STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Jefferson	900 North Taylor Street Arlington, VA 22203

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 0552 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, facility document review, the facility staff failed to uphold a resident's right to refuse care and treatment causing harm and resulting in a hospitalization for one of 36 residents in the survey sample, Resident #42. The findings include:For Resident #42 (R42), the facility staff forced the procedure to obtain a urine sample by physically restraining and forcing the insertion of a catheter causing harm resulting in hospitalization. R42 was admitted to the facility with diagnosis that included but was not limited to benign prostatic hyperplasia (1). On the most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/20/2025, R42 scored 4 (four) out of 15 on the BIMS (brief interview for mental status), indicating R42 was severely impaired of cognition for making daily decisions. Section H0300 Urinary Continence coded R42 as being Always incontinent. The physician's order for R42 dated 01/24/2025 documented, UA (urinalysis) (2) C (culture) & (and) S (sensitivity) (3) every shift for 3 (three) days. The facility's Health Status Note for R42 dated 01/28/2025 at 11:35 p.m. documented, Note Text: Guest have (sic) order UA C&S, Guest unable to urinate on (sic) urinal so in and out catheterization (4) performed for urine sample collection, bright blood noted in the urine sample collected, in and out catheter removed, no signs of shock or distress noted, Guest appeared anxious but stable. on call NP (nurse practitioner) (Name of NP) made aware NP state to monitor Guest. Will continue to monitor. The facility's Health Status Note for R42 dated 01/28/2025 at 11:54 p.m. documented, Note Text: Daughter (Name of Daughter) made aware. The facility's Health Status Note for R42 dated 01/29/2025 at 7:59 a.m. documented, Note Text: Around 5AM (5:00 a.m.) Guest noted discomfortable and have pain during urinating, hematuria (5) , blood clot noted on brief. vitals checked BP (blood pressure) 135/65 (135 over 65), P (pulse) 81 (beats per minute), R (respiration) 19, T (temperature) 97.7 (degrees Fahrenheit), O2 (oxygen) 97% (percent) room air. on call NP notified and NP gave order to send guest to ER (emergency room), POA (power of attorney) daughter made aware, guest sent to (Name of Hospital). The facility's Health Status Note for R42 dated 01/29/2025 at 3:30 p.m. documented, Note Text: Guest return form [sic] (Name of Hospital) d/t (due to) hematuria. Came in with indwelling urinary catheter with Blood in the urine. Vital BP 165/70,HR 61,T 98.4,RR 18,O2 96 ON R/A (room air) no pain. Guest is stable at this time with no distress noted. Daughter is aware guest has return to facility. The facility's Grievance Report for R42 dated 01/29/2025 documented in part, Describe concerns using factual terms: Resident had catheter used for urine sample against his will resulting in injury and hospitalization. What other action was taken to resolve this concern?: Dismissal of responsible staff. Was grievance resolved? Yes, resident received psychiatric follow-up to address trauma, accused staff dismissed from company. Summary Statement of the resident's grievance: Catheter placed for urine sample following resident's refusal. Resident sent out with bleeding in the groin area. Steps taken to investigate grievance: FRI (facility reported incident) initiated on 1/29/25. Responsible staff provided statements prior to placement on administrative leave. Summary of the pertinent findings or conclusions regarding the resident's concern(s): Resident was found to have bleeding and refusal of care following traumatic incident. The facility's synopsis of events for R42 dated 01/29/2025 documented in part, Incident: (R42's) friend (Name of Friend) (continued on next page)

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

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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 0552 Level of Harm - Actual harm Residents Affected - Few	reported on 1/29/2025 concerns about the care provided to (R42) on the evening of 1/28/2025. Investigation: At around 3:00 PM (p.m.) on 01//29/2025, (Name of R42's Friend) came to speak with the Director of Nursing (DON), (Name of Previous Director of Nursing) and Senior Director of Nursing. At that time (Name of R42's Friend) reported she had been visiting with (R42) the evening of 01/28/2025 when a nurse entered his room to insert a catheter. (Name of R42's Friend) reported that (R42) stated Don't do that and crossed his legs. (Name of R42's Friend) then reported the nurse called out for additional staff to assist her and two staff entered the room and asked her to step out into the hallway. While in the hallway, (Name of R42's Friend), stated she heard (R42) yelling out, but could not make out his words. When the staff left the room, (Name of R42's Friend) returned to bedside and stayed with (R42) until 11:30 PM (p.m.). During (Name of R42's Friend) report, the administrator entered the office. (Name of R42's Friend) was able to provide descriptions of the staff and the (Name of Facility) staff were able to identify the staff providing care to (R42) on 01/28/2025. Each of the three staff members were interviewed Certified Nursing Assistant (CNA #14) reported that on the evening of 01/28/2025, he was called into (R42's) room by Certified Nursing Assistant (CNA #15) because he and Licensed Practical Nurse (LPN #11) were attempting to collect urine and (R42) was combative. (CNA #14) stated he went to assist with getting the urine, he stated verbally to the Administrator and Director of Nursing that he and (CNA #15), held (r42) legs and arms while the nurse catheterized him. Certified Nursing Assistant (CNA #15) stated that he and (CNA #14) were assisting the nurse because she needed to draw urine, the urine was drawn, he and (CNA #14) changed (R42) and repositioned him in bed, then left the room. Licensed Practical Nurse, (LPN #11), stated she had an order for a urine specimen, attempted to catheterize (R42) and he became combative. She stated she then called for two Certified Nursing Assistant to get the urine specimen, she stopped the catheterization when blood was noted to be entering the foley tube. (LPN #11) contacted the on call nurse practitioner, their direction was to monitor the resident. On the morning of 01/29/2025, blood was noted, an order was then obtained to transfer (R42) to the hospital. Under Findings it documented in part, The written and verbal statements provided by the staff involved in this incident support that the Certified Nursing Assistants did hold (R42's) legs and arms when the Licensed Practical Nurse catheterized him. This allegation of abuse is substantiated. Law enforcement has been notified.The three staff members involved (LPN #11, CNA #14 and CNA #15) will be terminated from (Name of Facility) and their license will be reported to the Virginia Board of Nursing. The facility's Statement of Event dated 01/29/2025 and written by LPN #11 regarding R42 documented, Guest have [sic] a urine sample order from MD (medical doctor). Writer tried to collect urine but guest is not oriented so unable to pee on [sic] urinal, writer tried to do in and out catheter. During this procedure guest was combative so write called two CNA [sic] to help get the urine. During procedure writer noted blood is [sic] coming in foley tube so stoped [sic] the procedure and help [sic] guest to be on [sic] comfortable position and monitoring if he [sic] still bleeding but no blood noted. Called to [sic] an on call NP and notified NP. (unrecognizable words) monitor guest. For the (unrecognizable word) night guest was ok around 5 Am (5:00 a.m.) guest start [sic] to pee and noted [sic] uncomfortable and is in pain, blood noted in the urine. writer [sic] help [sic] guest to [sic] clean up and get (unrecognizable word) call Np made aware and sent resident to (Name of Hospital) for further evaluation. The facility's Statement of Event dated 01/29/2025 and written by CNA #14 regarding R42 documented, 1-28-25 evening (unrecognizable word) when (CNA #15) call [sic] me to help with (R42) because they are trying to get some urine but he was fighting so I went to help together with the nurse. so [sic] in all we were 3 (three) people that take care [sic] of (R42) to get the urine. that [sic] is what happened and before we assist [sic] the patient, the visitor went out. The facility's Statement of Event dated 01/29/2025 documented in part, Interviews were conducted with the staff involved. (Name of LPN #11): (LPN #11) confirmed that (R42) was restrained during the procedure. She stated that he was combative, even during routine care such as brief changes, and that restraining residents was common practice. She expressed surprise when informed that residents (continued on next page)

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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 0552 Level of Harm - Actual harm Residents Affected - Few	have the right to refuse care and cannot be restrained against their will. (LPN #11) stated that (R42) did not verbally refuse the procedure; (Name of CNA #14): (CNA #14) admitted to restraining (R42's) arms while (LPN #11) attempted the catheter insertion. He confirmed that (CNA #15) retrained (R42's) legs. He stated that the procedure was stopped due to bleeding; (Name of CNA #15): (CNA #15) denied physically restraining (R42), stating that he was only assisting (LPN #11) and (CNA #14), The facility's Statement of Event dated 01/30/2025 and written by the previous Director of Nursing documented, On January 29, 2025, (Name of R42's Friend), came into my office to express her concerns with an incident she witnessed the night of January 28, 2025. She described being in (R42's) room while a nurse attempted to insert a foley catheter. She voiced that at some point (R42) told the nurse to stop and he grabbed his penis to stop her. She then stated that the nurse called out to people to come and help her. She stated that while the staff entered the room they asked her to step out . While at the door she could hear (R42) yelling but could not make out what he said. She verbalized that she knew that the staff had held him down and was overwhelmed by this event. At that time I notified my CNA to come into my office so that he could hear her statement. We interviewed the staff (CNA #14 and CNA #15). (CNA #14) voiced that he was called to help the nurse and he held (R42's) legs while (CNA #15) held his arms so that the nurse could obtain the urine specimen. We interviewed the nurse (LPN #11) and she voiced that she called on (CNA #14 and CNA #15) to assist her with collecting (R42's) urine sample. The facility's Social Services Note for R42 dated 01/30/2025 at 12:44 p.m. documented, Late Entry: Note Text: Met with the resident for a touchbase [sic] following readmission from (Name of Hospital) on 1/29/2025 at or around 6:15pm (p.m.). Writer asked the resident is he was feeling okay, in which he responded with not too good. Writer asked the resident why he did not feel good. Resident did not respond. Asked the resident if he was feeling uncomfortable in any way. Resident nodded his head. When asked where he was feeling uncomfortable, he pointed to the area below the waist. Writer asked the resident if that area was painful in hisrecent [sic] hospitalization. Resident nodded his head. Met with the resident for a follow-up on the morning of 1/30/2025. Writer asked the resident if he was experiencing any pain or discomfort at the time. Resident informed the writer that he is feeling goodthis [sic] morning, and looking forward to lunch. Resident shook his head, denying any pain. Writer performed PHQ2:9 (patient health question) (6) and BIMS (brief interview for mental status) assessment to determine depression. Resident scored a 3 (severely impaired of cognition for making daily decisions). He was unable to repeat words from assessment. Resident was aware of the date, and unaware of year, and day. Resident was able to recall only one word. Resident has severe cognitive impairment and remains at risk for disorganized thinking, and inattention. Resident is a poor historian regarding recent events. Resident was able to recall his lifelong profession of MD, internist (specializes in internal medicine). Writer thanked the resident for his participation. Resident is not at risk of adverse psychosocial impacts.The facility's Physician/Practitioner Progress Note for R42 dated 02/06/2025 documented, Narrative Note Text: GERIATRIC PSYCHIATRIC EVALUATION. The patient was seen for an initial comprehensive consultation today. I examined the patient, reviewed the medical records, and discussed care with the staff. A comprehensive, detailed report will follow. The patientis [sic] an [AGE] year-old retired pediatrician with a documented history of underlying dementia (7), referred for reevaluation of any psychiatric consequences following a recent traumatic urinary catheterization. I met at length with the patient's private duty aide, who cares for him at home and provided additional history. Since that episode, there has been no evidence of any dramatic change in mental status. The patient has no recollection of the event. He remains profoundly confused. I see no evidence of any sequelae resulting from the event. I will continue to follow the patient, and their mental health needs will be met here. On 02/19/2026 at approximately 12:57 p.m. an attempt to contact and interview CNA #15 by telephone was unsuccessful. A message was left on the voice mail requesting a call back. By the time of the survey exit, CNA #15 had not returned the phone call. On 02/19/2026 at approximately 1:00 p.m. a telephone interview was conducted with LPN #11 regarding her attempt to obtain a urine (continued on next page)

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F 0552 Level of Harm - Actual harm Residents Affected - Few	sample from R42 on 01/28/2025. LPN # 11 stated that she recalled the incident and R42. She stated that there was a physician's order to obtain a urine sample from R42 and that R42 had a low cognition and was not able to use the toilet. LPN #11 stated she noticed blood and stopped the catheterization and notified the physician and monitored R42 during the night and in the morning when R42's brief was being changed, she noticed blood in the brief, notified the physician and sent R42 to the hospital. When asked about abuse toward R42 during the procedure to collect a urine sample she stated that she did everything correctly. On 02/19/2026 at approximately 1:48 p.m. an interview was conducted with the Senior Director of Nursing Services regarding the incident of LPN #11 attempt to obtain a urine sample from R42 and CNA #14 and CNA #15 hold R42 down during the procedure on 01/28/2025. She stated she recalled the incident and R42 was in the facility at the time. When asked to describe the procedure to obtain a urine sample from a resident she stated approach the resident and tell them what procedure needs to be done and how it needs to be done and if the resident will allow the procedure to be done regardless of the resident's cognition level. Check with the resident's CNA to determine if the resident can void normally, in the toilet or urinal. If the resident is unable to, contact the physician for an order to use a straight cath (catheter) procedure (6). She further stated that if the resident refused the procedure, asked to stop, or showed distress, the procedure should be stopped and the physician notified that the urine could not be obtained. When asked if a resident has the right to refuse care, treatments or procedures she stated yes. After reviewing the incident involving R42, LPN #11, CNA #14 and CNA #15, the Senior Director of Nursing Services agreed that R42's rights were violated. On 02/19/2026 at approximately 2:50 p.m. a telephone interview was conducted with CNA #14 regarding the incident of holding R42 down while the nurse tried inserting a catheter to obtain a urine sample on 01/28/2025. CNA #14 stated he recalled the incident and R42. He stated that he and another CNA were in R42's room helping the nurse obtain a urine sample from R42. He stated that he held R42's hand so he would not grab his penis while the nurse was inserting the catheter. On 02/20/2026 at approximately 11:00 a.m. an interview was conducted with CNA #4 regarding abuse. When asked if a resident has the right to refuse care, treatments or procedures she stated yes. After reviewing the incident involving R42, LPN #11, CNA #14 and CNA #15, CNA #4 agreed that R42's rights were violated. On 02/20/2026 at approximately 12:00 p.m. an interview was conducted with LPN #1. When asked to describe the procedure for obtaining a urine sample from a male resident she stated that the nurse should check and be sure there is a physician's order to obtain the sample, collect the supplies, a catheter set, let the resident know what you are going to do, ask the resident if you could proceed with the procedure, remove the resident's pants, then their undergarment or brief, clean the resident's penis, lubricate the catheter, insert the catheter going slowly letting the resident know what is happening. When asked to describe the procedure if the resident becomes distressed or is demonstrating resistance to the catheterization she stated that the nurse should stop the procedure and if the urine could not be collected, the physician should be notified. When asked if forcing a resident to comply and participate in a procedure that they do not want is against their rights she stated yes and that it is a violation of the resident's right to refuse care, treatments or procedures. After reviewing the incident involving R42, LPN #11, CNA #14 and CNA #15, LPN #1 agreed that R42's rights were violated. The facility policy Abuse, Neglect & (and) Exploitation - Prevention, Reporting and Investigation documented in part, Policy Statement. It is the policy of the community that: a) Each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Team Members must not engage in, nor permit anyone else to engage in abuse, neglect or exploitation of any resident. On 02/19/2026 at approximately 5:00 p.m., the Administrator (ADM), and the DON, were made aware of a concern for harm. No further information was provided prior to exit. References:(1) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. (2) A test of your urine. It is often done to check for a urinary tract infection, kidney problems, or diabetes. This information was obtained from the website: https://medlineplus.gov/urinalysis.html (3) An antibiotic sensitivity test is (continued on next page)

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F 0552 Level of Harm - Actual harm Residents Affected - Few	used to help find the best treatment for a bacterial infection and certain fungal infections. This information was obtained from the website: https://medlineplus.gov/lab-tests/antibiotic-sensitivity-test/. (4) Is the insertion and removal of a catheter several times a day to empty the bladder. The purpose of catheterization is to drain urine from a bladder that is not emptying adequately. This information was obtained from the website: https://www.urotoday.com/urinary-catheters-home/intermittent-catheters/description/definition-intermittent-cath (5) Blood in the urine. This information was obtained from the website: https://medlineplus.gov/ency/article/003138.htm. (6) The PHQ-2 is the ultra-brief version of the questionnaire. It consists of just two questions that focus on anhedonia (loss of interest in things you used to enjoy) and depressed mood. Because it takes less than a minute to complete, it is often used as a quick first step. The PHQ-9 is the full version of the module. It incorporates the two questions from the PHQ-2 but expands to cover physical and cognitive symptoms. It looks at sleep patterns, energy levels, appetite, concentration, and physical movement. While the PHQ-2 screens for the presence of a concern, the PHQ-9 helps estimate severity and how symptoms may be affecting daily life. This information was obtained from the website: https://phq-9.org/blog/phq-2-vs-phq-9-a-guide-to-mood-screening-scoring-edited. (7) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

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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, facility document review and clinical record review, the facility staff failed to notify the physician and/or the responsible party when medications are not available for administration for one of 36 residents in the survey sample, Resident #24.The findings include:For Resident #24 (R24), the facility staff failed to notify the physician when medication were not administered.The physician order dated, 1/21/2026 documented, Metoprolol Succinate Oral Capsule ER (extended Release) (1) 24 hours Sprinkle 25 MG (milligrams); Give 1 tablet by mouth one time a day for Heart failure.The January 2026 MAR (medication administration record) documented the above order. On 1/21/2026, a 9 was documented for the 9:00 a.m. dose of Metoprolol. A 9 indicated, Other/See Progress Note. A review of the progress note dated, 1/21/2026 at 11:53 a.m. documented, Awaiting pharmacy supply.The physician order dated, 1/17/2026, documented, Bumetanide Oral Tablet 0.5 MG (milligrams); Give 0.5 MG by mouth one time a day for diuretic.The January 2026 Mediation Administration Record (MAR) documented the above order. On 1/21/2026 for the 9:00 a.m. dose a 9 was documented. A 9 indicates Other/See Progress Notes.Review of the progress notes dated, 1/21/2026 at 11:53 a.m. documented, Awaiting pharmacy supply.An interview was conducted with LPN (licensed practical nurse) #1, on 2/20/2026 at 12:05 p.m. LPN #1 stated if a medication is not in the medication cart, the nurse should check in the back up pharmacy system to see if it's there. If it's not there, the nurse needs to notify the pharmacy of the missing medication and notify the physician it was not given.An interview was conducted with the Director of Nursing (DON), on 2/20/2026 at 12:57 p.m. The above information was shared with the DON. She stated the nurse should check the backup system and if not there, call the pharmacy. After that the nurse needs to notify the physician and the responsible party that the medication is not available and document in the medical record.The facility stated they had no policy on notification of the physician or responsible party.The Administrator, DON, General Manager, and the Senior Director of Nursing Services, were made aware of the above concerns on 2/20/2026 at 2:26 p.m.No further information was provided prior to exit. 1. Metoprolol Tartrate is used to treat high blood pressure. This information was obtained from the following website: https://medlineplus.gov/druginfo /meds/a682864.html2. Bumetanide is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease. Bumetanide is in a class of medications called diuretics ('water pills'). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a684051.html.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **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 protect the resident from physical abuse while obtaining a urine sample that resulted in hospitalization, thus resulting in the determination of Immediate Jeopardy (IJ) for one of 36 residents in the survey sample, Resident #42. After IJ was removed, the scope and severity was lowered to a level 3 (three), isolated, harm. The findings include: For Resident #42 (R42), the facility staff failed to protect the resident from physical abuse while obtaining a urine sample which resulted in IJ and harm. R42 was admitted to the facility with diagnosis that included but was not limited to benign prostatic hyperplasia (1). On the most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/20/2025, R42 scored 4 (four) out of 15 on the BIMS (brief interview for mental status), indicating R42 was severely impaired of cognition for making daily decisions. Section H0300 Urinary Continence coded R42 as being Always incontinent. The physician's order for R42 dated 01/24/2025 documented, UA (urinalysis) (2) C (culture) & (and) S (sensitivity) (3) . every shift for 3 (three) days. The facility's Health Status Note for R42 dated 01/28/2025 at 11:35 p.m. documented, Note Text: Guest have [sic] order UA C&S, Guest unable to urinate on [sic] urinal so in and out catheterization (4) performed for urine sample collection, bright blood noted in the urine sample collected, in and out catheter removed, no signs of shock or distress noted, Guest appeared anxious but stable. on call NP (nurse practitioner) (Name of NP) made aware NP state to monitor Guest. Will continue to monitor. The facility's Health Status Note for R42 dated 01/28/2025 at 11:54 p.m. documented, Note Text: Daughter (Name of Daughter) made aware. The facility's Health Status Note for R42 dated 01/29/2025 at 7:59 a.m. documented, Note Text: Around 5AM (5:00 a.m.) Guest noted discomfortable and have pain during urinating, hematuria (5) , blood clot noted on brief. vitals checked BP (blood pressure) 135/65 (135 over 65), P (pulse) 81 (beats per minute), R (respiration) 19, T (temperature) 97.7 (degrees Fahrenheit), O2 (oxygen) 97% (percent) room air. on call NP notified and NP gave order to send guest to ER (emergency room), POA (power of attorney) daughter made aware, guest sent to (Name of Hospital). The facility's Health Status Note for R42 dated 01/29/2025 at 3:30 p.m. documented, Note Text: Guest return form [sic] (Name of Hospital) d/t (due to) hematuria. Came in with indwelling urinary catheter with Blood in the urine. Vital BP 165/70,HR 61,T 98.4,RR 18,O2 96 ON R/A (room air) no pain. Guest is stable at this time with no distress noted. Daughter is aware guest has return to facility. The facility's Grievance Report for R42 dated 01/29/2025 documented in part, Describe concerns using factual terms: Resident had catheter used for urine sample against his will resulting in injury and hospitalization. What other action was taken to resolve this concern?: Dismissal of responsible staff. Was grievance resolved? Yes, resident received psychiatric follow-up to address trauma, accused staff dismissed from company. Summary Statement of the resident's grievance: Catheter placed for urine sample following resident's refusal. Resident sent out with bleeding in the groin area. Steps taken to investigate grievance: FRI (facility reported incident) initiated on 1/29/25. Responsible staff provided statements prior to placement on administrative leave. Summary of the pertinent findings or conclusions regarding the resident's concern(s): Resident was found to have bleeding and refusal of care following traumatic incident. The facility's synopsis of events for R42 dated 01/29/2025 documented in part, Incident: (R42's) friend (Name of Friend) reported on 1/29/2025 concerns about the care provided to (R42) on the evening of 1/28/2025. Investigation: At around 3:00 PM (p.m.) on 01//29/2025, (Name of R42's Friend) came to speak with the Director of Nursing, (Name of Previous Director of Nursing) and Senior Director of Nursing. At that time (Name of R42's Friend) reported she had been visiting with (R42) the evening of 01/28/2025 when a nurse entered his room to insert a catheter. (Name of R42's Friend) reported that (R42) stated Don't do that and crossed his legs. (Name of R42's Friend) then (continued on next page)

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	495269	A. Building B. Wing	03/12/2026

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The Jefferson	900 North Taylor Street Arlington, VA 22203

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reported the nurse called out for additional staff to assist her and two staff entered the room and asked her to step out into the hallway. While in the hallway, (Name of R42's Friend), stated she heard (R42) yelling out, but could not make out his words. When the staff left the room, (Name of R42's Friend) returned to bedside and stayed with (R42) until 11:30 PM (p.m.). During (Name of R42's Friend) report, the administrator entered the office. (Name of R42's Friend) was able to provide descriptions of the staff and the (Name of Facility) staff were able to identify the staff providing care to (R42) on 01/28/2025. Each of the three staff members were interviewed Certified Nursing Assistant (CNA #14) reported that on the evening of 01/28/2025, he was called into (R42's) room by Certified Nursing Assistant (CNA #15) because he and Licensed Practical Nurse (LPN #11) were attempting to collect urine and (R42) was combative. (CNA #14) stated he went to assist with getting the urine, he stated verbally to the Administrator and Director of Nursing that he and (CNA #15), held (R42) legs and arms while the nurse catheterized him. Certified Nursing Assistant (CNA #15) stated that he and (CNA #14) were assisting the nurse because she needed to draw urine, the urine was drawn, he and (CNA #14) changed (R42) and repositioned him in bed, then left the room. Licensed Practical Nurse, (LPN #11), stated she had an order for a urine specimen, attempted to catheterize (R42) and he became combative. She stated she then called for two Certified Nursing Assistant to get the urine specimen, she stopped the catheterization when blood was noted to be entering the foley tube. (LPN #11) contacted the on call nurse practitioner, their direction was to monitor the resident. On the morning of 01/29/2025, blood was noted, an order was then obtained to transfer (R42) to the hospital. Under Findings it documented in part, The written and verbal statements provided by the staff involved in this incident support that the Certified Nursing Assistants did hold (R42's) legs and arms when the Licensed Practical Nurse catheterized him. This allegation of abuse is substantiated. Law enforcement has been notified.The three staff members involved (LPN #11, CNA #14 and CNA #15) will be terminated from (Name of Facility) and their license will be reported to the Virginia Board of Nursing. The facility's Statement of Event dated 01/29/2025 and written by LPN #11 regarding R42 documented, Guest have [sic] a urine sample order from MD (medical doctor). Writer tried to collect urine but guest is not oriented so unable to pee on [sic] urinal, writer tried to do in and out catheter. During this procedure guest was combative so write called two CNA [sic] to help get the urine. During procedure writer noted blood is [sic] coming in foley tube so stoped [sic] the procedure and help [sic] guest to be on [sic] comfortable position and monitoring if he [sic] still bleeding but no blood noted. Called to [sic] an on call NP and notified NP. (unrecognizable words) monitor guest. For the (unrecognizable word) night guest was ok around 5 Am (5:00 a.m.) guest start [sic] to pee and noted [sic] uncomfortable and is in pain, blood noted in the urine. writer [sic] help [sic] guest to [sic] clean up and get (unrecognizable word) call Np made aware and sent resident to (Name of Hospital) for further evaluation. The facility's Statement of Event dated 01/29/2025 and written by CNA #14 regarding R42 documented, 1-28-25 evening (unrecognizable word) when (CNA #15) call [sic] me to help with (R42) because they are trying to get some urine but he was fighting so I went to help together with the nurse. so [sic] in all we were 3 (three) people that take care [sic] of (R42) to get the urine. that [sic] is what happened and before we assist [sic] the patient, the visitor went out. The facility's Statement of Event dated 01/29/2025 documented in part, Interviews were conducted with the staff involved. (Name of LPN #11): (LPN #11) confirmed that (R42) was restrained during the procedure. She stated that he was combative, even during routine care such as brief changes, and that restraining residents was common practice. She expressed surprise when informed that residents have the right to refuse care and cannot be restrained against their will. (LPN #11) stated that (R42) did not verbally refuse the procedure; (Name of CNA #14): (CNA #14) admitted to restraining (R42's) arms while (LPN #11) attempted the catheter insertion. He confirmed that (CNA #15) retrained (R42's) legs. He stated that the procedure was stopped due to bleeding; (Name of CNA #15): (CNA #15) denied physically restraining (R42), stating that he was only assisting (LPN #11) and (CNA #14), The facility's Statement of Event dated 01/30/2025 and written by the previous Director (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of Nursing documented, On January 29, 2025, (Name of R42's Friend), came into my office to express her concerns with an incident she witnessed the night of January 28, 2025. She described being in (R42's) room while a nurse attempted to insert a foley catheter. She voiced that at some point (R42) told the nurse to stop and he grabbed his penis to stop her. She then stated that the nurse called out to people to come and help her. She stated that while the staff entered the room they asked her to step out . While at the door she could hear (R42) yelling but could not make out what he said. She verbalized that she knew that the staff had held him down and was overwhelmed by this event. At that time I notified my CNA to come into my office so that he could hear her statement. We interviewed the staff (CNA #14 and CNA #15). (CNA #14) voiced that he was called to help the nurse and he held (R42's) legs while (CNA #15) held his arms so that the nurse could obtain the urine specimen. We interviewed the nurse (LPN #11) and she voiced that she called on (CNA #14 and CNA #15) to assist her with collecting (R42's) urine sample. The facility's Social Services Note for R42 dated 01/30/2025 at 12:44 p.m. documented, Late Entry: Note Text: Met with the resident for a touchbase [sic] following readmission from (Name of Hospital) on 1/29/2025 at or around 6:15pm (p.m.). Writer asked the resident is he was feeling okay, in which he responded with not too good. Writer asked the resident why he did not feel good. Resident did not respond. Asked the resident if he was feeling uncomfortable in any way. Resident nodded his head. When asked where he was feeling uncomfortable, he pointed to the area below the waist. Writer asked the resident if that area was painful in hisrecent [sic] hospitalization. Resident nodded his head. Met with the resident for a follow-up on the morning of 1/30/2025. Writer asked the resident if he was experiencing any pain or discomfort at the time. Resident informed the writer that he is feeling goodthis [sic] morning, and looking forward to lunch. Resident shook his head, denying any pain. Writer performed PHQ2:9 (patient health question) (6) and BIMS (brief interview for mental status) assessment to determine depression. Resident scored a 3 (severely impaired of cognition for making daily decisions). He was unable to repeat words from assessment. Resident was aware of the date, and unaware of year, and day. Resident was able to recall only one word. Resident has severe cognitive impairment and remains at risk for disorganized thinking, and inattention. Resident is a poor historian regarding recent events. Resident was able to recall his lifelong profession of MD, internist (specializes in internal medicine). Writer thanked the resident for his participation. Resident is not at risk of adverse psychosocial impacts.The facility's Physician/Practitioner Progress Note for R42 dated 02/06/2025 documented, Narrative Note Text: GERIATRIC PSYCHIATRIC EVALUATION. The patient was seen for an initial comprehensive consultation today. I examined the patient, reviewed the medical records, and discussed care with the staff. A comprehensive, detailed report will follow. The patientis [sic] an [AGE] year-old retired pediatrician with a documented history of underlying dementia (7), referred for reevaluation of any psychiatric consequences following a recent traumatic urinary catheterization. I met at length with the patient's private duty aide, who cares for him at home and provided additional history. Since that episode, there has been no evidence of any dramatic change in mental status. The patient has no recollection of the event. He remains profoundly confused. I see no evidence of any sequelae resulting from the event. I will continue to follow the patient, and their mental health needs will be met here. On 02/19/2026 at approximately 12:57 p.m. an attempt to contact and interview CNA #15 by telephone was unsuccessful. A message was left on the voice mail requesting a call back. By the time of the survey exit, CNA #15 had not returned the phone call. On 02/19/2026 at approximately 1:00 p.m. a telephone interview was conducted with LPN #11 regarding her attempt to obtain a urine sample from R42 on 01/28/2025. LPN # 11 stated that she recalled the incident and R42. She stated that there was a physician's order to obtain a urine sample from R42 and that R42 had a low cognition and was not able to use the toilet. LPN #11 stated she noticed blood and stopped the catheterization and notified the physician and monitored R42 during the night and in the morning when R42's brief was being changed, she noticed blood in the brief, notified the physician and sent R42 to the hospital. When asked about abuse toward R42 during the procedure to collect a urine sample she stated that (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	she did everything correctly. On 02/19/2026 at approximately 1:48 p.m. an interview was conducted with the Senior Director of Nursing Services regarding the incident of LPN #11 attempt to obtain a urine sample from R42 and CNA #14 and CNA #15 hold R42 down during the procedure on 01/28/2025. She stated she recalled the incident and R42 was in the facility at the time. When asked to describe the procedure to obtain a urine sample from a resident she stated approach the resident and tell them what procedure needs to be done and how it needs to be done and if the resident will allow the procedure to be done regardless of the resident's cognition level. Check with the resident's CNA to determine if the resident can void normally, in the toilet or urinal. If the resident is unable to, contact the physician for an order to use a straight cath (catheter) procedure (6). She further stated that if the resident refused the procedure, asked to stop, or showed distress, the procedure should be stopped and the physician notified that the urine could not be obtained. When asked to describe abuse she stated that it would be forcing a resident to do something against their will or treating them in a manner that causes injury. After reviewing the incident of LPN #11 attempting to obtain a urine sample by use of a catheter without a physician's order resulting in R42 bleeding and needing to be sent to the hospital the Senior Director of Nursing Services considered it abuse. On 02/19/2026 at approximately 2:50 p.m. a telephone interview was conducted with CNA #14 regarding the incident of holding R42 down while the nurse tried inserting a catheter to obtain a urine sample on 01/28/2025. CNA #14 stated he recalled the incident and R42. He stated that he and another CNA were in R42's room helping the nurse obtain a urine sample from R42. He stated that he held R42's hand so he would not grab his penis while the nurse was inserting the catheter. On 02/20/2026 at approximately 11:00 a.m. an interview was conducted with CNA #4 regarding abuse. When asked to describe examples of abuse to a resident she stated that it would be physically hitting a resident, forcing a resident to do something and causing an injury. When informed of the incident where the nurse was inserting a catheter into R42 while he was refusing the procedure, causing bleeding and being sent to the hospital she stated that it would be considered abuse. On 02/20/2026 at approximately 1:54 p.m. a telephone interview was conducted with the Medical Director regarding the procedure for obtaining a urine sample from a resident. When asked how he would expect a nurse to obtain a urine sample he stated that he would indicate it on the order if the nurse would not be able to obtain a Clean catch (normal voiding/ voiding into a toilet, specimen cup or urinal). He further stated that if the nurse is unable to collect the urine by natural voiding, the nurse should obtain a physician's order for a catheter to be used. On 02/20/2026 at approximately 12;00 p.m. an interview was conducted with LPN #1. When asked to describe the procedure for obtaining a urine sample from a male resident she stated that the nurse should check and be sure there is a physician's order to obtain the sample, collect the supplies, a catheter set, let the resident know what you are going to do, ask the resident if you could proceed with the procedure, remove the resident's pants, then their undergarment or brief, clean the resident's penis, lubricate the catheter, insert the catheter going slowly letting the resident know what is happening. When asked to describe the procedure if the resident becomes distressed or is demonstrating resistance to the catheterization she stated that the nurse should stop the procedure and if the urine could not be collected, the physician should be notified. When informed of the incident where the nurse was inserting a catheter into R42 while he was refusing the procedure, causing bleeding and being sent to the hospital she stated that it would be considered abuse. The facility policy Abuse, Neglect & (and) Exploitation - Prevention, Reporting and Investigation documented in part, Definitions: Abuse: means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. On 02/19/2026 at approximately 5:00 p.m., the administrator (ADM), and the DON, were made aware of a concern for harm. On 03/10/2025 at 12:15 p.m. the facility Administrator, Director of Nursing, Senior Director of Nursing Services, Regional Director of Resident Care, and the General Manager, were notified of immediate jeopardy (IJ). The facility presented the following IJ plan which was accepted on 03/12/2026 at 9:37 a.m. Immediate corrective action: The incident occurred January 2025, Resident has been discharged (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	from the facility. The allegation was reported, investigated and substantiated for abuse. Staff members involved were placed on paid administrative leave pending investigation and subsequently terminated and reported to their respective licensing agencies. Immediate skin assessment completed on Resident 42. No skin impairment or changes noted. Resident 42 was evaluated by the facility social worker for psychosocial distress related to the incident and no distress was reported or observed.Identify other residents that may potentially have been affected by this deficiency and what corrective actions will be completed: Residents identified as having potential to be affected by this deficiency were residents with orders for straight catheterization. Immediate skin checks were done for all residents. Interviews were done with residents and no care issues or abuse issues were identified. At the time of the incident, Resident #42 was the only resident with an order for straight catheterization from January 2025 through February 2025. Measures will be put in place or systemic changes will be made to ensure deficient practice will not reoccur: CNAs, LPNs, RNs, Dietary, Social Services, Housekeeping, Therapy, Maintenance, Activities and MDS Coordinator were in serviced and educated on abuse policies and procedures and who the abuse coordinator is at The [NAME] on 1/29/2025-1/31/2025. Staff were also educated on a resident's right to refuse or decline care and procedures and how nursing staff are to respond when a resident refuses care or treatment. The team members indicated as being trained were educated to offer alternatives if possible and provide education on the needed treatment. New hire and annual training continues to be assigned and measured for completion. Corrective actions/system changes be monitored to ensure the deficient practice will not reoccur: Abuse and Neglect Prevention Training will be assigned and monitored for all new hires during orientation and annually for all employees. This will be monitored by the Administrator or designee. Resident Grievances are monitored continually by the administrator/or designee for concerns regarding abuse. All Skilled Nursing Facility Team members are trained upon hire and annually to observe signs of abuse with cognitively impaired residents and report concerns to the administrator. The DON/or designee will audit skin checks weekly for 50% of resident census weekly x 8 weeks or as determined by the QAPI committee to monitor for concerns. The Administrator/or designee will conduct 5 resident interviews weekly x 8 weeks or as determined by the QAPI committee to monitor satisfaction with care and monitor for reports of abuse. Compliance and audit results are monitored through the facility QAPI program, and the Administrator is responsible for ongoing compliance. Compliance Date: 2/4/2025.On 03/12/2026 the survey team, through observation, interviews and documentation review, verified the removal plan had been fully implemented by the facility. On 03/12/2026 at 3:15 p.m. the facility's Administrator, Director of Nursing, Senior Director of Nursing Services, Regional Director of Resident Care, Director of Skilled Services Division, and the General Manager, were informed the removal plan had been verified and the IJ had been abated.No further information was provided prior to exit. References:(1) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. (2) A test of your urine. It is often done to check for a urinary tract infection, kidney problems, or diabetes. This information was obtained from the website: https://medlineplus.gov/urinalysis.html (3) An antibiotic sensitivity test is used to help find the best treatment for a bacterial infection and certain fungal infections. This information was obtained from the website: https://medlineplus.gov/lab-tests/antibiotic-sensitivity-test/. (4) Is the insertion and removal of a catheter several times a day to empty the bladder. The purpose of catheterization is to drain urine from a bladder that is not emptying adequately. This information was obtained from the website: https://www.urotoday.com/urinary-catheters-home/intermittent-catheters/description/definition-intermittent-cath (5) Blood in the urine. This information was obtained from the website: https://medlineplus.gov/ency/article/003138.htm. (6) The PHQ-2 is the ultra-brief version of the questionnaire. It consists of just two questions that focus on anhedonia (loss of interest in things you used to enjoy) and depressed mood. Because it takes less than a minute to complete, it is often used (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	as a quick first step. The PHQ-9 is the full version of the module. It incorporates the two questions from the PHQ-2 but expands to cover physical and cognitive symptoms. It looks at sleep patterns, energy levels, appetite, concentration, and physical movement. While the PHQ-2 screens for the presence of a concern, the PHQ-9 helps estimate severity and how symptoms may be affecting daily life. This information was obtained from the website: https://phq-9.org/blog/phq-2-vs-phq-9-a-guide-to-mood-screening-scoring-edited. (7) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

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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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **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 keep the resident from being physically restrained while obtaining a urine sample that resulted in hospitalization, thus resulting in the determination of Immediate Jeopardy (IJ) for one of 36 residents in the survey sample, Resident #42, (R42). After IJ was removed, the scope and severity was lowered to a level 3 (three), isolated, harm. The findings include: For Resident #42 (R42), the facility staff failed to protect the resident from being physically restrained while obtaining a urine sample which resulted in IJ and harm. R42 was admitted to the facility with diagnosis that included but was not limited to benign prostatic hyperplasia (1). On the most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/20/2025, R42 scored 4 (four) out of 15 on the BIMS (brief interview for mental status), indicating R42 was severely impaired of cognition for making daily decisions. Section H0300 Urinary Continence coded R42 as being Always incontinent. The physician's order for R42 dated 01/24/2025 documented, UA (urinalysis) (2) C (culture) & (and) S (sensitivity) (3) . every shift for 3 (three) days. The facility's Health Status Note for R42 dated 01/28/2025 at 11:35 p.m. documented, Note Text: Guest have [sic] order UA C&S, Guest unable to urinate on [sic] urinal so in and out catheterization (4) performed for urine sample collection, bright blood noted in the urine sample collected, in and out catheter removed, no signs of shock or distress noted, Guest appeared anxious but stable. on call NP (nurse practitioner) (Name of NP) made aware NP state to monitor Guest. Will continue to monitor. The facility's Health Status Note for R42 dated 01/28/2025 at 11:54 p.m. documented, Note Text: Daughter (Name of Daughter) made aware. The facility's Health Status Note for R42 dated 01/29/2025 at 7:59 a.m. documented, Note Text: Around 5AM (5:00 a.m.) Guest noted discomfortable and have pain during urinating, hematuria (5) , blood clot noted on brief. vitals checked BP (blood pressure) 135/65 (135 over 65), P (pulse) 81 (beats per minute), R (respiration) 19, T (temperature) 97.7 (degrees Fahrenheit), O2 (oxygen) 97% (percent) room air. on call NP notified and NP gave order to send guest to ER (emergency room), POA (power of attorney) daughter made aware, guest sent to (Name of Hospital). The facility's Health Status Note for R42 dated 01/29/2025 at 3:30 p.m. documented, Note Text: Guest return form [sic] (Name of Hospital) d/t (due to) hematuria. Came in with indwelling urinary catheter with Blood in the urine. Vital BP 165/70,HR 61,T 98.4,RR 18,O2 96 ON R/A (room air) no pain. Guest is stable at this time with no distress noted. Daughter is aware guest has return to facility. The facility's Grievance Report for R42 dated 01/29/2025 documented in part, Describe concerns using factual terms: Resident had catheter used for urine sample against his will resulting in injury and hospitalization. What other action was taken to resolve this concern?: Dismissal of responsible staff. Was grievance resolved? Yes, resident received psychiatric follow-up to address trauma, accused staff dismissed from company. Summary Statement of the resident's grievance: Catheter placed for urine sample following resident's refusal. Resident sent out with bleeding in the groin area. Steps taken to investigate grievance: FRI (facility reported incident) initiated on 1/29/25. Responsible staff provided statements prior to placement on administrative leave. Summary of the pertinent findings or conclusions regarding the resident's concern(s): Resident was found to have bleeding and refusal of care following traumatic incident. The facility's synopsis of events for R42 dated 01/29/2025 documented in part, Incident: (R42's) friend (Name of Friend) reported on 1/29/2025 concerns about the care provided to (R42) on the evening of 1/28/2025. Investigation: At around 3:00 PM (p.m.) on 01//29/2025, (Name of R42's Friend) came to speak with the Director of Nursing, (Name of Previous Director of Nursing) and Senior Director of Nursing. At that time (Name of R42's Friend) reported she had been visiting with (R42) the evening of 01/28/2025 when a nurse entered his room to insert a catheter. (Name of R42's Friend) reported that (R42) stated Don't do that (continued on next page)

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	495269	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Jefferson	900 North Taylor Street Arlington, VA 22203

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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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and crossed his legs. (Name of R42's Friend) then reported the nurse called out for additional staff to assist her and two staff entered the room and asked her to step out into the hallway. While in the hallway, (Name of R42's Friend), stated she heard (R42) yelling out, but could not make out his words. When the staff left the room, (Name of R42's Friend) returned to bedside and stayed with (R42) until 11:30 PM (p.m.). During (Name of R42's Friend) report, the administrator entered the office. (Name of R42's Friend) was able to provide descriptions of the staff and the (Name of Facility) staff were able to identify the staff providing care to (R42) on 01/28/2025. Each of the three staff members were interviewed Certified Nursing Assistant (CNA #14) reported that on the evening of 01/28/2025, he was called into (R42's) room by Certified Nursing Assistant (CNA #15) because he and Licensed Practical Nurse (LPN #11) were attempting to collect urine and (R42) was combative. (CNA #14) stated he went to assist with getting the urine, he stated verbally to the Administrator and Director of Nursing that he and (CNA #15), held (R42's) legs and arms while the nurse catheterized him. Certified Nursing Assistant (CNA #15) stated that he and (CNA #14) were assisting the nurse because she needed to draw urine, the urine was drawn, he and (CNA #14) changed (R42) and repositioned him in bed, then left the room. Licensed Practical Nurse, (LPN #11), stated she had an order for a urine specimen, attempted to catheterize (R42) and he became combative. She stated she then called for two Certified Nursing Assistant to get the urine specimen, she stopped the catheterization when blood was noted to be entering the foley tube. (LPN #11) contacted the on call nurse practitioner, their direction was to monitor the resident. On the morning of 01/29/2025, blood was noted, an order was then obtained to transfer (R42) to the hospital. Under Findings it documented in part, The written and verbal statements provided by the staff involved in this incident support that the Certified Nursing Assistants did hold (R42's) legs and arms when the Licensed Practical Nurse catheterized him. This allegation of abuse is substantiated. Law enforcement has been notified.The three staff members involved (LPN #11, CNA #14 and CNA #15) will be terminated from (Name of Facility) and their license will be reported to the Virginia Board of Nursing. The facility's Statement of Event dated 01/29/2025 and written by LPN #11 regarding R42 documented, Guest have [sic] a urine sample order from MD (medical doctor). Writer tried to collect urine but guest is not oriented so unable to pee on [sic] urinal, writer tried to do in and out catheter. During this procedure guest was combative so write called two CNA [sic] to help get the urine. During procedure writer noted blood is [sic] coming in foley tube so stoped [sic] the procedure and help [sic] guest to be on [sic] comfortable position and monitoring if he [sic] still bleeding but no blood noted. Called to [sic] an on call NP and notified NP. (unrecognizable words) monitor guest. For the (unrecognizable word) night guest was ok around 5 Am (5:00 a.m.) guest start [sic] to pee and noted [sic] uncomfortable and is in pain, blood noted in the urine. writer [sic] help [sic] guest to [sic] clean up and get (unrecognizable word) call Np made aware and sent resident to (Name of Hospital) for further evaluation. The facility's Statement of Event dated 01/29/2025 and written by CNA #14 regarding R42 documented, 1-28-25 evening (unrecognizable word) when (CNA #15) call [sic] me to help with (R42) because they are trying to get some urine but he was fighting so I went to help together with the nurse. so [sic] in all we were 3 (three) people that take care [sic] of (R42) to get the urine. that [sic] is what happened and before we assist [sic] the patient, the visitor went out. The facility's Statement of Event dated 01/29/2025 documented in part, Interviews were conducted with the staff involved. (Name of LPN #11): (LPN #11) confirmed that (R42) was restrained during the procedure. She stated that he was combative, even during routine care such as brief changes, and that restraining residents was common practice. She expressed surprise when informed that residents have the right to refuse care and cannot be restrained against their will. (LPN #11) stated that (R42) did not verbally refuse the procedure; (Name of CNA #14): (CNA #14) admitted to restraining (R42's) arms while (LPN #11) attempted the catheter insertion. He confirmed that (CNA #15) retrained (R42's) legs. He stated that the procedure was stopped due to bleeding; (Name of CNA #15): (CNA #15) denied physically restraining (R42), stating that he was only assisting (LPN #11) and (CNA #14), The facility's Statement of Event dated (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	01/30/2025 and written by the previous Director of Nursing documented, On January 29, 2025, (Name of R42's Friend), came into my office to express her concerns with an incident she witnessed the night of January 28, 2025. She described being in (R42's) room while a nurse attempted to insert a foley catheter. She voiced that at some point (R42) told the nurse to stop and he grabbed his penis to stop her. She then stated that the nurse called out to people to come and help her. She stated that while the staff entered the room they asked her to step out . While at the door she could hear (R42) yelling but could not make out what he said. She verbalized that she knew that the staff had held him down and was overwhelmed by this event. At that time I notified my CNA to come into my office so that he could hear her statement. We interviewed the staff (CNA #14 and CNA #15). (CNA #14) voiced that he was called to help the nurse and he held (R42's) legs while (CNA #15) held his arms so that the nurse could obtain the urine specimen. We interviewed the nurse (LPN #11) and she voiced that she called on (CNA #14 and CNA #15) to assist her with collecting (R42's) urine sample. The facility's Social Services Note for R42 dated 01/30/2025 at 12:44 p.m. documented, Late Entry: Note Text: Met with the resident for a touchbase [sic] following readmission from (Name of Hospital) on 1/29/2025 at or around 6:15pm (p.m.). Writer asked the resident is he was feeling okay, in which he responded with not too good. Writer asked the resident why he did not feel good. Resident did not respond. Asked the resident if he was feeling uncomfortable in any way. Resident nodded his head. When asked where he was feeling uncomfortable, he pointed to the area below the waist. Writer asked the resident if that area was painful in hisrecent [sic] hospitalization. Resident nodded his head. Met with the resident for a follow-up on the morning of 1/30/2025. Writer asked the resident if he was experiencing any pain or discomfort at the time. Resident informed the writer that he is feeling goodthis [sic] morning, and looking forward to lunch. Resident shook his head, denying any pain. Writer performed PHQ2:9 (patient health question) (6) and BIMS (brief interview for mental status) assessment to determine depression. Resident scored a 3 (severely impaired of cognition for making daily decisions). He was unable to repeat words from assessment. Resident was aware of the date, and unaware of year, and day. Resident was able to recall only one word. Resident has severe cognitive impairment and remains at risk for disorganized thinking, and inattention. Resident is a poor historian regarding recent events. Resident was able to recall his lifelong profession of MD, internist (specializes in internal medicine). Writer thanked the resident for his participation. Resident is not at risk of adverse psychosocial impacts.The facility's Physician/Practitioner Progress Note for R42 dated 02/06/2025 documented, Narrative Note Text: GERIATRIC PSYCHIATRIC EVALUATION. The patient was seen for an initial comprehensive consultation today. I examined the patient, reviewed the medical records, and discussed care with the staff. A comprehensive, detailed report will follow. The patientis [sic] an [AGE] year-old retired pediatrician with a documented history of underlying dementia (7), referred for reevaluation of any psychiatric consequences following a recent traumatic urinary catheterization. I met at length with the patient's private duty aide, who cares for him at home and provided additional history. Since that episode, there has been no evidence of any dramatic change in mental status. The patient has no recollection of the event. He remains profoundly confused. I see no evidence of any sequelae resulting from the event. I will continue to follow the patient, and their mental health needs will be met here. On 02/19/2026 at approximately 12:57 p.m. an attempt to contact and interview CNA #15 by telephone was unsuccessful. A message was left on the voice mail requesting a call back. By the time of the survey exit, CNA #15 had not returned the phone call. On 02/19/2026 at approximately 1:00 p.m. a telephone interview was conducted with LPN #11 regarding her attempt to obtain a urine sample from R42 on 01/28/2025. LPN # 11 stated that she recalled the incident and R42. She stated that there was a physician's order to obtain a urine sample from R42 and that R42 had a low cognition and was not able to use the toilet. She also stated that there were two CNAs in R42's room to help her obtain the urine and that they had to hold the resident down because he was putting his hand on his penis to stop her from inserting the catheter. When asked about restraint of R42 when CNA #14 and CNA #15 held down R42 down during the procedure to collect a urine sample she stated that she (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	did everything correctly. On 02/19/2026 at approximately 1:48 p.m. an interview was conducted with the Senior Director of Nursing Services regarding the incident of LPN #11 attempt to obtain a urine sample from R42 and CNA #14 and CNA #15 hold R42 down during the procedure on 01/28/2025. She stated she recalled the incident and R42 was in the facility at the time. When asked to describe the procedure to obtain a urine sample from a resident she stated approach the resident and tell them what procedure needs to be done and how it needs to be done and if the resident will allow the procedure to be done regardless of the resident's cognition level. Check with the resident's CNA to determine if the resident can void normally, in the toilet or urinal. If the resident is unable to, contact the physician for an order to use a straight cath (catheter) procedure (6). She further stated that if the resident refused the procedure, asked to stop, or showed distress, the procedure should be stopped and the physician notified that the urine could not be obtained. When asked to describe abuse she stated that it would be forcing a resident to do something against their will or treating them in a manner that causes injury. After reviewing the incident of CNA #14 and CNA #15 holding R42 down while LPN #11 tried inserting a catheter the Senior Director of Nursing Services considered it to be restraining R42 against his will. On 02/19/2026 at approximately 2:50 p.m. a telephone interview was conducted with CNA #14 regarding the incident of holding R42 down while the nurse tried inserting a catheter to obtain a urine sample on 01/28/2025. CNA #14 stated he recalled the incident and R42. He stated that he and another CNA were in R42's room helping the nurse obtain a urine sample from R42. He stated that he held R42's hand so he would not grab his penis while the nurse was inserting the catheter. When asked what the other CNA was doing at the time he stated that the other CNA was holding R42's other hand. When asked about restraining R42 during the procedure CNA #14 stated he was just holding his hand and telling R42 It's okay, it's okay. On 02/20/2026 at approximately 11:00 a.m. an interview was conducted with CNA #4 regarding restraint of a resident. When asked to describe restraint she stated it was holding a resident from doing what they wanted to do. When informed of the incident where two CNAs held R42 down while the nurse tried to insert a catheter she stated that it would be considered restraining the resident. On 02/20/2026 at approximately 1:54 p.m. a telephone interview was conducted with the Medical Director regarding the procedure for obtaining a urine sample from a resident. When asked how he would expect a nurse to obtain a urine sample he stated that he would indicate it on the order if the nurse would not be able to obtain a Clean catch (normal voiding/ voiding into a toilet, specimen cup or urinal). He further stated that if the nurse is unable to collect the urine by natural voiding, the nurse should obtain a physician's order for a catheter to be used. On 02/20/2026 at approximately 12:00 p.m. an interview was conducted with LPN #1. When asked to describe the procedure for obtaining a urine sample from a male resident she stated that the nurse should check and be sure there is a physician's order to obtain the sample, collect the supplies, a catheter set, let the resident know what you are going to do, ask the resident if you could proceed with the procedure, remove the resident's pants, then their undergarment or brief, clean the resident's penis, lubricate the catheter, insert the catheter going slowly letting the resident know what is happening. When asked if the resident should be held down to conduct the procedure she stated no that it would be inappropriate and holding a resident down against their will would be considered restraining the resident. When informed of the incident where two CNAs held R42 down while the nurse tried to insert a catheter she stated that it would be considered restraining the resident. The facility policy Abuse, Neglect & (and) Exploitation - Prevention, Reporting and Investigation documented in part, Definitions: Abuse: means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. On 02/19/2026 at approximately 5:00 p.m., the administrator (ADM), and the DON, were made aware of a concern for harm. On 03/10/2025 at 12:15 p.m. the facility Administrator, Director of Nursing, Senior Director of Nursing Services, Regional Director of Resident Care, and the General Manager, were notified of immediate jeopardy (IJ). The facility presented the following IJ plan which was accepted on 03/12/2026 at 9:37 a.m. Immediate corrective action: The incident occurred January (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2025, Resident has been discharged from the facility. The allegation was reported, investigated and substantiated for restraint. Staff members involved were placed on paid administrative leave pending investigation and subsequently terminated and reported to their respective licensing agencies. Immediate skin assessment completed on Resident 42. No skin impairment or changes noted. Resident 42 was evaluated by the facility social worker for psychosocial distress related to the incident and no distress was reported or observed. Identify other residents that may potentially have been affected by this deficiency and what corrective actions will be completed: Residents identified as having potential to be affected by this deficiency were residents with orders for straight catheterization. Immediate skin checks were done for all residents. Interviews were conducted with residents, and no care issues or restraint issues were identified. At the time of the incident, Resident #42 was the only resident with an order for straight catheterization from January 2025 through February 2025. Measures will be put in place or systemic changes will be made to ensure deficient practice will not reoccur: CNAs, LPNs, RNs, Dietary, Social Services, Housekeeping, Therapy, Maintenance, Activities and MDS Coordinator were in serviced and educated on restraint policies and procedures and who the coordinator to whom concerns should be reported at The Jefferson. Staff were also educated on a resident's right to refuse or decline care and procedures and how nursing staff are to respond when a resident refuses care or treatment. Staff attending the training were educated to offer alternatives if possible and provide education on the needed treatment. New hire and annual training to be assigned and monitored for completion. Corrective actions/system changes be monitored to ensure the deficient practice will not reoccur: Training will be given regarding restraint use for all new hires during orientation and annually for all employees. Resident Grievances are monitored continually for concerns regarding restraint use. The DON/or designee will audit skin checks weekly for 50% of resident census weekly x 8 weeks or as determined by the QAPI committee to monitor for concerns. The Administrator/or designee will conduct 5 resident interviews weekly x 8 weeks or as determined by the QAPI committee to monitor satisfaction with care and monitor for reports of restraint use. Compliance and audit reports are monitored through the facility QAPI program. The Administrator is responsible for ongoing compliance. Date of compliance: 3/12/2026On 03/12/2026 the survey team, through observation, interviews and documentation review, verified the removal plan had been fully implemented by the facility. On 03/12/2026 at 3:15 p.m. the facility's Administrator, Director of Nursing, Senior Director of Nursing Services, Regional Director of Resident Care, Director of Skilled Services Division, and the General Manager, were informed the removal plan had been verified and the IJ had been abated.No further information was provided prior to exit. References:(1) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. (2) A test of your urine. It is often done to check for a urinary tract infection, kidney problems, or diabetes. This information was obtained from the website: https://medlineplus.gov/urinalysis.html (3) An antibiotic sensitivity test is used to help find the best treatment for a bacterial infection and certain fungal infections. This information was obtained from the website: https://medlineplus.gov/lab-tests/antibiotic-sensitivity-test/. (4) Is the insertion and removal of a catheter several times a day to empty the bladder. The purpose of catheterization is to drain urine from a bladder that is not emptying adequately. This information was obtained from the website: https://www.urotoday.com/urinary-catheters-home/intermittent-catheters/description/definition-intermittent-cath (5) Blood in the urine. This information was obtained from the website: https://medlineplus.gov/ency/article/003138.htm. (6) The PHQ-2 is the ultra-brief version of the questionnaire. It consists of just two questions that focus on anhedonia (loss of interest in things you used to enjoy) and depressed mood. Because it takes less than a minute to complete, it is often used as a quick first step. The PHQ-9 is the full version of the module. It incorporates the two questions from the PHQ-2 but expands to cover physical and cognitive symptoms. It looks at sleep patterns, energy levels, appetite, concentration, and physical movement. While the PHQ-2 screens for the (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	presence of a concern, the PHQ-9 helps estimate severity and how symptoms may be affecting daily life. This information was obtained from the website: https://phq-9.org/blog/phq-2-vs-phq-9-a-guide-to-mood-screening-scoring-edited. (7) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on staff interview and clinical record review, the facility staff failed to follow professional standards of practice for one of 36 residents in the survey sample, Resident #42. The findings include:For Resident #42 (R42), the facility staff failed to obtain a physician's order to use a straight catheter method to obtain a urine sample. R42 was admitted to the facility with diagnosis that included but was not limited to benign prostatic hyperplasia (1). On the most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/20/2025, R42 scored 4 (four) out of 15 on the BIMS (brief interview for mental status), indicating R42 was severely impaired of cognition for making daily decisions. Section H0300 Urinary Continence coded R42 as being Always incontinent. The physician's order for R42 dated 01/24/2025 documented, UA (urinalysis) (2) C (culture) & (and) S (sensitivity) (3) every shift for 3 (three) days. The facility's Health Status Note for R42 dated 01/28/2025 at 11:35 p.m. documented, Note Text: Guest have [sic] order UA C&S, Guest unable to urinate on [sic] urinal so in and out catheterization (4) performed for urine sample collection, bright blood noted in the urine sample collected, in and out catheter removed, no signs of shock or distress noted, Guest appeared anxious but stable. on call NP (nurse practitioner) (Name of NP) made aware NP state to monitor Guest. Will continue to monitor. The facility's Health Status Note for R42 dated 01/28/2025 at 11:54 p.m. documented, Note Text: Daughter (Name of Daughter) made aware. The facility's Health Status Note for R42 dated 01/29/2025 at 7:59 a.m. documented, Note Text: Around 5AM (5:00 a.m.) Guest noted discomfortable and have pain during urinating, hematuria (5) , blood clot noted on brief. vitals checked BP (blood pressure) 135/65 (135 over 65), P (pulse) 81 (beats per minute), R (respiration) 19, T (temperature) 97.7 (degrees Fahrenheit), O2 (oxygen) 97% (percent) room air. on call NP notified and NP gave order to send guest to ER (emergency room), POA (power of attorney) daughter made aware, guest sent to (Name of Hospital). The facility's Health Status Note for R42 dated 01/29/2025 at 3:30 p.m. documented, Note Text: Guest return form [sic] (Name of Hospital) d/t (due to) hematuria. Came in with indwelling urinary catheter with Blood in the urine. Vital BP 165/70,HR 61,T 98.4,RR 18,O2 96 ON R/A (room air) no pain. Guest is stable at this time with no distress noted. Daughter is aware guest has return to facility. The facility's Grievance Report for R42 dated 01/29/2025 documented in part, Describe concerns using factual terms: Resident had catheter used for urine sample against his will resulting in injury and hospitalization. What other action was taken to resolve this concern?: Dismissal of responsible staff. Was grievance resolved? Yes, resident received psychiatric follow-up to address trauma, accused staff dismissed from company. Summary Statement of the resident's grievance: Catheter placed for urine sample following resident's refusal. Resident sent out with bleeding in the groin area. Steps taken to investigate grievance: FRI (facility reported incident) initiated on 1/29/25. Responsible staff provided statements prior to placement on administrative leave. Summary of the pertinent findings or conclusions regarding the resident's concern(s): Resident was found to have bleeding and refusal of care following traumatic incident. The facility's synopsis of event for R42 dated 01/29/2025 documented in part, Incident: (R42's) friend (Name of Friend) reported on 1/29/2025 concerns about the care provided to (R42) on the evening of 1/28/2025. Investigation: At around 3:00 PM (p.m.) on 01//29/2025, (Name of R42's Friend) came to speak with the Director of Nursing (DON), (Name of Previous Director of Nursing) and Senior Director of Nursing. At that time (Name of R42's Friend) reported she had been visiting with (R42) the evening of 01/28/2025 when a nurse entered his room to insert a catheter. (Name of R42's Friend) reported that (R42) stated Don't do that and crossed his legs. (Name of R42's Friend) then reported the nurse called out for additional staff to assist her and two staff entered the room and asked her to step out into the hallway. While in the hallway, (Name of R42's Friend), stated she heard (R42) yelling out, but could not make out his words. When the staff left the room, (Name of R42's Friend) returned to bedside and stayed with (R42) until 11:30 PM (p.m.). During (Name of R42's Friend) report, the administrator entered the office. (continued on next page)

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	495269	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Jefferson	900 North Taylor Street Arlington, VA 22203

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Name of R42's Friend) was able to provide descriptions of the staff and the (Name of Facility) staff were able to identify the staff providing care to (R42) on 01/28/2025. Each of the three staff members were interviewed Certified Nursing Assistant (CNA #14) reported that on the evening of 01/28/2025, he was called into (R42's) room by Certified Nursing Assistant (CNA #15) because he and Licensed Practical Nurse (LPN #11) were attempting to collect urine and (R42) was combative. (CNA #14) stated he went to assist with getting the urine, he stated verbally to the Administrator and Director of Nursing that he and (CNA #15), held (r42) legs and arms while the nurse catheterized him. Certified Nursing Assistant (CNA #15) stated that he and (CNA #14) were assisting the nurse because she needed to draw urine, the urine was drawn, he and (CNA #14) changed (R42) and repositioned him in bed, then left the room. Licensed Practical Nurse, (LPN #11), stated she had an order for a urine specimen, attempted to catheterize (R42) and he became combative. She stated she then called for two Certified Nursing Assistant to get the urine specimen, she stopped the catheterization when blood was noted to be entering the foley tube. (LPN #11) contacted the on call nurse practitioner, their direction was to monitor the resident. On the morning of 01/29/2025, blood was noted, an order was then obtained to transfer (R42) to the hospital. Under Findings it documented in part, The written and verbal statements provided by the staff involved in this incident support that the Certified Nursing Assistants did hold (R42's) legs and arms when the Licensed Practical Nurse catheterized him. This allegation of abuse is substantiated. Law enforcement has been notified.The three staff members involved (LPN #11, CNA #14 and CNA #15) will be terminated from (Name of Facility) and their license will be reported to the Virginia Board of Nursing. The facility's Statement of Event dated 01/29/2025 and written by LPN #11 regarding R42 documented, Guest have [sic] a urine sample order from MD (medical doctor). Writer tried to collect urine but guest is not oriented so unable to pee on [sic] urinal, writer tried to do in and out catheter. During this procedure guest was combative so write called two CNA [sic] to help get the urine. During procedure writer noted blood is [sic] coming in foley tube so stoped [sic] the procedure and help [sic] guest to be on [sic] comfortable position and monitoring if he [sic] still bleeding but no blood noted. Called to [sic] an on call NP and notified NP. (unrecognizable words) monitor guest. For the (unrecognizable word) night guest was ok around 5 Am (5:00 a.m.) guest start [sic] to pee and noted [sic] uncomfortable and is in pain, blood noted in the urine. writer [sic] help [sic] guest to [sic] clean up and get (unrecognizable word) call Np made aware and sent resident to (Name of Hospital) for further evaluation. The facility's Statement of Event dated 01/29/2025 and written by CNA #14 regarding R42 documented, 1-28-25 evening (unrecognizable word) when (CNA #15) call [sic] me to help with (R42) because they are trying to get some urine but he was fighting so I went to help together with the nurse. so [sic] in all we were 3 (three) people that take care [sic] of (R42) to get the urine. that [sic] is what happened and before we assist [sic] the patient, the visitor went out. The facility's Statement of Event dated 01/29/2025 documented in part, Interviews were conducted with the staff involved. (Name of LPN #11): (LPN #11) confirmed that (R42) was restrained during the procedure. She stated that he was combative, even during routine care such as brief changes, and that restraining residents was common practice. She expressed surprise when informed that residents have the right to refuse care and cannot be restrained against their will. (LPN #11) stated that (R42) did not verbally refuse the procedure; (Name of CNA #14): (CNA #14) admitted to restraining (R42's) arms while (LPN #11) attempted the catheter insertion. He confirmed that (CNA #15) retrained (R42's) legs. He stated that the procedure was stopped due to bleeding; (Name of CNA #15): (CNA #15) denied physically restraining (R42), stating that he was only assisting (LPN #11) and (CNA #14), The facility's Statement of Event dated 01/30/2025 and written by the previous Director of Nursing documented, On January 29, 2025, (Name of R42's Friend), came into my office to express her concerns with an incident she witnessed the night of January 28, 2025. She described being in (R42's) room while a nurse attempted to insert a foley catheter. She voiced that at some point (R42) told the nurse to stop and he grabbed his penis to stop her. She then stated that the nurse called out to people to come and help her. She stated that (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	while the staff entered the room they asked her to step out . While at the door she could hear (R42) yelling but could not make out what he said. She verbalized that she knew that the staff had held him down and was overwhelmed by this event. At that time I notified my CNA to come into my office so that he could hear her statement. We interviewed the staff (CNA #14 and CNA #15). (CNA #14) voiced that he was called to help the nurse and he held (R42's) legs while (CNA #15) held his arms so that the nurse could obtain the urine specimen. We interviewed the nurse (LPN #11) and she voiced that she called on (CNA #14 and CNA #15) to assist her with collecting (R42's) urine sample. The facility's Social Services Note for R42 dated 01/30/2025 at 12:44 p.m. documented, Late Entry: Note Text: Met with the resident for a touchbase [sic] following readmission from (Name of Hospital) on 1/29/2025 at or around 6:15pm (p.m.). Writer asked the resident is he was feeling okay, in which he responded with not too good. Writer asked the resident why he did not feel good. Resident did not respond. Asked the resident if he was feeling uncomfortable in any way. Resident nodded his head. When asked where he was feeling uncomfortable, he pointed to the area below the waist. Writer asked the resident if that area was painful in hisrecent [sic] hospitalization. Resident nodded his head. Met with the resident for a follow-up on the morning of 1/30/2025. Writer asked the resident if he was experiencing any pain or discomfort at the time. Resident informed the writer that he is feeling goodthis [sic] morning, and looking forward to lunch. Resident shook his head, denying any pain. Writer performed PHQ2:9 (patient health question) (6) and BIMS (brief interview for mental status) assessment to determine depression. Resident scored a 3 (severely impaired of cognition for making daily decisions). He was unable to repeat words from assessment. Resident was aware of the date, and unaware of year, and day. Resident was able to recall only one word. Resident has severe cognitive impairment and remains at risk for disorganized thinking, and inattention. Resident is a poor historian regarding recent events. Resident was able to recall his lifelong profession of MD, internist (specializes in internal medicine). Writer thanked the resident for his participation. Resident is not at risk of adverse psychosocial impacts. On 02/19/2026 at approximately 12:57 p.m. an attempt to contact and interview CNA #15 by telephone was unsuccessful. A message was left on the voice mail requesting a call back. By the time of the survey exit, CNA #15 had not returned the phone call. On 02/19/2026 at approximately 1:00 p.m. a telephone interview was conducted with LPN #11 regarding her attempt to obtain a urine sample from R42 on 01/28/2025. LPN # 11 stated that she recalled the incident and R42. She stated that there was a physician's order to obtain a urine sample from R42 and that R42 had a low cognition and was not able to use the toilet. LPN #11 stated she noticed blood and stopped the catheterization and notified the physician and monitored R42 during the night and in the morning when R42's brief was being changed, she noticed blood in the brief, notified the physician and sent R42 to the hospital. When asked about following professional; standards during the procedure to collect a urine sample she stated that she did everything correctly. On 02/19/2026 at approximately 1:48 p.m. an interview was conducted with the Senior Director of Nursing Services regarding the incident of LPN #11 attempt to obtain a urine sample from R42 and CNA #14 and CNA #15 hold R42 down during the procedure on 01/28/2025. She stated she recalled the incident and R42 was in the facility at the time. When asked to describe the procedure to obtain a urine sample from a resident she stated approach the resident and tell them what procedure needs to be done and how it needs to be done and if the resident will allow the procedure to be done regardless of the resident's cognition level. Check with the resident's CNA to determine if the resident can void normally, in the toilet or urinal. If the resident is unable to, contact the physician for an order to use a straight cath (catheter) procedure (6). She further stated that if the resident refused the procedure, asked to stop, or showed distress, the procedure should be stopped and the physician notified that the urine could not be obtained. When asked to describe abuse she stated that it would forcing a resident to do something against their will or treating them in a manner that causes injury. After reviewing the incident of LPN #11 attempting to obtain a urine sample by use of a catheter without a physician's order resulting in R42 bleeding and needing to be sent to the hospital and CNA #14 and CNA #15 holding R42 down the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Senior Director of Nursing Services stated that LPN #11, CNA #14 and CNA #15 failed to follow professional standards to obtain a urine sample from R42. On 02/19/2026 at approximately 2:50 p.m. a telephone interview was conducted with CNA #14 regarding the incident of holding R42 down while the nurse tried inserting a catheter to obtain a urine sample on 01/28/2025. CNA #14 stated he recalled the incident and R42. He stated that he and another CNA were in R42's room helping the nurse obtain a urine sample from R42. He stated that he held R42's hand so he would not grab his penis while the nurse was inserting the catheter. On 02/20/2026 at approximately 1:54 p.m. a telephone interview was conducted with the Medical Director regarding the procedure for obtaining a urine sample from a resident. When asked how he would expect a nurse to obtain a urine sample he stated that he would indicate it on the order if the nurse would not be able to obtain a Clean catch (normal voiding/ voiding into a toilet, specimen cup or urinal). He further stated that if the nurse is unable to collect the urine by natural voiding, the nurse should obtain a physician's order for a catheter to be used. On 02/20/2026 at approximately 12:00 p.m. an interview was conducted with LPN #1. When asked to describe the procedure for obtaining a urine sample from a male resident she stated that the nurse should check and be sure there is a physician's order to obtain the sample, collect the supplies, a catheter set, let the resident know what you are going to do, ask the resident if you could proceed with the procedure, remove the resident's pants, then their undergarment or brief, clean the resident's penis, lubricate the catheter, insert the catheter going slowly letting the resident know what is happening. When asked to describe the procedure if the resident becomes distressed or is demonstrating resistance to the catheterization she stated that the nurse should stop the procedure and if the urine could not be collected, the physician should be notified. After reviewing the incident of LPN #11 attempting to obtain a urine sample by use of a catheter without a physician's order resulting in R42 bleeding and needing to be sent to the hospital and CNA #14 and CNA #15 holding R42 down the Senior Director of Nursing Services stated that LPN #11, CNA #14 and CNA #15 failed to follow professional standards to obtain a urine sample from R42. On 02/19/2026 at approximately 5:00 p.m., the administrator (ADM), and the DON, were made aware of the above concern. No further information was provided prior to exit. References:(1) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. (2) A test of your urine. It is often done to check for a urinary tract infection, kidney problems, or diabetes. This information was obtained from the website: https://medlineplus.gov/urinalysis.html (3) An antibiotic sensitivity test is used to help find the best treatment for a bacterial infection and certain fungal infections. This information was obtained from the website: https://medlineplus.gov/lab-tests/antibiotic-sensitivity-test/. (4) Is the insertion and removal of a catheter several times a day to empty the bladder. The purpose of catheterization is to drain urine from a bladder that is not emptying adequately. This information was obtained from the website: https://www.urotoday.com/urinary-catheters-home/intermittent-catheters/description/definition-intermittent-cath (5) Blood in the urine. This information was obtained from the website: https://medlineplus.gov/ency/article/003138.htm. (6) The PHQ-2 is the ultra-brief version of the questionnaire. It consists of just two questions that focus on anhedonia (loss of interest in things you used to enjoy) and depressed mood. Because it takes less than a minute to complete, it is often used as a quick first step. The PHQ-9 is the full version of the module. It incorporates the two questions from the PHQ-2 but expands to cover physical and cognitive symptoms. It looks at sleep patterns, energy levels, appetite, concentration, and physical movement. While the PHQ-2 screens for the presence of a concern, the PHQ-9 helps estimate severity and how symptoms may be affecting daily life. This information was obtained from the website: https://phq-9.org/blog/phq-2-vs-phq-9-a-guide-to-mood-screening-scoring-edited. (7) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility document review, the facility staff failed to maintain emergency medical equipment in a sanitary manner and ensure the supplies on the emergency medical cart were not expired, for one of one unit.Observation was made on [DATE] at 12:13 p.m. of the emergency medical cart (crash cart) on the health care unit. The following observations were made:Oxygen tank was 2% full, nearly empty.Top of the cart:Suction machine was not covered, only a mesh covering so air and dust can get through. There was no oxygen mask, no nasal cannula or normal saline, per their list of required items. The Ambu bag (used for resuscitation) was not in a bag to protect it.Lubricating jelly - two packages that were expired [DATE] and one package with an unreadable expiration date.[NAME] suctioning catheter package had a rip in it, making it not sterile any longer.The Connecting tubing, for the suction machine, expired on [DATE].The non - conductive connecting tubing, for the suction machine, expired on [DATE].First drawer:Bandage scissors are to be in the cart, the ones in the drawer were not bandage scissors and were dirty.Second Drawer:The box of large gloves expired on [DATE].Four packages of lubricating jelly expired on [DATE].Five packages of lubricating jelly expired on [DATE].Third Drawer:There was no blood spill kit in the cart per their list of required itemsFourth Drawer:Nonrebreather mask, there was only one where there should be two.There were no standard oxygen masks.The surgical masks box that was open, expired [DATE].Fifth Drawer:There was only one distilled water in the cart, their list documents two.An interview was documented with LPN (licensed practical nurse) #10 on [DATE] at 12:34 p.m. When asked who is responsible for ensuring the crash cart is stocked and does not have expired items, LPN #10 stated it's the responsibility of the night shift nurse. LPN #10 looked at the crash cart and stated, the oxygen tank is empty and that it is very important to have it available in an emergency. She stated the Ambu bag was open and not sterile. She stated all supplies should be up to date and available for an emergency.An interview was conducted with the Director of Nursing (DON) on [DATE] at 12L41 p.m. She stated the process for checking the crash cart, is for the night nurse to check it every time and go to the supply room and replace items that need to be replaced. She stated if the cart is used, it should be restocked immediately afterwards. The findings above were shared with the DON.Review of the Skilled Nursing Unit Emergency Cart Daily Checklist documented the cart had been checked every day from February 1, 2026 through February 18, 2026.A request was made for the code status of all current residents on the health care unit. Of the current 25 residents, 24 out of the 25 were documented as full code, which means the facility must start CPR (cardiopulmonary resuscitation) in the event the resident stops breathing or their heart stops. This is when the crash cart would be utilized.The review of the facility assessment failed to evidence documentation of the required emergency equipment needed to address medical emergencies.The facility policy, CPR Certification documented in part, The DNS (director of nursing Services)/Designee will ensure that the center has an emergency cart containing: a. Oxygen and oxygen delivery system, b. Suction Machine, tubing and catheters, c. Disposable airways, d. Ambu bag.f. CPR mouth guard, g. CPR back board, h. stethoscope, i. BP (blood pressure) cuff. The Licensed Nurse will routinely validate the emergency cart contents using the Emergency Cart Daily Checklist.The Administrator, DON, General Manager, and the Senior Director of Nursing Services, were made aware of the above concerns on [DATE] at approximately 4:30 p.m.No further information was provided prior to exit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, and clinical record review, the facility staff failed to prevent administration of unnecessary medications for three of 36 residents in the survey sample, Residents #34, #24, and #14. The findings include:1. For Resident #34 (R34), the facility staff failed to monitor the resident for side effects from the anticoagulant (blood thinning) medication Enoxaparin Sodium. A review of R34's clinical record revealed a physician's order dated 2/11/26 for Enoxaparin Sodium 40 mg (milligrams)/0.4 ml (milliliters)-inject 0.4 ml one time a day for deep vein thrombosis (blood clot) prophylaxis. A review of R34's medication administration record for February 2026 revealed the resident was administered Enoxaparin Sodium every day 2/12/26 through 2/20/26. A physician's order dated 2/12/26 documented, ANTICOAGULANT MEDICATION-MONITOR FOR DISCOLORED URINE, BLACK TARRY STOOLS, SUDDEN SEVERE HEADACHE, N&V (nausea and vomiting), DIARRHEA, MUSCLE JOINT PAIN, LETHARGY, BRUISING, SUDDEN CHANGES IN MENTAL STATUS AND/ OR V/S (vital signs), SOB (shortness of breath), NOSE BLEEDS. Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. Further review of R34's clinical record (including the February 2026 medication administration record, treatment administration record, and nurses' notes) failed to reveal the above physician's order was implemented. On 2/19/26 at 1:42 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 stated residents should be monitored for side effects from anti-coagulant medication to ensure they are not receiving too much of the medication. LPN #2 stated anticoagulant monitoring is ordered or care planned and nurses sign off on the medication administration record to evidence the monitoring was done. On 2/21/26 at 3:05 p.m., the Administrator and Director of Nursing were made aware of the above concern. The facility did not provide a specific policy regarding Enoxaparin Sodium monitoring. No further information was presented prior to exit. 2. For Resident #24 (R24), the facility staff failed to monitor blood pressure, prior to the administration of a medication with parameters. The physician order dated, 2/4/2026, documented, Metoprolol Tartrate Oral Tablet (1) 12.5 MG (milligrams); Give 1 tablet by mouth one time a day for HTN (high blood pressure), Hold for SBP (systolic blood pressure) < (less than) 100. The February 2026 MAR (medication administration record) documented the above order. There was no place on the MAR for the blood pressure reading prior to the administration of the medication. A review was made of the vital signs tab in the clinical record. There were no documented blood pressures for 2/8/2026, 2/11/2026, and 2/13/2026. Review of the skilled nurse's notes for the above dates, failed to evidence a blood pressure reading taken on the above dates. An interview was conducted with LPN (Licensed practical nurse) #1, on 2/20/2026 at 12:05 p.m. LPN (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 stated if a medication has parameters for administration, the nurse should take the blood pressure and if held, notify the physician. The Administrator, Director of Nursing, General Manager, and the Senior Director of Nursing Services, were made aware of the above concerns on 2/20/2026 at 2:26 p.m. No further information was provided prior to exit. References: 1. Metoprolol Tartrate is used to treat high blood pressure. This information was obtained from the following website: h ttps://medlineplus.gov/druginfo /meds/a682864.html 3. For Resident #14 (R14) the facility staff failed to monitor for side effects related to the use of an anticoagulant. R14 diagnoses include but were not limited to hypertension (1), and atrial fibrillation (2) with a pacemaker (3). The most recent MDS (minimum data set) assessment, a 5-day assessment with an ARD (assessment reference date) of 1/2/26 documented R14 receiving anticoagulants while at the facility. The comprehensive care plan dated 12/27/25 documented, FOCUS: The resident receiving anticoagulant therapy related to atrial fibrillation. INTERVENTIONS: The resident will be free of discomfort or adverse reactions related to anticoagulant use through the review. The physician's order dated 12/28/25 documented Apixaban (4) Oral Tablet 2.5 mg (milligrams), give (1) tablet orally every morning and at bedtime for coagulation management. R14's MARs (medication administration record) for December 2025, January and February 2026, failed to evidence documentation of anticoagulation monitoring since his admission on [DATE]. On 2/19/2026 at 10:12 AM an interview was conducted with LPN (licensed practical nurse) #1. When asked, what is their process for monitoring for side effects of anticoagulants. LPN #1 stated, they monitor for blood in the stool and/or urine, bruises on the skin and ecchymosis (5). LPN#1 further stated she would notify the provider, possibly receive and implement any new orders. She stated that this was important because a provider needed to know if a resident was bleeding so it could be treated, get it under control or be sent out of the facility if needed. On 2/19/2026 at 5:00 PM, the Administrator, Senior Director of Nursing and DON (director of nursing), were notified of the findings. No further information was provided prior to exit. References: 1. Is when blood puts too much pressure against the walls of your arteries. https://medlineplus.gov/bloodpressuremedicines.html (continued on next page)

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The Jefferson	900 North Taylor Street Arlington, VA 22203

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Atrial fibrillation, also known as AFib or AF, is one of the most common types of arrhythmias. Arrhythmias are problems with the rate or rhythm of your heartbeat. https://medlineplus.gov/atrialfibrillation.html 3. a small, battery-operated device that senses when your heart is beating irregularly or too slowly. https://medlineplus.gov/ency/patientinstructions/000097.htm 4. Apixaban is in a class of medications called factor Xa inhibitors. It works by blocking a natural substance that helps blood clots to form. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a613032.html 5. Bleeding into the skin can occur from broken blood vessels. https://medlineplus.gov/ency/article/003235.htm

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on staff interview, facility document review, and clinical record review, the facility staff failed to obtain physician ordered laboratory tests for two of 36 residents in the survey sample, Residents #6 and #24. The findings include:1. For Resident #6 (R6), the facility staff failed to obtain a physician ordered Vancomycin trough level (a measurement of an antibiotic medication) on 2/16/26. A review of R6's clinical record revealed a physician's order dated 2/11/26 with a start date of 2/16/26 for a Vancomycin trough level every Monday. Further review of R6's clinical record failed to reveal the laboratory results for a Vancomycin trough level that was due to be obtained on Monday 2/16/26. On 2/20/26 at 2:33 p.m., the Director of Nursing stated she could not provide the laboratory results for a Vancomycin trough level from 2/16/26. On 2/21/26 at 11:04 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #4. LPN #4 stated lab orders are entered and scheduled in the computer system then written in a lab communication book. LPN #4 stated the night before a lab is due, the night shift nurse verifies the lab is due and places a face sheet in the lab communication book. LPN #4 stated the day the lab is due, someone from an outside lab company obtains the lab. On 2/21/26 at 3:05 p.m., the Administrator and Director of Nursing were made aware of the above concern. The facility did not provide a policy regarding laboratory services. No further information was presented prior to exit. 2. For Resident #24 (R24), the facility staff failed to obtain laboratory tests per the physician orders. The physician orders documented: 1/19/2026 – CBC (complete blood count) and CMP (comprehensive metabolic panel) every night shift for 1 day. (due 1/20/2026). 1/23/2026 – CBC, CMP every night shift every 4 weeks on Mon (Monday) (due 1/26/2026). 1/28/2026 – CBC, BMP (basic metabolic panel) every night shift every Thu. (due1/29/2026). Review of the clinical record failed to evidence the laboratory (lab) results for the order of 1/19/2026. Further review of the clinical record documented lab results ordered on 1/23/2026 were dated 1/27/2026. The laboratory results ordered on 1/28/2026 were dated 1/30/2026. An interview was conducted with LPN (licensed practical nurse) #1, on 2/20/2026 at 12:05 p.m. LPN #1 stated the doctor orders the laboratory tests and the night nurse fills out the laboratory request form and a copy of the resident's face sheet. The laboratory technician comes during the night shift to draw blood. She stated the facility has a lab technician coming in every morning except the weekend. When asked if laboratory test was ordered for Monday and it's not done until Tuesday, is that following the physician orders, LPN #1 stated, no, that is not. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/202/2026 at 1:55 p.m. the Director of Nursing (DON), stated she could not find any documentation as to why the lab tests for were done a day late and verified that the lab tests ordered for 1/20/2026 were not completed as ordered. The Administrator, DON, General Manager, and the Senior Director of Nursing Services, were made aware of the above concerns on 2/20/2026 at 2:26 p.m. No further information was provided prior to exit.

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility staff failed to prevent an allergic reaction to a documented food allergy which resulted in the resident requiring emergency medical treatment, thus resulting in a determination of Jeopardy (IJ) for one of 36 residents in the survey sample, Resident #43. After IJ was removed, the scope and severity was lowered to a level 3 (three), isolated, harm. The findings include: For Resident 43 (R43), facility staff served the resident lobster ravioli when he had a documented shellfish allergy which resulted in IJ and harm. R43 was admitted to the facility with diagnoses that included but were not limited to cognitive communication deficit (1). The facility's diagnoses list in the EHR (electronic health record) for R43 documented in part. Allergies: Shellfish. On the most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/06/2025, R43 scored 12 out of 15 on the BIMS (brief interview for mental status), indicating R43 was moderately impaired of cognition for making daily decisions. The EHR for R43 documented in part, Care Profile. Allergy: Shellfish. Category: Food. Reaction Manifestation: Severe. Severity: Severe. Date: 12/19/2024. The facility's dinner menu for the skilled nursing care floor (3rd floor) dated 11/23/2026 documented in part, Lobster Ravioli. The facility's Health Status Note dated 11/23/2025 for R43 documented, Note Text: At about 1745 (5:45 p.m.) writer answer to guest's call light, and writer was informed by guest that the dinner served to him was shellfish which he is allergic to. Writer observed that guest ate 100% of his dinner. He stated he was having difficulty breathing. Vitals taken: BP (blood pressure)124/74 (124 over 74), HR (heart rate)121 (beats per minute), T (temperature) 97.8 (degrees Fahrenheit), O2 (oxygen) 96% (percent) on room air. (Name of Physician On-Call Service) on-call service called unable to reach. Guest was sent out to the emergency room via (by) 911 for further eval (evaluation) and medical management. Guest is his own RP (responsible party). Emergency contact #1 (Name of Contact) wasmade [sic] aware of transfer to (Name of Hospital). The hospital Discharge Summary for R43 dated 11/28/2025 documented in part, admission: [DATE]. History and Hospital Course: .now presented from SNF (skilled nursing facility) (Name of Facility) 11/24 for acute onset SOB (shortness of breath) and undifferentiated (unspecified) shock (2) after exposure to shellfish, briefly requiring vasopressors (3) support. Found to have bronchiolitis (4) ddx (differential diagnosis) allergic reaction. Weaned off (gradually stopping) pressors and transferred to floor 11/24. The facility's synopsis of event dated 12/03/2025 documented in part, Incident: On 11/23/2025 at around 5:45 PM (p.m.), (R43) expressed difficulty breathing, suspected to be the result of an allergic reaction. Investigation: On 11/23/2025 at around 5:45 PM, (R43) rang his call bell and the nurse assigned to him answered. At that time, (R43) expressed that he was having difficulty breathing. He stated that he has a shellfish allergy and ordered lobster ravioli for dinner. Upon observation, the nurse noted that (R43) had consumed 100% of his meal. The nurse then attempted to notify the on call [sic] provider and sent (R43) to the emergency room for further evaluation and management. The emergency room noted that (R43) presented for acute onset of shortness of breath after eating lobster ravioli at an outside facility with patient reported allergy to shellfish and noted a low concern for anaphylaxis (5). (R43) was treated with 25mg (milligrams) of Benadryl. (6). Subsequently, (R43) was admitted for further evaluation. (R43) returned to the (Name of Facility) on 11/28/2025 and is doing well. On 02/24/2026 at approximately 8:25 a.m. an observation of the pantry on the skilled nursing floor (third floor) revealed a list of current residents with specific food allergies posted within the kitchen area where facility staff could access. On 02/23/2026 at approximately 11:40 a.m. an interview was conducted with LPN (licensed practical nurse) #1 regarding R43's allergic reaction on 11/23/2025. She stated that while she was passing medications around dinner time R43 rang the call bell and when she went to his room R43 stated that he was having difficulty breathing. LPN #1 stated that she obtained R43's vital signs (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and found them to be within normal limits but R43 stated he was having trouble breathing so she called the on-call physician and then called 911 to have R43 sent to the hospital for further evaluation. When asked where R43 obtained the lobster ravioli she stated that it came from the facility. On 02/23/2026 at approximately 12:00 p.m. an interview was conducted with the facility's Dietician regarding R43's allergic reaction on 11/23/2025. The Dietician stated she recalled R43 and the incident and heard that R43 was sent to the hospital for respiratory difficulties. She further stated that R43 knew he ordered lobster ravioli. When asked to describe the procedure that is followed to prevent a resident receiving a food item that they are allergic to she stated that when they (dietary department) receives information regarding a resident's food allergies, a notify form is completed and sent to the pantry (satellite kitchen on the skilled nursing floor) and posted in the panty for the kitchen aides to reference when plating the resident's meals. She further explained that the meals for the residents on the skilled nursing floor are prepared in the facility's main kitchen and sent to the pantry where a kitchen aide plates each resident's meal. The Dietician also stated that they (dietary department) see themselves as The last line of defense in preventing residents from receiving the wrong diet/food and that the dietary aide should have caught R43's allergy to shellfish. On 02/24/2026 at approximately 9:23 a.m. an interview was conducted with Dietary Aide #10 regarding the procedure for serving meals on the skilled nursing floor (3rd floor). The Dietary Aide #10 stated that she has worked in the pantry on the 3rd floor. She stated that she would plate the resident's food (taking the food from the steam table and placing it on the resident's plate) and the CNAs (certified nursing assistants) take the plated food to the residents in the dining room or to the resident's room. She stated that the residents select the food items from the menu and she serves the resident what they selected. When asked how the dietary aides prevent resident receiving food items that they are allergic to she stated that there is a list of residents and their allergies posted in the pantry that they refer to before plating the resident's meal to make sure they are not getting something they are allergic to. On 02/23/2026 at approximately 5:25 p.m., the administrator (ADM), and the DON, were made aware of a concern for harm. On 03/10/2025 at 12:15 p.m. the facility Administrator, Director of Nursing, Senior Director of Nursing Services, Regional Director of Resident Care, and the General Manager, were notified of immediate jeopardy (IJ). The facility presented the following IJ plan which was accepted on 03/12/2026 at 10:45 a.m. Immediate corrective action: The incident occurred 11/23/2025 following resident #43 request for food items, facility cannot correct the action that occurred. Immediate corrective action occurred with reinforcement of communication log posted in Skilled Nursing pantry. This occurred on 11/25/2025. Identify other residents that may potentially have been affected by this deficiency and what corrective actions will be completed: Potentially affected residents are residents with food allergies. Dietary staff now verifies any identified residents with food allergies at each meal service. This is achieved by a daily updated log and dietary notification communication of resident allergies provided to the dining staff. Measures will be put in place or systemic changes will be made to ensure deficient practice will not reoccur: All Skilled Nursing Facility staff including agency staff will be educated on facility process which includes: Order entry into PCC by nursing staff; Diet notification form completed by nursing includes food allergies and is provided to the dietary department; Allergy is reflected on Menu ticket following manual order transcription- implemented 3/10/2026; Kitchen staff receive and verify diet order including any food allergies; Kitchen staff sign and acknowledge resident food allergy via the compliance log with every meal- implemented 12/2/2025; All nursing and Dietary staff will be educated before start of their shift if assigned to work by 3/12/2026 Education will be in person or via phone/email/certified mail; Staff currently on PTO will be educated upon their return prior to the start of the next assigned shift. Corrective actions/system changes be monitored to ensure the deficient practice will not reoccur: DON/or designee will audit 5 new admission records weekly to ensure the data entry and communication form process was followed x8 weeks or as determined by the QAPI committee. The Dietary Manager/or designee will monitor 100% of meal tickets for residents (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	with food allergies weekly to ensure food allergies are included on the meal ticket x 8 weeks or as determined by the QAPI committee. Process compliance including audit results will be monitored monthly in the facility QAPI program. The administrator is responsible for ongoing compliance. Date of compliance: 3/12/2026.On 03/12/2026 the survey team, through observation, interviews and documentation review, verified the removal plan had been fully implemented by the facility. On 03/12/2026 at 3:15 p.m. the facility's Administrator, Director of Nursing, Senior Director of Nursing Services, Regional Director of Resident Care, Director of Skilled Services Division, and the General Manager, were informed the removal plan had been verified and the IJ had been abated.No further information was provided prior to exit. References:(1) Refer to communication difficulties that stem from underlying cognitive impairments. These disorders affect how individuals think, remember, process information, and communicate. Unlike speech or language disorders, which directly involve the production or comprehension of words, cognitive-communication disorders are rooted in deficits in cognitive functions such as attention, memory, and executive functioning. This information was obtained from the website: https://speechtherapy.org/disorders/adults/cognitive-communication/. (2) A life-threatening condition that occurs when the body is not getting enough blood flow. Lack of blood flow means the cells and organs do not get enough oxygen and nutrients to function properly. Many organs can be damaged as a result. Shock requires immediate treatment and can get worse very rapidly. This information was obtained from the website: https://medlineplus.gov/ency/article/000039.htm. (3) Help you raise your blood pressure when it's so low that you can't get enough blood to your organs. This is the case with shock victims and people with other conditions that make their blood pressure very low. Providers often give vasopressor drugs to you through an IV. This information was obtained from the website: https://my.clevelandclinic.org/health/treatments/23208-vasopressors. (4) Swelling and mucus buildup in the smallest air passages in the lungs (bronchioles). This information was obtained from the website: https://medlineplus.gov/ency/article/000975.htm. (5) A severe, whole-body allergic reaction to a chemical that has become an allergen. This information was obtained from the website: https://medlineplus.gov/ency/article/000844.htm. (6) (Benadryl) is in a class of medications called antihistamines. It works by blocking the action of histamine, a substance in the body that causes allergic symptoms. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682539.html.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on staff interview and facility document review, the facility staff failed to review and revise the document with administrative staff changes and address the emergency equipment to address the emergent medical needs of the residents.The facility assessment, reviewed on 2/3/2025, documented in part, 6. Medical and non-medical equipment required: Facility has Hoyer lifts sliding boards, reais to toilet devices, grab bars, wheelchair accessible vans and buses for transportation, feeding tube equipment and bolus services, wheelchairs, specialty wheelchair cushions, air mattresses, nebulizer and oxygen services. The facility does not have access to rental c-pap and bi-pap machines. All new admissions after January 1, 2024, must provide their own devices and supplies (excluding distilled water). Facility has a variety of different wheelchairs and rollators to aid in trials for best device recommendations prior to return to the community. There was no mention of emergency medical equipment required to meet the emergent needs of the residents.The facility assessment failed to evidence the current Medical Director, Director of Nursing, Administrator, Social Worker, and Representative from the Governing Body.An interview was conducted with the Administrator (ADM) on 2/19/2026 at approximately 4:00 p.m. The ADM stated he had only been here a month and hadn't gotten to look at the facility assessment. The Director of Nursing had been at the facility since July 2025. He stated the facility assessment must be reviewed at least annually but if there are any changes in the administrative staff members. The ADM stated he would have expected to see the emergency equipment in the assessment.The facility policy, Governing Body, documented in part, 3. The Skilled Nursing Administrator (SNA) is responsible for reporting the following to the Governing Body through Sunrise database(s), Centers for Medicare & Medicaid Services (CMS)/ Certification and Survey Provider Enhanced Reporting (CASPER) reports, state agency surveys, and other key data metrics, to include quarterly clinical and operational reviews. Data is reviewed regularly, with trends identified and responded to through the community and regional QAPI programs. Data may include, but is not limited to: a. Annual review and ongoing update of the Facility Assessment as needed.The Administrator, Director of Nursing, General Manager, and the Senior Director of Nursing Services, were made aware of the above concerns on 2/19/2026 at approximately 4:30 p.m.No further information was provided prior to exit.