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	04/24/2026

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 observation, resident interview, staff interview, clinical record review and facility document review, facility staff failed to develop and/or implement the comprehensive care plan for nine of 50 residents in the survey sample, Residents #6, #18, #4, #2, #5, #43, #67, #77 and #96. The findings include: 1. For Resident #6 (R6), facility staff failed to follow the comprehensive care plan for the use of non-pharmacological interventions. R6 was admitted to the facility with diagnosis that included but not limited to lower back pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/05/2026, R6 scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating R6 was cognitively intact for making daily decisions. Section J Health Conditions coded R6 as having frequent pain with a pain level of eight out of ten, with ten being the worse pain. The physician's orders for R6 documented in part, Acetaminophen (1) Tablet 325 MG (Acetaminophen). Give 2 (two) tablet [sic] by mouth every 4 hours as needed for Mild Pain More than 3 (three) doses in 48 hours, notify physician/advanced practice provider(APP).Do not exceed 3g/day (three grams per day). Order Date: 12/8/2025 and Oxycodone (2) HCl (hydrochloride) Oral Tablet 5 (five) MG (Oxycodone HCl) *Controlled Drug* Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain, moderate to severe. Order Date: 01/8/2026. The comprehensive care plan for R6 dated 06/09/2025 documented in part, Focus. Resident exhibits or is at risk for altercations in comfort related to acute pain. Date Initiated: 06/09/2025. Under Interventions it documented in part, Evaluate pain characteristics: quality, severity, location, precipitating/relieving factors. Date Initiated: 06/09/2025. Review of the eMAR (electronic medication administration record) for R6 dated April 2026 documented the physician's orders as stated above for Acetaminophen and Oxycodone. The eMAR revealed that R6 was given Acetaminophen in 12 of 23 opportunities and oxycodone in 13 of 46 opportunities. Review of the facility's nursing progress notes for R6 dated 04/01/2026 through 04/23/2026 failed to evidence documentation of non-pharmacological interventions in 13 of 46 opportunities. On 4/23/2026 at approximately 1:58 p.m. an interview was conducted with the Unit Manager for Unit 200. She stated that the purpose of a care plan is to guide and help the facility staff provide the appropriate care for every resident. She stated that all the nurses and the entire interdisciplinary team are responsible for implementing each resident's care plan. After reviewing the comprehensive (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2026
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plan, nursing progress notes and the eMAR for R4, she agreed that the care plan was not being followed for the use of non-pharmacological interventions. On 04/23/2026 at approximately 5:04 p.m. the Administrator and DON (director of nursing) were informed of the above findings. No further information was provided prior to exit. References: (1) Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. (2) Used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html. 2. For Resident #18 (R18), facility staff failed to follow the comprehensive care plan for the use of non-pharmacological interventions. R18 was admitted to the facility with diagnosis that included but not limited to chronic pain. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 02/01/2026, R18 scored a 10 out of 15 on the BIMS (brief interview for mental status), indicating R18 was moderately impaired of cognition for making daily decisions. Section J Health Conditions coded R18 as having occasional pain with a pain level of five out of ten, with ten being the worse pain. The physician's orders for R18 documented the following: Dilaudid (1) Oral Tablet 2 MG (Hydromorphone HCl) *Controlled Drug* Give 1.5 tablet by mouth every 8 hours as needed for severe pain. Order Date: 04/04/2026. Dilaudid Oral Tablet 2 MG (Hydromorphone HCl) *Controlled Drug* Give 1.5 tablet by mouth every 8 hours as needed for pain, moderate to severe. Order Date: 04/09/2026. Dilaudid Oral Tablet 2 MG (Hydromorphone HCl) *Controlled Drug* Give 1.5 tablet by mouth every 6 (six) hours as needed for pain, moderate to severe. Order Date: 04/20/2026. Review of the eMAR (electronic medication administration record) for R18 dated April 2026 documented the physician's orders as stated above. Further review of the eMAR failed to evidence reveal non-pharmacological interventions on 04/03/2026 at 10:46 a.m., 04/06/2026 at 7:59 p.m., 04/10/2026 at 1:20 p.m. and at 10:33 p.m., 04/11/2026 at 8:06 a.m. and at 4:14 p.m. and on 04/12/2026 at 9:20 a.m. Review of the facility's nursing progress notes for R18 dated 04/01/2026 through 04/23/2026 failed to evidence documentation of non-pharmacological interventions for dates and times listed above. The comprehensive care plan for R18 dated 01/28/2026 documented in part, Focus. Resident exhibits or is at risk for alterations in comfort related to pain, c/o left shoulder pain Date Initiated: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/28/2026. Under Interventions it documented in part, Offer non-pharmacologic interventions prior to PRN pain medication administration Date Initiated: 01/28/2026. On 4/23/2026 at approximately 1:58 p.m. an interview was conducted with the Unit Manager for Unit 200. She stated that the purpose of a care plan is to guide and help the facility staff provide the appropriate care for every resident. She stated that all the nurses and the entire interdisciplinary team are responsible for implementing each resident's care plan. After reviewing the comprehensive care plan, nursing progress notes and the eMAR for R18, she agreed that the care plan was not being followed for the use of non-pharmacological interventions for the dates and times listed above. On 04/23/2026 at approximately 5:04 p.m. the Administrator and DON (director of nursing were informed of the above findings. No further information was provided prior to exit. References: (1) Used to relieve severe pain. This information was obtained from the website: https:medlineplus.gov/druginfo/meds/a682013.html. 3. For Resident #4 (R4), the facility staff failed to follow the resident's care plan to obtain the urinary output totals for the indwelling urinary catheter on multiple shifts between 4/9/26 and 4/17/26. On the following dates and times, R4 was observed sitting up in his room; at each observation, the tubing from the resident's indwelling urinary catheter was visible: 4/21/26 at 1:55 p.m. and 4/22/26 at 8:57 a.m. A review of R4's clinical record reviewed the following order dated 4/8/26: Keep pt (patient) hydrated.I/O (intake and output) daily, report to NP (nurse practitioner) if UO (urinary output) < (is less than) 1200 mls (milliliters) daily. A review of R4's April 2026 TAR (treatment administration record) revealed no recorded output for the following dates and shifts: 4/9/26 day shift, 4/13/26 day and evening shifts, 4/14/26 day shift, and 4/16-17/26-night shift. A review of R4's care plan dated 4/8/26 revealed, in part: Resident requires indwelling.catheter.Monitor output for odor, color, consistency, and amount. On 4/23/26 at 1:46 p.m., LPN (licensed practical nurse) #4, a unit manager, was interviewed. She stated that the purpose of a care plan is to guide and help the facility staff provide the appropriate care for every resident. She stated that all the nurses and the entire interdisciplinary team are responsible for implementing each resident's care plan. On 4/23/26 at 4:50 p.m., the Administrator and Director of Nursing were notified of these concerns. No additional information was provided prior to exit. 4.a. The facility staff failed to implement the comprehensive care plan for urinary catheter care / monitoring for Resident #2 (R2). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ESRD (end stage renal disease), Hemodialysis and DM (diabetes mellitus). The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 4/3/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers/bathing/dressing and hygiene. A review of the comprehensive care plan revised 4/11/26 revealed, FOCUS: Resident requires indwelling catheter due to neurogenic bladder. INTERVENTIONS: Catheter care twice a day and as needed (PRN). Record output. A review of the physician orders 4/2/26 reveals Empty catheter drainage bag at least once every eight hours to when it becomes 1/2 to 2/3 full as needed AND every shift. Perform Indwelling Catheter Care every shift. A review of the TAR (treatment administration record) reveals missing evidence of care for recording output on day shift: 4/15, 4/17, 4/18 and 4/21 and night shift: 4/4, 4/9 and 4/17; missing evidence of catheter care on day shift: 4/15, 4/17 and night shift 4/9. An interview was conducted on 4/23/26 at 1:45 PM with LPN (licensed practical nurse) #4. Asked the purpose of the care plan, LPN #4 stated, the purpose of the care plan is to implement the plan of care for the resident. When asked if there is no evidence of interventions being implemented, is the care plan being followed/implemented, LPN #4 stated, no, it is not. On 4/23/26 at 5:00 PM, the Administrator and Director of Nursing were made aware of the findings. No further information was provided prior to exit. 4.b. The facility staff failed to develop the comprehensive care plan for fluid restriction monitoring for Resident #2 (R2). R2 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ESRD (end stage renal disease), Hemodialysis and DM (diabetes mellitus). The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 4/3/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers/bathing/dressing and hygiene. A review of the comprehensive care plan revised 4/2/26 revealed, FOCUS: Resident exhibits or is at risk for impaired renal function and is at risk for complications related to hemodialysis. INTERVENTIONS: Medicate as ordered and monitor effectiveness and monitor for side effects, report to physician as indicated. A review of the physician orders 4/3/26 reveals Monitor Daily Fluid Restriction Total 1500 ml (must match diet order); dietary 840mL Breakfast tray 360 ml; Lunch tray 240 ml; and Dinner tray 240 ml; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing 660 ml every shift for dialysis. There was no evidence on the April 2026 MAR-TAR (medication administration record-treatment administration record) for fluid restriction monitoring. An interview was conducted on 4/23/26 at 1:45 PM with LPN (licensed practical nurse) #4. Asked the purpose of the care plan, LPN #4 stated, the purpose of the care plan is to implement the plan of care for the resident. Asked if fluid restriction monitoring should be on the care plan, LPN #4 stated, yes. When asked if there is no evidence of fluid restriction on the care plan, was the care plan developed, LPN #4 stated, no, it is not been developed. On 4/23/26 at 5:00 PM, the Administrator and Director of Nursing were made aware of the findings. No further information was provided prior to exit. 5. The facility staff failed to implement the comprehensive care plan for transfers for Resident #5 (R5). R5 was admitted to the facility on [DATE] with diagnosis that included but were not limited to cellulitis, lymphedema, CHF (congestive heart failure) and lung cancer. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 2/3/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assist for mobility/transfers/bathing/dressing and hygiene. A review of the comprehensive care plan revised 2/6/26 revealed, FOCUS: Resident is at risk for decreased ability to perform ADL(s) in bed mobility and transfer related to recent illness. INTERVENTIONS: Provide resident with maximal assist of one-two staff for transfers. A review of the ADL (activities of daily living) reveals, missing evidence of care for recording transfers on day shift: 3/2, 3/6, 3/13, 3/14, 3/15, 3/16, 3/25, 3/26, 3/30, 4/1, 4/2, 4/9, 4/12, 4/18; evening shift: 3/9, 3/12, 3/16, 3/18, 3/27, 3/29, 4/3, 4/10, 4/16 and night shift 3/18, 3/27, 3/31, 4/3, 4/6 and 4/10. An interview was conducted on 4/23/26 at 1:45 PM with LPN (licensed practical nurse) #4. Asked the purpose of the care plan, LPN #4 stated, the purpose of the care plan is to implement the plan of care for the resident. When asked if there is no evidence of interventions being implemented, is the care plan being followed/implemented, LPN #4 stated, no, it is not. An interview was conducted on 4/23/26 at 2:30 PM with CNA (certified nursing assistant) #3. When asked where transfers are documented, CNA #3 stated, it is documented in PCC (point click care). Asked what missing documentation means, CNA #3 stated, if there is no documentation it did not happen. On 4/23/26 at 5:00 PM, the administrator and director of nursing were made aware of the findings. No further information was provided prior to exit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6.a. For Resident #43 (R43) the facility staff failed to implement the comprehensive care plan to engage in the resident's preferred activities, to vote in elections. R43 was admitted to the facility on [DATE] with diagnosis that included but not limited to advanced multiple sclerosis, major depression disorder, chronic respiratory failure. A review of R43's Quarterly MDS (minimum data set) assessment, with an ARD (assessment reference date) of 3/19/26 reveals the resident scored a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions, was coded as being dependent for transfer, mobility, and maximum assistance with hygiene and bathing. On 4/22/2026 at 11:30 AM an interview was conducted with R43. She stated, No one came to me about voting on Tuesday. Review of the comprehensive care plan documented, Focus: while in the facility, it is important that s/he has the opportunity to engage in daily routines that are meaningful relative to their preferences. Intervention: important for me to vote. On 4/23/26 at 3:46 p.m., Licensed Practical Nurse (LPN) #4, Unit Manager, was interviewed. She stated the purpose of the care plan is to guide and assist facility staff in providing appropriate care for each resident. She further stated that nurses and the interdisciplinary team are responsible for implementing each resident's care plan. The Administrator and Director of Nursing were made aware of these concerns on 4/23/2026 at 5:08 PM. No additional information was provided prior to exit. 6.b. Facility failed to implement the care plan for activities of preference. Review of the comprehensive care plan focus documentation revealed, While in the facility, it is important that s/he has the opportunity to engage in daily routines that are meaningful relative to their preferences. Intervention: I am religious. On 4/22/2026 at 11:30 AM an interview was conducted with R43. She stated, There is a Chaplain who comes in to see me sometimes. I have to ask someone if I want to see him more. Review of Resident #43 comprehensive care plan dated 3/31/2026 documented in part, Focus: while in the facility, R43 states that it is important that she has the opportunity to engage in daily routines that are meaningful relative to their preferences. Intervention: I am religious. On 4/23/26 at 3:46 p.m., Licensed Practical Nurse (LPN) #4, Unit Manager, was interviewed. She stated the purpose of the care plan is to guide and assist facility staff in providing appropriate care for each resident. She further stated that nurses and the interdisciplinary team are responsible for implementing each resident's care plan. The Administrator and Director of Nursing were made aware of these concerns on 4/23/2026 at 5:08 PM. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided prior to exit. 7.a. For Resident #67 (R67), the facility staff failed to develop and implement a care plan for limited range of motion. For R67 a review of the clinical record revealed an occupational therapy (OT) order/intervention for a left-hand splint. Review of the resident's comprehensive care plan failed to reveal updated documentation addressing the left-hand splint. On 4/23/26 at 3:46 p.m., Licensed Practical Nurse (LPN) #6, a Unit Manager, was interviewed. She stated the purpose of the care plan is to guide and assist facility staff in providing appropriate care for each resident. She further stated that nurses and the interdisciplinary team are responsible for implementing each resident's care plan. On 4/24/26 at 8:46 a.m., the MDS (minimum data set) Coordinator was interviewed. She confirmed that everyone is responsible for updating the care plan to reflect current orders and resident needs. The Administrator and Director of Nursing were made aware of these concerns on 4/23/2026 at 5:08 PM. 7.b. For Resident #67 (R67), the facility staff failed to implement the comprehensive care plan to provide dialysis (1) communication with the dialysis center. The comprehensive care plan for R67 documented in part, Resident exhibits or is at risk for impaired renal function and is at risk for complications related to hemodialysis, hx (history) of CKD (chronic kidney disease) (2). Date Initiated: 06/13/2023. Under Interventions it documented in part, .Send communication book to dialysis and review book upon return. Date Initiated: 03/06/2026. On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 1/25/2026, the resident was assessed as receiving dialysis. The physician orders for R67 documented in part, Dialysis center main phone number is: [Phone number] Dialysis days: Mon, Wed, & Fri. Chair time: 2pm, pickup 1pm. Transport to: [Name and address of dialysis center], DX (diagnosis) CKD. Review of the dialysis communication record for R67 failed to evidence dialysis communication completed on 1/28/2026, 1/30/2026, 3/13/2026, and 3/27/2026. On 4/23/26 at 1:46 p.m., an interview was conducted with licensed practical nurse (LPN) #4 who stated that the purpose of a care plan is to guide and help the facility staff provide the appropriate care for every resident. She stated that all the nurses and the entire interdisciplinary team are responsible for implementing each resident's care plan. On 4/23/2026 at 2:56 PM, an interview was conducted with LPN #6 who stated that prior to a resident going to dialysis they completed the dialysis communication form and placed it in the communication book which was sent to dialysis with the resident. She stated that when the resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/2026 at 3:56 PM, an interview was conducted with R77 who stated that they required the mechanical lift to get out of bed into the wheelchair. R77 was observed in bed. R77 stated that they did not get out of bed every day and staff offered to get them up when they had enough staff to have two people to get them up, but it was not often. On 4/22/2026 at 10:10 AM, R77 was observed in bed. At 3:45 PM, R77 was observed in bed. Review of the ADL documentation for R77 from 2/1/2026-2/28/2026, 3/1/2026-3/31/2026 and 4/1/2026-4/30/2026 documented R77 being transferred out of bed six times in February 2026, nine times in March 2026, and six times in April 2026. Not applicable or Not attempted due to medical condition or safety concerns were documented on days when transfers were not documented. On 4/23/26 at 1:46 p.m., an interview was conducted with licensed practical nurse (LPN) #4 who stated that the purpose of a care plan is to guide and help the facility staff provide the appropriate care for every resident. She stated that all the nurses and the entire interdisciplinary team are responsible for implementing each resident's care plan. On 4/23/2026 at 2:31 PM, an interview was conducted with certified nursing assistant (CNA) #3 who stated that the CNAs documented their care in the ADL documentation and if it was not documented, there was no evidence that it was done. She stated that there were different codes for the code and not applicable should only be used when the resident was not in the building. CNA #3 stated that if a resident was dependent for transferring then not applicable would not make any sense unless they were not allowed to get out of bed. She stated that all residents should be offered to get out of bed each day and it should be documented if the resident refused to get out of bed. On 4/23/2026 at 2:56 PM, an interview was conducted with LPN #6 who stated that residents should be encouraged to get out of bed every day. She stated that it should be documented that they were encouraged to get up and if they refused it should be reported to the physician and the family to see if they could speak with them about getting up. LPN #6 stated that R77 did not get up very often and she thought it was because of a problem with their leg. On 4/23/2026 at 3:19 PM, an interview was conducted with LPN #3 who stated that residents should be offered to get out of bed daily and it should be reported to the nurse when they refuse. She stated that if a resident refused to get out of bed they reported it to the physician and the responsible party and documented the refusals. LPN #3 stated that even if the resident had a history of refusing they still needed to offer to get them up daily. On 4/23/2026 at 5:07 PM, the Administrator and Director of Nursing were made aware of the concern. No further information was provided prior to exit. 9. For Resident #96 (R96), the facility staff failed to implement the comprehensive care plan to provide showers twice a week during 6/1/2025-6/30/2025, and 7/1/2025-7/31/2025. The comprehensive care plan for R96 documented in part, While in the facility, resident/patient states that it is important that s/he has the opportunity to engage in daily routines that are meaningful relative to their preferences. Date Initiated: 10/20/2024. Revision on: 11/18/2025. Under Interventions it documented in part, .It is important for me to choose between a shower or bed bath. Date Initiated: 10/20/2024. Revision on: 11/18/2025 . The care plan further documented, (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident/Patient requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: chronic illness, activity intolerance, confusion. Daughter has requested resident stay in bed, not to be up in chair. Date Initiated: 10/25/2024. Revision on: 11/18/2025. Under Interventions it documented in part, .Provide resident/patient with extensive assist of 1 for bathing. Date Initiated: 10/25/2024. Revision on: 11/18/2025 . On the most recent minimum data set (MDS), a significant change assessment with an assessment reference date (ARD) of 9/2/2025, the resident was assessed as being severely impaired for making daily decisions and requiring partial/moderate assistance for shower/bathing. Review of the ADL documentation for R96 from 6/1/2025-6/30/2025, and 7/1/2025-7/31/2025 documented R96 receiving one shower in June 2025, and five showers in July 2025. The resident census documentation showed R96 out of the facility on 7/8/2025 during the dates above. On 4/23/26 at 1:46 p.m., an interview was conducted with licensed practical nurse (LPN) #4 who stated that the purpose of a care plan is to guide and help the facility staff provide the appropriate care for every resident. She stated that all the nurses and the entire interdisciplinary team are responsible for implementing each resident's care plan. On 4/23/2026 at 2:31 PM, an interview was conducted with certified nursing assistant (CNA) #3 who stated that they evidenced their care provided by the documentation in the ADLs. She stated that the codes for bathing were B for bed bath and S for shower and showers were provided twice a week. CNA #3 stated that showers were provided twice a week by a shower schedule and any refusals were documented in the clinical record and reported to the nurse. On 4/23/2026 at 3:19 PM, an interview was conducted with LPN #3 who stated that showers are given according to a schedule twice a week and if refused the nurse verified the resident was refusing and then notified the physician and the family. On 4/24/2026 at 12:10 PM, the Administrator and Director of Nursing were made aware of the concern. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on resident interview, staff interview and clinical record review, the facility staff failed to provide ADL (activities of daily living) for one of 50 residents, Resident #11.The findings include:For R11, the facility staff failed to offer showers or bed baths.R11 was admitted to the facility with diagnoses that included but were not limited to muscle weakness.On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 03/19/2026, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R11 was cognitively intact for making daily decisions. Under Section GG Functional Abilities R11 was coded as requiring Partial/moderate assistance for Showering/bathe self.The facility's 200 Wing Shower List revealed R11 was scheduled for showers on Mondays and Thursdays during the 7:00 a.m. - 3:00 p.m. shift.The ADL (activities of daily living) sheet for R11 dated March 2026 revealed the following: 03/06/2026 was coded 09 (zero-nine) on the day shift (7:00 a.m. - 3:00 p.m.) 88 on the evening shift (3:00 p.m. - 11:00 p.m.), 09 on night shift (11:00 p.m. - 7:00 a.m.); 03/23/2026 was blank on the day shift (7:00 a.m. - 3:00 p.m.) 09 on the evening shift (3:00 p.m. - 11:00 p.m.), 09 on night shift (11:00 p.m. - 7:00 a.m.).The ADL sheet for R11 dated April 2026 revealed the following: 04/13/2026 was coded 98 on the day shift (7:00 a.m. - 3:00 p.m.) 88 on the evening shift (3:00 p.m. - 11:00 p.m.), 09 on night shift (11:00 p.m. - 7:00 a.m.); 04/20/2026 was coded 09 on the day shift (7:00 a.m. - 3:00 p.m.) 09 on the evening shift (3:00 p.m. - 11:00 p.m.), 09 on night shift (11:00 p.m. - 7:00 a.m.).The legend on the ADL sheets documented in part, 09 - Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. 88 - not attempted due to medical condition or safety concerns. On 04/23/2026 at approximately 4:50 p.m. an interview was conducted with CNA (certified nursing assistant) #5 regarding showers for R#11. CNA #5 stated she provided care and showers to R11 and R11's shower days were Mondays and Thursdays during the 7:00 a.m. - 3:00 p.m. shift. After reviewing the ADL sheets for the dates listed above she stated that she did not know why R11 did not receive showers or bed baths. She further stated that R11 should have been offered a shower or bed bath on the dates listed above. After further review of the ADL sheets CNA #5 was sked if there was evidence R11 was offered a shower or bed bath on the dates listed above. She stated no.On 04/24/2026 at approximately 12:32 p.m. the Administrator and DON (director of nursing) were informed of the above findings.No further information was provided prior to exit.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and responsible party interview, 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 to dependent residents for five of 50 residents in the survey sample, Residents #96, #77, #5, #43 and #105.The findings include:1. For Resident #96 (R96), the facility staff failed to provide showers twice a week during 6/1/2025-6/30/2025, and 7/1/2025-7/31/2025. On the most recent minimum data set (MDS), a significant change assessment with an assessment reference date (ARD) of 9/2/2025, the resident was assessed as being severely impaired for making daily decisions and requiring partial/moderate assistance for shower/bathing. Review of the ADL documentation for R96 from 6/1/2025-6/30/2025, and 7/1/2025-7/31/2025 documented R96 receiving one shower in June 2025, and five showers in July 2025. The resident census documentation showed R96 out of the facility on 7/8/2025 only. The comprehensive care plan for R96 documented in part, While in the facility, resident/patient states that it is important that s/he has the opportunity to engage in daily routines that are meaningful relative to their preferences. Date Initiated: 10/20/2024. Revision on: 11/18/2025. Under Interventions it documented in part, .It is important for me to choose between a shower or bed bath. Date Initiated: 10/20/2024. Revision on: 11/18/2025 . The care plan further documented, Resident/Patient requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: chronic illness, activity intolerance, confusion. Daughter has requested resident stay in bed, not to be up in chair. Date Initiated: 10/25/2024. Revision on: 11/18/2025. Under Interventions it documented in part, .Provide resident/patient with extensive assist of 1 for bathing. Date Initiated: 10/25/2024. Revision on: 11/18/2025 . On 4/23/2026 at 2:31 PM, an interview was conducted with certified nursing assistant (CNA) #3 who stated that they evidenced their care provided by the documentation in the ADLs. She stated that the codes for bathing were B for bed bath and S for shower and showers were provided twice a week. CNA #3 stated that showers were provided twice a week by a shower schedule and any refusals were documented in the clinical record and reported to the nurse. On 4/23/2026 at 3:19 PM, an interview was conducted with licensed practical nurse (LPN) #3 who stated that showers are given according to a schedule twice a week and if refused the nurse verified the resident was refusing and then notified the physician and the family. The facility policy Activities of Daily Living revised 5/1/23 documented in part, .Based on the comprehensive assessment of a patient and consistent with the patient's needs and choices, the Center must provide the necessary care and services to ensure that a patient's activities of daily living (ADL) abilities are maintained or improved and do not diminish unless circumstances of the patient's clinical condition demonstrate that a change was unavoidable . A patient who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene . On 4/24/2026 at 12:10 PM, the administrator and director of nursing were made aware of the concern. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit. 2. For Resident #77 (R77), the facility staff failed to offer to get them out of bed daily. On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 3/19/2026, the resident scored 14 out of 15 on the brief interview for mental status (BIMS) assessment, indicating they were cognitively intact for making daily decisions. The assessment documented impairment on one side in the upper and lower extremity, R77 using a wheelchair and dependent on staff for transfers. On 4/21/2026 at 3:56 PM, an interview was conducted with R77 who stated that they required the mechanical lift to get out of bed into the wheelchair. R77 was observed in bed. R77 stated that they did not get out of bed every day and staff offered to get them up when they had enough staff to have two people to get them up, but it was not often. On 4/22/2026 at 10:10 AM, R77 was observed in bed. At 3:45 PM, R77 was observed in bed. Review of the ADL documentation for R77 from 2/1/2026-2/28/2026, 3/1/2026-3/31/2026 and 4/1/2026-4/30/2026 documented R77 being transferred out of bed six times in February 2026, nine times in March 2026, and six times in April 2026. Not applicable or Not attempted due to medical condition or safety concerns were documented on days when transfers were not documented. The comprehensive care plan for R77 documented in part, Resident/Patient requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to: general weakness, decreased mobility, physical deconditioning. Date Initiated: 05/30/2024. Revision on: 09/26/2025. Under Interventions it documented in part, Assist of 2 using total mechanical lift for transfers. Date Initiated: 05/30/2024. Revision on: 01/22/2025. On 4/23/2026 at 2:31 PM, an interview was conducted with certified nursing assistant (CNA) #3 who stated that the CNAs documented their care in the ADL documentation and if it was not documented, there was no evidence that it was done. She stated that there were different codes for the code and not applicable should only be used when the resident was not in the building. CNA #3 stated that if a resident was dependent for transferring then not applicable would not make any sense unless they were not allowed to get out of bed. She stated that all residents should be offered to get out of bed each day and it should be documented if the resident refused to get out of bed. On 4/23/2026 at 2:56 PM, an interview was conducted with licensed practical nurse (LPN) #6 who stated that residents should be encouraged to get out of bed every day. She stated that it should be documented that they were encouraged to get up and if they refused it should be reported to the physician and the family to see if they could speak with them about getting up. LPN #6 stated that R77 did not get up very often and she thought it was because of a problem with their leg. On 4/23/2026 at 3:19 PM, an interview was conducted with LPN #3 who stated that residents should be offered to get out of bed daily and it should be reported to the nurse when they refuse. She stated that if a resident refused to get out of bed they reported it to the physician and the responsible party and documented the refusals. LPN #3 stated that even if the resident had a history of refusing they still needed to offer to get them up daily. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/2026 at 5:07 PM, the administrator and director of nursing were made aware of the concern. No further information was provided prior to exit. 3. The facility staff failed to provide ADL (activities of daily living) specifically transfers for a maximal assist, Resident #5 (R5). R5 was admitted to the facility on [DATE] with diagnosis that included but were not limited to cellulitis, lymphedema, CHF (congestive heart failure) and lung cancer. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 2/3/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assist for mobility/transfers/bathing/dressing and hygiene. A review of the comprehensive care plan revised 2/6/26 revealed, FOCUS: Resident is at risk for decreased ability to perform ADL(s) in bed mobility and transfer related to recent illness. INTERVENTIONS: Provide resident with maximal assist of one-two staff for transfers. A review of the ADL (activities of daily living) reveals, missing evidence of care for recording transfers on day shift: 3/2, 3/6, 3/13, 3/14, 3/15, 3/16, 3/25, 3/26, 3/30, 4/1, 4/2, 4/9, 4/12, 4/18; evening shift: 3/9, 3/12, 3/16, 3/18, 3/27, 3/29, 4/3, 4/10, 4/16 and night shift 3/18, 3/27, 3/31, 4/3, 4/6 and 4/10. An interview was conducted on 4/23/26 at 2:30 PM with CNA (certified nursing assistant) #3. When asked where transfers are documented, CNA #3 stated, it is documented in PCC (point click care). Asked what missing documentation means, CNA #3 stated, if there is no documentation it did not happen. On 4/23/26 at 5:00 PM, the administrator and director of nursing were made aware of the findings. No further information was provided prior to exit. 4. Resident #43 (R43), the facility failed to promote the resident's activities of daily living: by not assisting the resident to shave her facial hair. R43 was admitted to the facility on [DATE] with diagnosis that included but were not limited to advanced multiple sclerosis, depression, gout and hypertension. A review of R43's Quarterly Minimum Data Set (MDS), completed on 3/19/26, reveals BIMS (Brief Interview for Mental Status) score13/15, indicating the resident was not cognitively impaired for making daily decisions. In Section GG – Functional status, the resident was coded as being dependent of staff for transfers, mobility, maximum assistance with hygiene and bathing. On 4/22/2026 at 10:30 AM an interview and observation were conducted with R43. The resident was observed to have a large amount of facial hair. She stated I am waiting for my brother to bring in an electric shaver. I am unable to use the razors here because I have keloids (1). When asked how this made her feel, I just have to wait. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed a photo of the resident dated 10/17/2025 without facial hair. Physical therapy encounter note dated 4/6/2026, documented in part, Patient reports she is waiting for her dad to come with her shaver before she is willing to get into Geri chair. Physical therapy encounter note dated 4/8/2026, documented in part, Agreeable to therapy but refused OOB (out of bed) to Geri chair or ROM (range of motion)/Mobility in supine stating, 'you aren't the one that has to do this looking like a man.' Therapist again encouraging patient to allow NSG (nursing) staff to assist in grooming task and patient reports 'I can do it myself' but continues to refuse participation due to unshaven face. On 4/23/26 at 2:35 P.M. Interview of the certified nursing assistant #3. She reports resident is totally dependent and allows the staff to take care of her totally. When questioned about #R43 facial hair, I believe she is waiting for someone to come and do it for her, she refuses a lot. The Administrator and Director of Nursing were made aware of these concerns on 4/23/2026 at 5:08 PM. No additional information was provided prior to exit. References: 1. A keloid is a growth of extra scar tissue. It occurs where the skin has healed after an injury. This information was obtained from the following website: https://medlineplus.gov/ency /article/000849.htm. 5. For Resident #105 (R105), the facility staff did not assist the dependent resident to transfer out of bed on 4/21/26 or 4/22/26 during the survey hours. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/18/26, R105 was coded as being severely cognitively impaired, having scored zero out of 15 on the BIMS (brief interview for mental status). He was coded as being completely dependent on the assistance of staff for transferring from bed to wheelchair. On the following dates and times, R105 was observed lying in bed: 4/21/26 at 1:21 p.m., 3:08 p.m., 4:57 p.m., 4/22/26 at 9:31 a.m., 11:04 a.m., 2:26 p.m., 3:05 p.m., and 4:15 p.m. At no time between surveyor entrance and exit on these two days was R105 out of bed. On 4/22/26 at 9:46 a.m., R105's RR (resident representative) was interviewed. She stated that she visits the resident at various times of the day and evening and has concerns about whether or not the staff is assisting the resident out of bed and into the wheelchair. On 4/22/26 at 3:21 p.m., CNA (certified nursing assistant) #2 was interviewed. She stated she is familiar with caring for R105 and was assigned to him on the day shift that day. She stated R105 is completely dependent on staff for all ADLs (activities of daily living). She explained that she did not have time to transfer the resident from his bed to his wheelchair that day because she came from the other side as a float CNA because one of the other CNAs had a family emergency. She stated this meant she arrived to R105's unit late and she had other residents to care for. She also explained that a physical therapy staff member told her that R105 did not need to get up today. She added; If I'd had (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	more time, I probably would have gotten him up. On 4/24/26 at 8:40 a.m., OSM (other staff member) #2, a physical therapy assistant, was interviewed. She stated that she did not instruct any CNA that R105 did not to be gotten out of bed on 4/22/26. She explained that it is beneficial for R105 to be out of bed and up in the wheelchair as much as he will tolerate every day. She explained that prior to his most recent readmission to the facility, he had up for much of the time each day. She stated that the resident needs to build his tolerance for being out of bed, and that the best way to do this is for him to be up in the wheelchair as much as possible. On 4/23/26 at 11:12 a.m., the Administrator and the Director of Nursing were informed of these concerns. No additional information was provided prior to exit.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a safe environment for one of 50 residents, Residents #49The findings include:The facility failed to provide a safe environment for Resident #49 (R49).Resident #49 was admitted to the facility on [DATE] with diagnosis that included but were not limited to DM (diabetes mellitus), Parkinsons Disease, dementia and Adult FTT (failure to thrive). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/25/26, coded the resident as scoring a 04 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bed mobility, transfer, hygiene and bathing; supervision for eating.A review of the comprehensive care plan dated 7/23/25, revised on 3/17/26 revealed, FOCUS: Resident is at risk for falls: Parkinson's disease, Dementia, poor safety awareness, general weakness. INTERVENTIONS: Bed rail(s) used as an enabler. Implement the following safety precautions- 2 staff to assist resident with repositioning /turning while in bed.A review of the progress note dated 3/9/26 at revealed The Change in Condition/s (CIC) reported on this CIC Evaluation are/were Falls. Nursing observations, evaluation, and recommendations are: Immediately upon entering room assessed resident, Patient did not hit head, as per CNA (certified nursing assistant). Patient complained of pain in left knee. NP contacted and patient assessed by NP (nurse practitioner). Xray ordered. Resident unable to verbalize what occurred, other than she fell out of bed. Skin check was performed, no skin tears, abrasions or bruising noted at this time. Assisted back to bed, via mechanical lift x(times) 2. resident assistance with bed mobility increased to 2 staff members. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: x-ray and assessed resident.A review of the Incident Synopsis follow-up on 3/10/26, Root cause analysis was conducted and found the CNA failed to ensure the low air loss mattress was on static mode prior to providing care. Immediate education with nursing staff on safe handling during care and steps to activate static mode on the mattress was completed. Resident's care plan was reviewed and updated as indicated.A review of the x-ray results taken 3/9/26 revealed, Left knee: FINDINGS: Subtle cortical disruption suggested at the distal medial femoral shaft/condylar junction on the AP (anterior/posterior) view.CONCLUSION: Question subtle distal femoral fracture, follow-up or CT (computed tomography) as warranted. Right knee: No acute fracture or dislocation. The osseous structures appear intact. Modest joint space narrowing. Soft tissues are unremarkable. CONCLUSION: No acute osseous findings. Recommend a repeat multi-view imaging in 1 (one) week or sooner if clinically warranted especially if symptoms continue to persist or progress.A review of the progress note dated 3/10/26 revealed, Pain, joint, knee, left Per x-ray possible fracture. recommendation for CT scan declined by hospice continue morphine for pain. Pt is followed closely by hospice. Per DON (director of nursing) hospice declined CT scan of left leg as recommended.An interview was conducted on 4/24/26 at 8:09 AM with the Director of Nursing. Asked about the incident with R49, the Director of Nursing stated, it was an agency CNA who had started working with us in March 2026, he had been here a week. The resident was a one person assist, she would hold onto the bedrail, she is alert but confused. The CNA did not put the mattress in static mode. The resident is on hospice, and they did not want any further testing done, neither did the daughter. An interview was conducted on 4/24/26 at 9:15 AM with the nurse practitioner (NP) who stated, Hospice makes the decision if they are going to continue with the CT scan. No bruises or swellings on either knee when I assessed her.On 4/24/26 at 11:00 AM, the Administrator and Director of Nursing were made aware of the findings.A review of the facility's Falls Management policy revealed, Implement and document patient-centered interventions according to (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individual risk factors in the patient's plan of care. Adjust and document individualized intervention strategies as patient condition changes.No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety on one of six hallways, the Cardinal hallway and in one of one kitchen.The findings include: 1. On 4/21/26 at 11:30 a.m. an observation was conducted in the kitchen with the following findings: a single 9x12 cutting board with dried red colored debris on the edge, two large ladles with draining holes in them with yellow debris and a partial noodle stuck on one of them, two 16x24 baking sheets with white thick debris. On one sheet, the debris was stuck to the front and on the other to the back of the sheet. There were a cake mixer guard and its stand with white debris and the electrical cord was stored inside the mixing bowl. On one four-tiered metal rack where dry dishes were stored there were 3 steam pans stacked varying in size that were wet on the top shelf. The MIT(manager in training)/cook stated these shouldn't be stacked wet. On a second four-tiered metal rack where dry dishes were stored there were five 9x12 baking sheets on the bottom shelf dripping with water onto the floor, when shown, the dietary manager spaced the baking sheets further apart on the shelf. In the refrigerator there was a 2-quart container with a thick yellow substance in it with no label or date. The dietary manager stated it was butter. In dry storage there was a 16oz open bag of potato chips, with no date and not closed after being opened ; there was a blue bag of parboiled rice left open exposing the rice to air inside of a 25lb box. The dietary manager stated the rice was in its original bag. There was a 14oz plastic container of chicken flavored base with the lid off sitting on a cart. The dietary manager placed the lid back onto the container. Temperature of the lunch food was taken with the MIT/cook prior to preparing trays on 4/21/26 at approximately12:15p.m. Five food items were found below 135 degrees Fahrenheit: mashed potatoes registered 123.5 degree Fahrenheit, puree peas 133.3 degree Fahrenheit, gravy 134.4 degree Fahrenheit, puree burger 110.0 degree Fahrenheit, and ground beef hamburger 127.0 degree Fahrenheit. They proceeded to serve lunch with the temperatures as recorded. On 4/21/26 at approximately 12:30 p.m., when asked, the dietary manager stated that the acceptable temperature to serve food is 135.0 degree Fahrenheit. A review of the facility's Dining Services Policy & Procedure Manual policy, revised 2/2023, revealed, all utensils, food equipment, and food contact surfaces will be clean and sanitized after every use, all foods will be held at appropriate temperatures greater than 135-degree Fahrenheit.for hot holding. Review of policy Food Storage: Dry Goods, revised 2/2023, revealed all packaged and canned food items will be kept clean, dry and properly sealed; storage areas will be neat arranged for easy identification and date marked as appropriate. On 4/23/26 at 11:15 a.m. the Administrator and Director of Nursing were made aware of the above findings. No further information was provided prior to exit. 2. On 4/22/26, the facility staff served expired milk for breakfast on the [NAME] hallway; and a facility staff member did not properly sanitize a pizza cutter prior to using it to serve the lunch meal. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 4/22/26 at 8:41 a.m., breakfast trays were observed during distribution to residents on the [NAME] hallway. On each tray containing milk, the milk carton displayed an expiration date of 4/21/26. A total of 12 expired cartons of milk were observed as the trays were being distributed and in the ready-to-distribute supply of milk on the top of the tray cart. On 4/22/26 at 9:01 a.m., CNA (certified nursing assistant) #7 was interviewed as she collected breakfast trays from residents who had finished their meal. She stated that the dietary staff puts all of the milk in the ice-filled container on top of the tray cart and the CNAs are responsible for putting the individual milk cartons on the trays per residents' requests. She stated she would need to check with the nurse to determine who is responsible for making sure all of the milk is in date. In two minutes, she returned and stated that the dietary staff is responsible for making sure the milk has not expired prior to providing it to the nursing staff on the floors, and the nursing staff is responsible for double checking to make sure they are not serving expired milk to the residents. On 4/23/26 at 9:08 a.m., the Dining Services Director was interviewed. She stated that she and the dietary aides are responsible for checking the dates on the milk cartons for expiration. She stated she ordinarily does not arrive at the facility until 8:00 am or 9:00 a.m., so the breakfast checks are up to the aides or to the manager in training who are present in the facility during breakfast preparation. She stated the milk bucket container for the [NAME] hallway was placed underneath the buckets for other hallways and she did not see the expired milk. She added that apparently no nursing staff checked the expiration dates either. On 4/23/26 at 4:50 p.m., the Administrator and Director of Nursing were notified of these concerns. b. On 4/22/26 at 12:32 p.m., the Dietary District Manager was observed in the facility kitchen. He carried a pizza cutter which had fallen to the floor to the three-compartment sink where he dipped the cutter into the wash sink, quickly removed and dipped it into the rinse sink, quickly removed it, and dipped it into the sanitizer sink, leaving it submerged for less than three seconds. He returned the pizza cutter to a dietary aide who used the pizza cutter to complete lunch service. On 4/23/26 at 9:08 a.m., the Dining Services Director was interviewed. She stated hand washed utensils should be thoroughly washed and rinsed and should be immersed in a sanitizer solution for at least 60 seconds. On 4/23/26 at 4:50 p.m., the Administrator and Director of Nursing were notified of these concerns. No additional information was provided prior to exit. 3. The facility staff failed to follow proper sanitation and handling practices to prevent possible foodborne illness. On 4/22/2026 at 9:26 AM an observation was made of a dietary staff member washing plastic tongs at the three-compartment sink. The dietary staff member was observed placing the plastic tongs in the sink with the sanitizer solution approximately 2-3 seconds and then placing them in the dish dryer rack. Testing of the sanitizer solution revealed 150ppm (parts per million) and the staff member proceeded to drain the sink and placed the plastic tongs to be rewashed. At 10:34 AM an observation was made of the corporate dietary staff member and a facility dietary staff member washing meal trays and plate dome covers in the three-compartment sink. Observations (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed between 10:34 AM and 11:22 AM revealed both staff members placing the trays and dome covers into the sanitizing solution after rinsing them. A third dietary staff member was observed removing the trays and dome covers immediately and placing them into drying racks and delivering them into the kitchen. Timing of the trays and dome covers submerged in the sanitizing solution was observed between 3.38 seconds to 40.83 seconds. At 11:04 AM, an observation was made of a dietary staff member washing plate dome covers and placing approximately 15 dome covers in the disinfectant sink. Approximately six of the dome covers were not fully submerged in the solution and observed above the disinfectant water line. At 11:12 AM, a dietary staff member was observed rolling a black utility cart to the meal carts containing the breakfast trays returned from the units. The staff member was observed wearing one glove on the right hand and placed the used plate dome covers and used plates from the meal cart onto the utility cart and proceeded to roll the cart with the dishes over to the three-compartment sink. The staff member stopped to pick up a plastic juice cup that was on the floor with the gloved hand and placed everything on the cart onto the sink area. The staff member then rolled the utility cart directly over to the disinfectant sink, put a glove on the left hand and began removing the washed dome lids from the disinfectant sink and placed them on the cart without cleaning the cart between. The utility cart surface contained visible water and debris from the soiled breakfast plates and dome lids that had been removed prior. The staff member was observed to stack 45 dome lids in total on the utility cart and took them over to the kitchen area and placed them on a large storage rack. At 11:18 AM, the staff member was observed to bring the cart back over to the three-compartment sink and removed 12 dome lids which were stacked on the cart and taken to the storage rack in the kitchen. On 4/23/2026 at 8:58 AM, an interview was conducted with the dietary manager who stated that they scraped any product off the dishes prior to putting them in the first sink to wash them, then rinsed them in the second sink and lastly put them in the sanitizer before air drying them. She stated that the dishes had to go in the sanitizer and there was no time that they had to sit in the sanitizer but needed to air dry afterwards. The dietary manager stated that the carts were cleaned every day and they should be cleaned after anything dirty was placed in them prior to putting anything clean on top of them. The manufacturer instructions for use provided by the facility, for the sanitizer used in the three-compartment sink Oasis 146 Multi-Quat Sanitizer documented in part, . To sanitize food contact surfaces, food processing equipment and other hard surfaces in food processing locations, dairies, or restaurants: Use Oasis 146 Multi-Quat Sanitizer to sanitize pre-cleaned hard non-porous surfaces of food processing equipment, dairy equipment, food utensils, dishes, silverware, glasses, sink tops, countertops and other hard non-porous surfaces in federally inspected meat and poultry plants or restaurants . Expose all surfaces to the sanitizing solution for a period of not less than 1 minute. Allow equipment to drain thoroughly and air dry . The facility policy Manual Warewashing (3-Compartment Sink) revised 1/2024, documented in part, . All cookware, dishware, and serviceware that is not processed through the dish machine will be manually washed and sanitized . Sanitize in the third sink: Chemical sanitizer testing and concentrations used according to manufacturer's guidelines . The facility policy Food Handling revised 1/26/24, documented in part, . Employees wear disposable gloves when handling food. Disposable gloves are considered a single-use item and are discarded when damaged, soiled, and after each use . (continued on next page)

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	495246	A. Building B. Wing	04/24/2026

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