who stated that the care plan was developed by staff based on the needs of the resident. She stated that a resident at risk for contractures or a resident who used a splint or brace should have it addressed on the care plan. She stated that normally there was an order for the splint or brace and a place for them to sign them off on the treatment record. On 8/27/2025 at 3:11 p.m., ASM (administrative staff member) #1 and ASM #2, the interim director of nursing were made aware of the concerns. No further information was provided prior to exit. 3. For R8, the facility staff failed to follow the comprehensive care plan for an indwelling urinary catheter (1). R8 was admitted to the facility with diagnoses that included but were not limited to urinary retention (2). The admission MDS (minimum data set) was not due at the time of the survey. The facility’s “Clinical Admission” assessment for R8 dated 08/14/2025 documented in part, “Level of cognitive impairment: b. alert (some forgetfulness).” On 08/26/2025 at approximately 8:18 a.m. observation of R8’s catheter collection bag (3) revealed it was lying flat on the floor next to R8’s bed. The comprehensive care plan for R8 dated 08/19/2025 documented in part, “Focus. Resident requires indwelling foley catheter Date Initiated: 08/19/2025. Under “Interventions” it documented in part, “Keep catheter off floor.” On 08/26/2025 at approximately 2:55 p.m. an interview was conducted with LPN (licensed practical nurse) #4. When asked about the purpose of a resident’s care plan she stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the purpose of the care plan is to document things we have seen and to put in intervention to prevent anything from happening and show the resident goals. It should be implemented, for resident safety. On 08/27/2025 at approximately 3:10 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, interim director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: (1) A tube placed in the body to drain and collect urine from the bladder. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm. (2) A condition where your bladder doesn’t empty all the way or at all when you urinate. This information was obtained from the website: https://my.clevelandclinic.org/health/disease/15427-urinary-retention. (3) Urine drainage bags collect urine. Your bag will attach to a catheter (tube) that is inside your bladder. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000142.htm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on staff interview, facility document review and clinical record review, the facility staff failed to review and revise the comprehensive care plan for four of ten residents, Residents #5, # 9, #1, and #10. The findings include: 1. For Resident #5 (R5), the facility staff failed to review and revise the resident's comprehensive care plan regarding a fall on 12/13/24. A review of R5's clinical record revealed a nurse's note dated 12/13/24 that documented the resident was observed lying on the floor in the bedroom. Further review of R5's clinical record failed to reveal the resident's comprehensive care plan dated 10/10/23 was reviewed and revised regarding the 12/13/24 fall. On 8/26/25 at 1:55 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the purpose of the care plan is to maintain each resident's well-being and safety. LPN #3 stated a resident's care plan should be updated when a resident falls. On 8/26/25 at 4:08 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the interim director of nursing) were made aware of the above concern. The facility policy titled, Person-Centered Care Plan documented, 7. Care plans will be: 7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals . No further information was presented prior to exit. 2. For Resident #9 (R9), the facility staff failed to review and revise the resident's comprehensive care plan regarding falls on 4/30/25 and 8/3/25. A review of R9's clinical record revealed a nurse's note dated 4/30/25 that documented the resident was observed sitting on the floor in the bathroom, and a nurse's note dated 8/3/25 that documented the resident was observed sitting on the floor in front of the bed. Further review of R9's clinical record failed to reveal the resident's comprehensive care plan dated 2/12/25 was reviewed and revised regarding the 4/30/25 and 8/3/25 falls. On 8/26/25 at 1:55 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the purpose of the care plan is to maintain each resident's well-being and safety. LPN #3 stated a resident's care plan should be updated when a resident falls. On 8/27/25 at 3:12 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the interim director of nursing) were made aware of the above concern. No further information was presented prior to exit. 3. For Resident #1 (R1), the facility staff failed to review and/or revise the comprehensive care plan after a fall on 6/16/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 1/9/2025, the resident was assessed as being severely impaired for making daily decisions. R1 was assessed as not having any falls since the previous assessment. The comprehensive care plan for R1 documented in part, “Resident is at risk for falls: cognitive loss, lack of safety awareness. Date Initiated: 03/18/2024.” The care plan failed to evidence a review or revision after the fall on 6/16/2024. Fall risk evaluations for R1 dated 3/17/24, 8/8/24, 9/7/24, 11/21/24 and 2/10/25 documented the resident at risk for falls. A change in condition evaluation dated 6/16/24 for R1 documented in part, “…Fall mats and low bed orders to be placed per DON (director of nursing) [Name of former DON]. This nurse was notified by nursing staff that the resident had fall [sic] onto the floor next to her bed. Upon entering her room, the resident was assisted back into bed with another nurse and staff. Neuro checks and vital signs checks were initiated. The resident reported that she attempted to get out of bed and rolled to the floor. No injuries were reported and no injuries observed during assessment. NP [Name of nurse practitioner] and resident RP (responsible party) [Name of RP] made aware of change in condition.” The evaluation failed to evidence a review and/or revision of the care plan. The neurological evaluation flow sheet documented checks completed per the protocol from 6/16/24-6/19/24. Review of the fall investigation dated 6/16/24 documented a fall with no injuries occurring in the resident’s room. The fall investigation failed to evidence a review and/or revision of the care plan. On 8/26/2025 at 2:55 p.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that the purpose of the care plan was to document the things that they identified and put in place for goals and to prevent anything from happening. LPN #4 reviewed R1’s care plan and stated that she did not see evidence that the care plan was reviewed and/or revised after the fall on 6/16/24. On 8/27/2025 at 1:56 p.m., an interview was conducted with LPN (licensed practical nurse) #7 who stated that the purpose of the care plan was to let staff know how to provide care and what to expect out of the resident. She stated that it documented behaviors, disease processes, and showed a quick synopsis of the patient and how to care for them. LPN #7 stated that the nurses updated the care plan after a fall and added an intervention as needed. She stated that this was done within 24 hours for prevention and safety to prevent further falls. The facility policy “Falls Management” revised 3/15/24 documented in part, “…Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. 2.1 Adjust and document individualized intervention strategies as patient condition changes…” On 8/27/2025 at 3:11 p.m., ASM (administrative staff member) #1 and ASM #2, the interim director of nursing were made aware of the concern. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit. 4. For Resident #10, the facility staff failed to review and revise the comprehensive care plan after falls on 11/18/24, 1/6/25, 2/13/25 and 5/16/25. The comprehensive care plan dated created on 9/5/24 and revised on 8/2/25, documented in part, “Focus: Resident had actual fall on 08/02/2025 d/t (due to) resident wanting to sit on floor, sliding from wheelchair, self-transferring and reaching for items on the floor. Resident is at risk for further falls r/t (related to) cognitive loss, lack of safety awareness and he has impulsive behaviors, sliding from wheelchair, self-transferring. Interventions: 9/5/24 – provide resident/patient with opportunities for choice. Arrange patient’s environment to enhance vision and maximize independence large print signs on dresser. Encourage resident to atte4nd activities that maximize their full potential while meeting their need to socialize. drawers, adequate lighting, keep items in same location per patient’s request/needs. Bed in low position. Gently guide the resident from the environment while speaking in a calm reassuring voice when needed. Assist resident/caregiver to organize belongings for a clutter-free environment in the resident’s room and consistent furniture arrangement. 11/22/24 – Bolsters to bed. Fall mats on both sides of the bed while in bed. 1/9/25 – Frequent monitoring when in bed to ensure proper positioning and the (R10) is in the center of the bed.2-3-25 – dycem under cushion to wheelchair. 2/6/25 – Use the 4Ps: consider pain, position, placement and personal needs. Provide pt (patient) assistance if needed, utilize DME (durable medical equipment) when necessary. 4/2/25 – Encourage resident to attend meals in the dining room and provide rest periods in bed after meals. If resident is up for long periods, he becomes tired will attempt self-transfer to bed and has h/o (history of) falls related to self-transferring. 6/19/25 – Reposition items as needed to location within visual field. When resident is in bed or bed-side chair place the flowing personal items within reach: fluids. When resident is up in wheelchair encourage him to be in highly visible area for cueing.” The nurse’s note 11/18/24 at 5:18 p.m. documented, “Note: responding to call for help, entered room to observe resident sitting on floor beside bed, resident stated I wanted to sit on the floor. Assessed resident. no injuries noted. Neuro (neurological) check WNL(within normal limits) for resident. assisted up and onto bed.” Review of the care plan failed to evidence documentation of the care plan being reviewed and/or revised for the above fall. The nurse’s note dated, 1/6/25 at 8:00 a.m. documented in part, “One of the nurses found him (R10) on the floor in another resident room. The resident said he was just sleeping.” Review of the care plan failed to evidence documentation of the care plan being reviewed and/or revised for the above fall. The nurse’s note dated, 2/13/25 at 7:38 a.m. documented in part, “CNA (certified nursing assistant) rounding found resident on the floor during her rounds. Resident state hi is okay, he fell by accident.” Review of the care plan failed to evidence documentation of the care plan being reviewed and/or revised for the above fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurse’s note dated 5/16/25 at 7:04 p.m. documented in part, “nurse is notified per CNA that pt slid down from the wheelchair, writer assessed the resident is next to the wheelchair, sit position, nurses help him back to his bed, denies pain, vital signs 121/73 (blood pressure),R (respirations)17,T (temperature)98.4,HR(heart rate)75.Head to toe assessment, sustain a laceration on the left intercostal/rib, ROM (range of motion) with easy, but not on left lower leg/contracture at that limb. Alertness at his baseline. Dr (doctor), aware and order neuro check, call back for changes. RP (responsible party), DON (director of nursing) aware.” Review of the care plan failed to evidence documentation of the care plan being reviewed and/or revised for the above fall. An interview was conducted with ASM (administrative staff member) #2, the acting DON, on 8/27/25 at 10:20 a.m. All of the above falls and the care plan were reviewed. ASM #2 stated that there was no evidence that the care plan was reviewed and revised for these falls ASM #1, the administrator and ASM #2 were made aware of the above concern on 8/27/25 at 3:11 p.m. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide ADL (activities of daily living) care for dependent residents to two of 10 residents in the survey sample, Residents #1 and #2.The findings include:1. For Resident #1 (R1), the facility staff failed to provide incontinence care/toileting assistance on multiple dates in December 2024, January 2025 and February 2025. On the most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 1/9/2025, the resident was assessed as being severely impaired for making daily decisions. R1 was assessed as always being incontinent of bowel and bladder and being dependent on staff for toileting hygiene. Review of the ADL (activities of daily living) documentation for R1 from 12/1/2024-12/31/2024 failed to evidence incontinence care provided on day shift on 12/20/24, 12/23/24, and 12/31/24, on evening shift on 12/12/24, 12/18/24, 12/20/24, and 12/23/24 and on night shift on 12/15/24 and 12/31/24. The dates were blank or documented with “-97” with the documentation key showing “-97-not applicable. ” Review of the ADL documentation for R1 from 1/1/2025-1/31/2025 failed to evidence incontinence care provided on day shift on 1/9/25, 1/13/25, 1/20/25, 1/24/25, 1/25/25, 1/28/15, and 1/29/25, on evening shift on 1/3/25, 1/5/25, 1/7/25, 1/9/25, 1/18/25, 1/20/25, 1/24/25, 1/27/25, and 1/30/25. The dates were blank or documented with “-97” with the documentation key showing “-97-not applicable.” Review of the ADL documentation for R1 from 2/1/2025-2/28/2025 failed to evidence incontinence care provided on day shift on 2/3/25 and 2/15/25, on evening shift on 2/11/25, 2/15/25, 2/16/25 and 2/19/25. The dates were blank or documented with “-97” with the documentation key showing “-97-not applicable.” The comprehensive care plan for R1 documented in part, “Resident is incontinent of bowel and bladder and is unable to cognitively or physically participate in a retraining program. Date Initiated: 03/29/2024.” Under “Interventions” it documented in part, “Provide incontinence care to maintain dignity and comfort and to prevent incontinence related complications… Date Initiated: 03/29/2024.” On 8/27/2025 at 11:30 a.m., an interview was conducted with CNA (certified nursing assistant) #4 who stated that incontinence care was provided every two hours and as needed during the shift. She stated that the care provided to residents was evidenced by their documentation in the electronic medical record. CNA #4 stated that there should be no blanks or “97” on the documentation because it meant “not applicable.” She stated that if a resident was always incontinent it should never be “not applicable” for incontinence care, and it should be dependent and 1- or 2-person assistance for each shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy “Activities of Daily Living (ADLs)” revised 5/1/23 documented in part, “…Activities of daily living (ADLs) include: Hygiene – bathing, dressing, grooming, and oral care; Mobility – transfer and ambulation, including walking; Elimination – toileting; Dining – eating, including meals and snacks; Communication – including speech, language, and other functional communication systems… Documentation of ADL care is recorded in the medical record and is reflective of the care provided by nursing staff…” On 8/27/2025 at 3:11 p.m., ASM (administrative staff member) #1 and ASM #2, the interim director of nursing were made aware of the concerns. No further information was provided prior to exit. 2. For R2, facility staff failed to provide oral hygiene twice a day on 02/09/2024, 02/10/2024, 02/11/2024 and on 02/12/2024. R2 was admitted to the facility with diagnoses that included but were not limited to muscle weakness. On the most recent MDS (minimum data set), a 5 (five)-Day assessment with an ARD (assessment reference date) of 02/12/2024, R2 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section GG “Functional Abilities” code R2 as requiring set-up or clean-up assistance with oral hygiene. The ADL (activities of daily living) oral hygiene tracking sheet for R2 dated February 2024 was reviewed. The ADL legend documented in part, “Oral Hygiene – The ability to use suitable items to clean teeth. Dentures (if applicable0: The ability to insert and remove dentures into and from the mouth and manage denture soaking and rinsing with the use of equipment.” On 02/09/2024 the evening shift (3:00 p.m. – 11:00 p.m.) was coded “03” (three) and the night shift (11:00 p.m. – 7:00 a.m.) was coded “97.” The ADL tracking sheet legend documented in part, “03- Personal Hygiene; 97 – not applicable.” On 02/10/2024 the day shift (7:00 a.m. – 3:00 p. m.) and evening shift were blank; the night shift was coded “01” (one). The ADL tracking sheet legend documented in part, “1- Oral Hygiene.” On 02/11/2024 the day shift (7:00 a.m. – 3:00 p.m.) and evening shift were blank; the night shift was coded “02” (two). The ADL tracking sheet legend documented in part, “2-Reason for Activity Not Occurring.” Further review of the coding on 02/11/2024 failed to evidence the reason for the activity not occurring. On 02/12/2024 the night shift was coded “03”; the day and evening shifts were blank. On 08/27/2025 at approximately 11:10 a.m. an interview was conducted with CNA (certified nursing assistant) #4. When asked to describe how often a resident should receive oral hygiene she stated two times a day. After reviewing R2’s ADL tracking sheet dated February 2024 for the coding for oral hygiene on 02/09/2024, 02/10/2024, 02/11/2024 and on 02/12/2024, CNA #4 stated R2 did not receive oral hygiene twice a day on 02/09/2024, 02/10/2024, 02/11/2024 and on 02/12/2024. On 08/27/2025 at approximately 3:10 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, interim director of nursing, were made aware of the above findings. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide care and services to promote healing of a pressure injury for two of 10 residents in the survey sample, Residents #1 and #7.The findings include:1. For Resident #1 (R1), the facility staff failed to provide pressure injury (1) treatment as ordered for dates in January and February 2025.On the most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 1/9/2025, the resident was assessed as being severely impaired for making daily decisions. R1 was assessed as having one Stage II pressure injury and two unstageable pressure injuries.The physician orders for R1 documented in part,- Venelex External Ointment (Balsam Peru Castor Oil) Apply to sacrum topically every day and evening shift for wound to sacrum. Start Date: 11/22/2024.- Calcium Alginate-Silver External Pad 4 (Calcium Alginate-Silver) Apply to Left Gluteus topically every day shift for Wound. Cleanse left Gluteus wound with NS (normal saline), pat dry, skin prep wound edges, apply calcium alginate - silver to wound bed and cover with dry dressing daily. Start Date: 12/28/2024.- Desitin Maximum Strength External Paste 40 % (Zinc Oxide (Topical)) Apply to sacrum topically every shift for MASD (moisture associated skin damage). Start Date: 12/27/2024.- Povidone-Iodine External Solution 10 % (Povidone-Iodine) Apply to right heel topically every day shift for wound care. Clean right heel with NS, pat dry, apply gauze soaked in Povidine and then dry gauze, wrap with Kling and ace bandage. Start Date: 01/15/2025.Review of the eTAR (electronic treatment administration record) for R1 dated 12/1-12/31/24 failed to evidence treatment to the sacrum on 12/24/24 evening shift.Review of the eTAR for R1 dated 1/1-1/31/25 failed to evidence treatment to the Left gluteus wound on 1/17/25, 1/19/25, 1/27/25, and 1/31/25, the sacrum on day shift on 1/17/25, and 1/19/25, and the right heel on 1/17/25, 1/19/25, 1/27/25, and 1/31/25.The progress notes for R1 failed to evidence refusal of the wound treatment on the dates listed above.The comprehensive care plan for R1 documented in part, Wound Management. Date Initiated: 03/18/2024. Under Interventions it documented in part, .Provide wound care per treatment order. Date Initiated: 03/18/2024.On 8/26/2025 at 2:55 p.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that wound care was completed by the wound nurse during the weekdays and by the floor nursing staff when she was not there and on weekends. She stated that the staff evidenced the treatments being done by dating the dressings before they applied them and by signing them off on the eTAR when done.The facility policy Skin Integrity and Wound Management revised 5/1/25 documented in part, .6. The licensed nurse will. 6.6 Perform daily monitoring of wounds or dressings for presence of complications or declines. 6.6.1 Document daily monitoring of ulcer/wound site with or without dressing.On 8/27/2025 at 3:11 p.m., ASM (administrative staff member) #1 and ASM #2, the interim director of nursing were made aware of the concerns.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. 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 when pressed. This is a sign that a pressure ulcer is 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. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.2. For Resident #7 (R7), the facility staff failed to provide pressure injury treatment as ordered on 8/15/2025.The MDS (minimum data set) assessment was not completed at the time of the survey.The nursing admission assessment dated [DATE] documented no skin issues.The physician orders for R7 documented in part, Clean area to right Ischial tuberosity with NS (normal saline), pat dry, apply calcium alginate and cover with dressing. Every day shift for wound care. Order Date: 08/11/2025. Review of the eTAR (electronic treatment administration record) for R7 dated 8/1/25-8/31/25 failed to evidence treatment to the right ischial tuberosity wound completed on 8/15/2025.The progress notes for R7 failed to evidence refusal of the wound treatment on 8/15/2025.The baseline care plan for R7 documented in part, Resident at risk for skin breakdown related to actual pressure ulcer, Advanced age(greater than 75 years), impaired cognition, incontinence, shear/friction risks. Resident has actual skin impairment: bruises to right outer forearm, right outer wrist, right and left antecubital space and left dorsum hand, and stage 2 to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, facility document review and clinical record review, the facility staff failed to implement interventions for the prevention of falls for two of 10 residents in the survey sample, Resident #3 and Resident #9. Resident #3 was assisted by one staff member on 9/24/23 at 2:00 a.m. Resident #3 was turned over in bed and rolled off the bed, suffering a right distal femoral fracture on the leg with a below the knee amputation, thus causing harm to the resident. The findings include: 1. For Resident #3 (R3), the facility staff failed to use two people to provide ADL (activities of daily living) care, per the care plan and CNA (certified nursing assistant) Kardex, resulting in the resident falling out of bed and suffering a right distal femoral fracture on the leg with a below the knee amputation. Additionally, the facility staff failed to provide evidence that a thorough investigation of the fall with serious injury. Resident #3 (R3) was admitted to the facility on [DATE], transferred to the hospital on 8/9/23. R3 was readmitted to the facility on [DATE] and discharged to the hospital on 8/20/23. The resident was readmitted on [DATE] and discharged back to the hospital on 9/18/23. R3 was readmitted back to the facility on 9/23/23 and discharged back to the hospital on 9/24/23. R3’s diagnoses included but were not limited to: dehiscence of amputation stump, disruption of wound, local infection of skin and subcutaneous tissue, congestive heart failure, heart disease, diabetes, obesity, atrial fibrillation, presence of automatic cardiac defibrillator, muscle weakness, shortness of breath, and complete traumatic amputation at level between knew and ankle. The admission nurse’s note dated, 9/23/23 at 2300 (11:00 p.m.), documented in part, “She is 2 person assist for her ADLs. Incontinence for her bowel and bladder.” The nurse’s note dated, 9/24/23 at 3:16 a.m. documented, “Resident had a fall at 0200 (2:00 a.m.). When the aide was changing her, she rolled over and slipped out of bed. She had a small skin tear on her right stump. Writer put a dressing on her right stump. Vitals are wnl (within normal limit). Resident complained for pain 10/10. Called 911 at 0245 (2:45 a.m.) Resident left the building at 0300 (3:00 a.m.). ” The comprehensive care plan dated, 9/15/23, and with a readmission date of 9/23/23, documented in part, “Focus: Resident/Patient requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to: Amputation of R (right) BKA (below the knee amputation).” The interventions documented in part, “8/17/23 - Provide resident/patient with extensive assist of 2 for bed mobility.” The CNA Kardex dated, 8/25/25, documented in part, “Ambulation/Mobility/Transfers - Provide - resident/patient with extensive assist of 2 for bed mobility.” The most recent MDS (minimum data set) assessment, a discharge assessment, with an assessment reference date (ARD) of 9/24/23, coded the resident as having no short- or long-term memory difficulties. In Section G – Functional Status, the resident was coded for bed mobility as activity occurred only once or twice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	The quarterly MDS assessment, with an ARD of 8/30/23, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section G – Functional Status, the resident was coded as requiring extensive assistance of one person for bed mobility. The hospital history and physical dated, 9/24/23 at 5:53 a.m. documented in part, “(R3), 61 y,o. (year old) female presented with leg pain. Patient was discharged from (initials of same hospital) yesterday. She went to (Name of facility) for rehab (rehabilitation). Patient says several hours passed between her arrival and someone finally attending to her. She made staff aware she needed to be changed. Staff left and came back. During the process of changing the patient was told to roll over and she inadvertently rolled off the bed. She landed in part on the right BKA stump. She had pain in leg after falling…On arrival imaging showed a right distal femoral fracture…A posterior splint was applied. Patient prefers not to return to same facility.” On 8/26/25 at 9:25 a.m.ASM (administrative staff member) #1, the administrator, stated they could not locate the investigation for the fall of 9/24/23. They were able to find three witness statements. The CNA # 2’s witness statement dated 9/25/23, documented, “On Saturday, September 23, 2023, I was doing my 3:00 a.m. rounds and when I got to room [ROOM NUMBER], she was asleep. I woke her up and asked her. Do she mind if I check to see if she was wet and she said yes, yes, she was wet, so I went to gather my supplies I need to change her with. I started to clean the front of her first. Then I asked her what was the best side to turn her on she said my good side so I went around the bed to the wall side of the bed, which is her right side, I asked her was she ready to turn on her side she say yes, I counted to three and said OK turn she grab the bed railing and started to turn on her side when she put her good leg around she just kept rolling over and she was not stopping and when she rolled over, she came down on both of her legs. I tried to stop the fall by grabbing under her shoulder blades so she will not hit her head on the dresser that was next to her bed, and as she was falling and I am screaming for help both of the LPNs (licensed practical nurses) run in to help me with her once we got her comfortable on the floor we picked her up with a Hoyer lift to put her back in bed until the ambulance got to her. Once we got her back in bed and safely. We can see that her leg was bleeding and one of the LPNs went and got some gauze and some saline water to clean the wounds to see if it was a deep cut. Once the ambulance got there and they took her to the hospital I asked do I need to do an accident report they say no because they never did accident reports on anybody there.” LPN #5’s witness statement, 9/25/23, documented, “Aide went to resident room to change resident. She rolled over to the side and slipped out of the bed. Aide called for help, writer and the other nurse went to her room right away and found resident sitting on the floor. Writer and the other nurse and the aide assisted her to the bed by using Hoyer lift. Assessed resident for injury and found skin tear to her right BKA. Writer clean the skin tear with Ns (normal saline) and put a foam dressing. Writer called the vis ta vis (on call doctor) and waited for 40 minutes but No one picked up. Then writer called on- call number in (name of facility) and talk to (LPN #6). (LPN #6) advised to send her to the hospital. Writer called 911 around 0245 (2:45 a.m.), resident left the building around 0300 (3:00 a.m.).” (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	The statement dated 9/25/23 from LPN #6, the unit manager at that time, documented, “In the early morning hours of Sunday 9/24 around 2am (on call phone has exact time) I was woken up out of my sleep with a phone call from (LPN #5) 11-7 LPN, letting me know that patient (R3) was being sent out to the hospital. She stated that the resident had just returned that evening/night before (Saturday 9/23), and that she had rolled off the bed onto the floor, and at that time the resident had some pain, but also had complaints of shortness of breath.” Three attempts were made to contact the CNA who changed the resident on 9/24/23 at 2:00 a.m. The phone did not have a voicemail system set up. No return call was received. An interview was conducted with LPN #6 on 8/26/25b at 10:10 a.m. LPN #6 reviewed her statement. She could not recall the resident or the incident. LPN #6 reviewed the care plan and stated the admission date is on the care plan so that it was in effect at the time of the fall. The Kardex was reviewed with LPN #6. LPN#6 stated even though it was dated 8/25/23, it was still in effect until any changes are made. An interview was conducted with LPN #3 on 8/26/25 at 10:46 a.m. When asked if a new admission or readmission arrives at the facility, how do you let the CNAs know how to care for the resident, LPN #3 stated she tells the CNAs assigned to the area where the resident will be and she relays what she got in report from the hospital on the resident’s care needs. LPN #3 stated the CNAs have a Kardex to refer to in PCC (initials of computerized medical record system) and once something changes it would be updated in the Kardex. LPN #3 stated the purpose of the care plan is to provide adequate care for the well-being of the residents. She stated it should be followed. The above care plan was reviewed with LPN #6. LPN #6 stated if the care plan says two person assist then there should be two people in the room while providing care. An interview was conducted with CNA #3 on 8/26/25 at 10:54 a.m. CNA #3 stated that when a new admission/readmission comes, she finds out how to care for the resident from the nurse from the report they receive from the hospital. She stated she makes the resident comfortable and waits for therapy to assess them. She stated they get a general report, and it gives them a general idea of how to care for the resident. CNA #3 stated whenever she has a new admission, she always takes two people in to provide care. She further stated once, the resident is in the computer system, she can find the information in the Kardex on how to care for the resident. CNA #3 stated the care plan information is transferred to the Kardex and that tells the CNAs how the resident transfers, how they eat, if they are a one or two person assist. It tells them everything they need to care for the resident. An interview was conducted with LPN #5, the nurse who was on duty at the time of the fall. LPN #5 stated she did recall the incident. LPN #5 stated that when a readmission/admission comes to the facility, the CNA gets verbal instructions from the nurse who received report from the hospital. She stated she believed she told the CNA involved in the fall that the resident was a two person assist. The admission note of 9/23/23 at 11:00 a.m. was reviewed with LPN #5. LPN #5 stated that the resident should have been a two person assist with her ADLs, that was her assessment of the resident upon admission. LPN #5 stated if the care plan says the resident is a two person assist for all ADLs, then yes, it should be a two person assist. ASM #1, and ASM #2, the acting director of nursing, and ASM #7, the clinical nurse consultant, were made aware of the concern for harm on 8/26/25 at 12:00 p.m. ASM #7 stated that they identified the concern this morning and stated, “We saw what you saw.” (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with ASM #3, the former director of nursing, on 8/26/25 at 1:13 p.m. The above incident was reviewed with ASM #3. ASM #3 stated she was off the weekend when it happened and did not find out about the fracture until about six months later when she was reviewing the facility quality measures. She stated the previous administrator had investigated this fracture. An interview was conducted with ASM #5, the former administrator, on 8/27/25 at 9:54 a.m. ASM #5 could not recall the incident. She stated the process for an unusual occurrence, like a fracture, they would do a thorough investigation to see if the staff member did not follow the facility policies, if the staff member needed education and/or disciplinary action. An interview was conducted with ASM #1, the current administrator, on 8/27/25 at 12:41 p.m. She stated the process for when a resident suffers a fall with injury is the CNA notifies the nurse immediately of the fall. During the week, before 5:00 p.m., the unit manager is notified, and the DON (director of nursing) is notified. If the fall occurs after hours, there is someone on call every day of the week and they are notified. First priority is to make sure the resident is safe and receives whatever care they require. Then the responsible party and doctor are notified. For a major injury the facility will send the resident out to the hospital. The fall would be investigated through the risk management program. It would be reviewed in clinical meeting. We would complete a root cause analysis. She stated she is a believer in return demonstration, if this occurred while she was here, she would have the CNA involved do a demonstration as to what happened. After the root cause analysis is completed, then, if needed, education would be provided and any disciplinary action would be taken. The facility policy, documented in part, “Fall Management,” documented in part, “PURPOSE • To identify risk for falls and minimize the risk of recurrence of falls. • To evaluate the patient for injury post-fall and provide appropriate and timely care. • To ensure the patient-centered care plan is reviewed and revised according to the patient’s fall risk status. PRACTICE STANDARDS 1. All patients will be assessed for risk of falls upon admission, with reassessments routinely (e.g., quarterly, post-fall) performed to determine ongoing need for fall prevention precautions. In the event a fall occurs, an assessment will be completed to determine possible injury. 2. Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. 2.1 Adjust and document individualized intervention strategies as patient condition changes. 3. To the extent possible, provide the patient and/or patient representative with opportunities to participate in the care planning process for risk reduction and fall reduction strategies. 4. Educate staff, patient, and/or patient representative(s) as appropriate to increase awareness of 'at risk' patients and to provide possible strategies to minimize risk for falls. Post-Fall Management: 5.1 Evaluate the patient for injury. 5.1.1 First aid will be provided for minor cuts and abrasions. 5.2 Notify the physician/advanced practice provider (APP) of the fall, report physical findings and extent of injuries, and obtain orders if indicated. 5.2.1 If the injury is of an emergent nature, the patient will be transported to the hospital. 5.2.2 If the extent of injuries cannot be determined, the nurse will notify emergency medical services (EMS) for evaluation and transport to the hospital. 5.3 Any patient who sustains an injury to the head from a fall and/or has a fall unwitnessed by staff will be observed for neurological abnormalities by performing neurological check, per policy. The physician/APP will be notified of any abnormal findings. 5.4 The patient's representative will be notified of the fall and any follow-up treatment needed. 5.5 Document circumstances of the fall, post-fall assessment, and patient outcome: 5.5.1 As a new event in the PointClickCare (PCC) Risk Management portal; 5.5.2 Change of Condition.” No further information was provided prior to exit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Resident #9 (R9) fell on 4/30/25 and 8/3/25. The facility staff failed to address and/or implement interventions to prevent future falls. A review of R9's clinical record revealed a nurse's note dated 4/30/25 that documented the resident was observed sitting on the floor in the bathroom. Further review of R9's clinical record (including the comprehensive care plan dated 2/12/25 and nurses' notes dated 4/30/25 through 8/3/25) failed to reveal the facility staff addressed and/or implemented interventions to prevent future falls. A nurse's note dated 8/3/25 documented R9 was observed sitting on the floor in front of the bed. Further review of R9's clinical record (including the comprehensive care plan dated 2/12/25 and nurses' notes dated 8/3/25 through 8/25/25) failed to reveal the facility staff addressed and/or implemented interventions to prevent future falls. On 8/26/25 at 1:55 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that after a resident falls, interventions such as monitoring, keeping the resident busy, and toileting the resident should be implemented to prevent future falls. On 8/27/25 at 3:12 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the interim director of nursing) were made aware of the above concern. No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation and clinical record review, facility staff failed to provide care and services for an indwelling catheter for one of ten residents in the survey sample, Resident #8 (R8). The findings include:For R8, the facility staff failed to keep the catheter collection bag (1) off the floor. R8 was admitted to the facility with diagnoses that included but were not limited to urinary retention (2). The admission MDS (minimum data set) was not due at the time of the survey. The facility's Clinical Admission assessment for R8 dated 08/14/2025 documented in part, Level of cognitive impairment: b. alert (some forgetfulness). On 08/26/2025 at approximately 8:18 a.m. observation of R8's catheter collection bag revealed it was lying flat on the floor next to R8's bed. The physician's order for R8 documented, Indwelling catheter (3)16FR (French) with 10cc (cubic centimeter) balloon to bedside straight drainage for diagnosis/Hx (history) of urinary retention. Order Date Date:8/14/2025. The comprehensive care plan for R8 dated 08/19/2025 documented in part, Focus. Resident requires indwelling foley catheter Date Initiated: 08/19/2025. Under Interventions it documented in part, Keep catheter off floor. On 08/27/2025 at approximately 3:10 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, interim director of nursing, were made aware of the above findings. No further information was provided prior to exit. References:(1) Urine drainage bags collect urine. Your bag will attach to a catheter (tube) that is inside your bladder. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000142.htm. (2) A condition where your bladder doesn't empty all the way or at all when you urinate. This information was obtained from the website: https://my.clevelandclinic.org/health/disease/15427-urinary-retention. (3) A tube placed in the body to drain and collect urine from the bladder. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview and facility document review, the facility staff failed to serve food in a sanitary manner in one of one facility kitchens. The findings include:On 08/25/2025 at approximately 1;30 p. m. an observation of the facility's dish room located in the kitchen was conducted with OSM (other staff member) 32, dietary manager. The observation revealed a 17-inch floor fan. Observation of the fan revealed it was sitting on the floor blowing air across the floor on to a rack of clean plate bases and covers. Further observation of the fan revealed the back fan guard with pieces of debris and greasy to the touch. When the observation of the fan as described above was pointed out to OSM #2, he agreed the fan was dirty immediately removed the fan from the dish room. On 08/25/0225 at approximately 4:30 p.m. an observation in the facility's kitchen revealed OSM #3 plating pureed cake into bowls for the resident's desert. Observation of OSM #3 revealed he sported a mustache and a tuff of hair under his lower lip. Further observation failed to evidence a covering over OSM 3's facial hair. At approximately 4:40 p.m., OSM #3 was observed on the tray line assembling resident's dinner trays without a cover over his facial hair. On 08/25/0225 at approximately 4:45 p.m. an observation in the facility's kitchen revealed OSM #4, cook wearing a pair of plastic gloves. Observations of OSM #4 revealed he opened and closed the walk-in refrigerator, wiping his hands on a dirty apron, handling resident's sandwiches, stacking dinner plates onto the tray line while placing fingers on the surface of the plates, plating dinner food items and placing his thumb on the surface of the plates, without changing his gloves between the tasks described. On 08/26/2025 at approximately12:49 p.m. an interview was conducted with OSM #1, district dietary manager and OSM #2, dietary manager. When asked to describe the procedure for keeping staff hair from falling into food OSM #2 stated staff wear hair nets and beard nets for facial hair. After describing the observation of OSM #3 without the mustache being covered OSM #2 stated the mustache should have been covered. When asked to describe the purpose of kitchen staff wearing gloves OSM #2 stated that it was to prevent staff from touching raw food and ready to eat food with their bare hands. After informed of the observation of OSM #4 as stated above OSM #2 stated that it was not sanitary, and the gloves should have been changed between each task. On 08/26/2025 at approximately 1:11 p.m. an interview was conducted with OSM #3, kitchen aide. After being informed of the observation of not having his mustache covered during meal preparation he stated that his mustache should have been covered. On 08/26/2025 at approximately 12:49 p.m. an interview was conducted with OSM #2, dietary manager. He stated that he started at the facility on January 15, 2025. When asked if he was aware of any concerns regarding meals being provided in a timely manner, providing meals according to resident preference and providing palatable food, he stated he had observations of the issues when he started based on his background of being a chef. OSM #1, district dietary manager, stated that the prior dietary manager was lacking in management that affected meals being provided in a timely manner, providing meals according to resident preference and providing palatable food. She further stated that the facility's kitchen was short staffed at that time. On 08/27/2025 at approximately 1:20 p.m. an interview was conducted with OSM #3 regarding the fan observed in the dish room. When asked why the fan should not be blowing on clean dishware he stated that it could cause contamination. The facility policy Staff Attire Procedures. 1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. On 08/26/2025 at approximately 4:00 p.m. ASM (administrative staff member) #1, administrator, and ASM #2, interim director of nursing, were informed of the above findings. No further information was provided prior to exit. Complaint deficiency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodmont Center	11 Dairy Lane Fredericksburg, VA 22405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to maintain a complete and accurate medical record for one of ten residents in the survey sample, Resident #1.The findings include:For Resident #1 (R1), the facility staff failed to maintain an accurate medical record.Review of R1's clinical record documented a discharge date of [DATE].The progress notes for R1 documented in part,- [DATE] 07:40 Note : Significant change to reflect hospice closed due to resident death on 2/21.- [DATE] 20:15 (8:15 p.m.) Date of Service: 2025-03-12, Visit Type: Advanced care planning, Details: Chief complaint: ACP (advanced care planning) discussion w/ RP (responsible party), daughter in presence of DON (director of nursing) as res (resident) continues to decline. Res is seen for overall decline in condition and has been hospitalized 5 times this year for various issues of PVD (peripheral vascular disease), anemia, AMS (altered mental status), wound infections and PN (pneumonia). Pt is seen today at bedside with daughter to discuss ACP. Spoke w/ RP in regards to overall decline, multiple hospitalizations. Res has become more contracted w/ poor po (by mouth) intake, continues w/ multiple nonhealing wounds. Informed RP daughter, [Name of daughter] of poor prognosis based on aforementioned. Recommended hospice at this time, suggested she speak with family about what they would like to do moving forward. Res is DNR (do not resuscitate). Answered questions in regards to current condition. Informed daughter about recommendations by vascular to not be aggressive but to continue current woud [sic] management and that surgery/amputations would hasten mortality. Daughter is still wanting to get recommendations on this from PCP (primary care physician) and is to have an appt within the week. Discussion 20 minutes in presence of DON. RP states she will speak with sisters and get back to staff. Signed Date : 2025-03-12.On [DATE] at 10:10 a.m., an interview was conducted with ASM (administrative staff member) #6, nurse practitioner. ASM #6 stated that she no longer worked at the facility but worked with R1 when they were there. She stated that she had written the note dated [DATE] and that it was prior to them leaving the facility and was after R1 had expired. She stated that it probably should have been a late entry.On [DATE] at 12:27 p.m., an interview was conducted with ASM #1, the administrator. ASM #1 reviewed the progress note for R1 dated [DATE] and stated that the resident was not in the facility on that date. She stated that the medical record was not accurate.The facility policy Clinical record: Charting and documentation dated [DATE] documented in part, . Documentation shall be completed at the time of service, but no later than during the shift in which the assessment, observation, or care service occurred. Documentation shall be timely and in chronological order. When documentation occurs after the fact, outside the acceptable time limits, the entry shall be clearly indicated as late entry.On [DATE] at 3:11 p.m., ASM #1, the administrator and ASM #2, the interim director of nursing were made aware of the findings.No further information was provided prior to exit.