STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER The Jefferson		STREET ADDRESS, CITY, STATE, ZIP CODE 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	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 (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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 (continued on next page)

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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 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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: (continued on next page)

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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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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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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 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) 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 (continued on next page)

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F 0552 Level of Harm - Actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0552 Level of Harm - Actual harm Residents Affected - Few	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 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 (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 0552 Level of Harm - Actual harm Residents Affected - Few	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on staff interview, and facility document review, the facility staff failed to ensure appropriate competencies for 15 of 15 nurses and for one of three CNA (Certified Nursing Assistant) records reviewed. The findings include:1. For 15 of 15 nurses, the facility staff failed to ensure competencies for PICC (peripherally inserted central catheter) line care. A review of a list of residents revealed three current residents were receiving PICC line care and services. Competencies regarding PICC line care were requested for an initial sample of five nurses. On 2/21/26 at 10:06 a.m., the Director of Nursing stated she did not have the requested competencies. The Director of Nursing stated she would talk to the Senior Director of Nursing Services to ask if the nurses should have competencies. On 2/21/26 at 3:05 p.m., the Administrator and Director of Nursing were made aware of the above concern. On 2/22/26 at 2:31 p.m., the Senior Director of Nursing Services stated the facility did not have PICC line care competencies for any of the current nurses. On 2/22/26 at 3:32 p.m., the Senior Director of Nursing Services stated the facility currently employed a total of 15 nurses (four facility nurses and 11 agency nurses). 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 nursing competencies. No further information was presented prior to exit. 2. For CNA (certified nursing assistant) #11, the facility failed to provide evidence that the CNA's competencies were verified at the time of hire. On 2/23/26 at 9:00 a.m., facility staff were requested to provide evidence that professional licensure was verified at the time of hire for CNA #11. According to information provided by the Director of Human Resources (HR), CNA #11 was hired 10/10/25. On 2/23/26 at 10:01 a.m., the Director of HR confirmed that she could not find any evidence of any information collected at or prior to the time of hire regarding CNA #11. She stated this included no evidence of CNA #11's licensure as a CNA. She stated she could not say for certain that CNA #11 was actually a licensed care provider during her time at the facility. She stated CNA #11 is no longer employed at the facility. On 2/23/26 at 5:02 p.m., the Administrator and Director of Nursing (DON) were informed of these concerns. On 2/24/26 at 11:30 a.m., the Director of Nursing (DON) was interviewed. She stated competency is (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	vital for staff members to provide quality resident care. She stated that without some type of evidence at the time of hire, the facility does not have a way to determine a CNA's ability to do a job. On 2/24/26 at 12:19 p.m., the Director of HR was interviewed. She stated that she is responsible for overall license verification. She explained that the potential employee is asked to bring a copy of their current license at the time of initial interview. Once she receives approval to move forward with the hiring process from management, she verifies the license through the state department of health professions. Once the new employee has started work with residents, the employee's manager is responsible for verifying the license one additional time. She stated her understanding that verifying a potential staff member's license at the time of hire is a part of the facility's abuse prevention program. She stated this verification is also important for making sure a new staff member is actually competent to perform the duties for resident care in the job description. No additional information was provided prior to exit.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on staff interview and facility document review, the facility staff failed to provide evidence of required CNA training for five of five CNA records reviewed: CNAs #5, #6, #7, #8, and #9.The findings include:The facility staff failed to provide evidence that CNA (certified nursing assistant) regular trainings were based on the results of individual annual performance reviews for CNAs #5, #6, #7, #8, and #9.On 2/20/26, evidence of annual performance reviews and that subsequent regular trainings were based on the results of these performance reviews was requested for CNAs #5, #6, #7, #8, and #9.On 2/23/26 at 10:01 a.m., the Director of Human Resources (HR) told the survey team that she had presented all the requested information she could locate at the time. She stated she did not have the evidence requested for the trainings for the CNAs.On 2/24/26 at 11:30 a.m., the Director of Nursing (DON) was interviewed. She stated that she had not been with this company for very long, and that when she first started work, the assistant DON was in charge of all evaluations. She added: I have not done [a CNA] evaluation since I have been here. She explained that it is her plan to take on the responsibility for CNA evaluations in order to become more familiar with the staff and their strengths and needs. She stated that evaluations help point out any training or competency gaps for staff. She stated she was not sure how CNA trainings were developed from the results of the annual evaluations and she would need to check with someone else about this.On 2/24/26 at 12:19 p.m., The Director of HR was interviewed. She stated that any trainings that needed to happen after the employee's initial 30 days on the job are tracked through a software system. She stated she receives notices from this system when trainings are due for all employees, and it is her responsibility to email employees to alert them of trainings that need to be completed. She stated she does not have any role in tailoring CNA training to the results of the CNAs' annual performance reviews.On 2/23/26 at 5:02 p.m., the administrator and director of nursing (DON) were informed of these concerns. A review of the facility policy, Team member Manager - Performance Reviews, revealed no information related to CNA trainings related to the outcome of annual performance reviews.No additional information was provided prior to exit.

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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.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on staff interview and facility document review, the facility staff failed to have evidence of QAPI (quality assurance and performance improvement) from July 2023 through December 2023.The findings include:A request was made upon entrance for the evidence of the facility conducting QAPI meetings since last survey of 1/12/2023. The facility failed to evidence any QAPI meetings from 7/23/2023 through 12/31/2023.An interview was conducted with the Administrator on 2/19/2026 at approximately 4:00 p.m. The Administrator stated the facility should conduct QAPI meetings at a minimum, quarterly. He stated he searched but could not find any notes from July 2023 through December 2023 to evidence that a QAPI meeting had occurred during that time frame. The facility policy, Quality Assurance and Performance Improvement (QAPI) Program, documented in part, b. Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary. 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.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on staff interview and facility document review, the facility staff failed to evidence the attendance at the QAPI (quality assurance and performance improvement) meetings for 2024.The findings include:A request was made upon entrance for the evidence of the participants of the QAPI meetings since the last survey, 1/12/2023.On 2/19/2026 at approximately 4:00 p.m. the Administrator stated that during the year of 2024, the facility used a computer program to list the attendants of the QAPI meetings. There were no signature sheets, just a printout of the names. The Administrator stated that he was under the understanding that you needed actual signatures for the attendance at meetings.The facility policy, Quality Assurance and Performance Improvement (QAPI) Program, documented in part, 2. The QAA Committee will be interdisciplinary and will: a. Consist at a minimum of: i. The Director of Nursing Services; ii. The Medical Director or his/her designee; iii. At least three other members of the community's staff, at least one of which must be the Administrator, Owner, a Board Member or other Individual in a leadership role; and iv. The Infection Preventionist.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.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **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 implement their policy to prevent abuse for one of 36 residents in the survey sample, Resident #42 and for four of five staff records reviewed, Licensed Practical Nurses #8, #9, #10 and #11. The findings include:1. 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 resulting bleeding and 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 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 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.
(continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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, 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 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:
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 2. The facility staff failed to verify licenses at the time of hire for LPN #8, LPN #9, CNA #10, and CNA (certified nursing assistant) #11. On 2/23/26 at 9:00 a.m., facility staff were requested to provide evidence that licensure was verified at the time of hire for LPN #8, LPN #9, CNA #10, and CNA #11. According to information provided by the Director of Human Resources (HR), LPN #8 was hired 3/18/25; LPN #9 was hired 3/24/25; CNA #10 was hired 5/13/25; and CNA #11 was hired 10/10/25. Despite multiple requests for license verification at the time of hire, no such evidence was provided by the facility staff. On 2/23/26 at 5:02 p.m., the Administrator and Director of Nursing (DON) were informed of these concerns. The director of nursing stated license verification at the time of hire is important to make sure staff members are competent and to prevent resident abuse. On 2/24/26 at 12:19 p.m., the Director of HR was interviewed. She stated that she is responsible for overall license verification. She explained that the potential employee is asked to bring a copy of their current license at the time of initial interview. Once she receives approval to move forward with the hiring process from management, she verifies the license through the state department of health professions. Once the new employee has started work with residents, the employee's manager is responsible for verifying the license one additional time. She stated her understanding that verifying a potential staff member's license at the time of hire is a part of the facility's abuse prevention program. A review of the facility's abuse policy revealed, in part: ABUSE POLICY: The Business Office Coordinator/designee performs background checks to screen prospective team members in accordance with state and federal law, and prior to hiring. The community must not employ or otherwise engage individuals who:a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law:b. Have a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; orHave a disciplinary action in effect against his or her (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment or residents or misappropriation of resident property. No additional information was provided prior to exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview facility document review and clinical record review, it was determined the facility staff failed to develop/implement the care plan for five of 36 residents in the survey sample, Resident #5, Resident #22, Resident #14, Resident #36 and Resident #24.The findings include: 1.The facility staff failed to implement the comprehensive care plan for incontinence care for Resident #5 (R5). R5 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident) with hemiparesis, hemiplegia and fibromyalgia. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 1/8/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers/bathing/dressing and supervision for eating. A review of the comprehensive care plan dated 1/8/26 revealed, FOCUS: Toilet use, the resident has bladder incontinence related to impaired mobility. INTERVENTIONS: I am dependent on the assistance of 1 helper with toilet use. The resident requires a walker for toilet use. Observe/document/report for possible causes of incontinence, such as bladder infection. Observations on 2/1826 at 8:00 AM and 2/19/26 at 8:15 AM revealed, R5 in bed with adult brief on. On 2/19/26 at 8:15 AM R5 described that she was in an adult brief as the night shift CNAs did not want to take the time to get her out of bed to the bathroom and wanted her to use the brief instead. They do not have female urinals or bedpans for me to use. R5 said she was not being treated with dignity and respect having to urinate in this manner. On 2/19/26 at 8:15 AM and 2:00 PM, there were no bedpans in the storage room on the unit. A review of the ADL (activities of daily living) document for January and February 2026 reveals missing documentation on the following shifts and dates: Day shift: 1/2/26, 1/18/26, 1/30/26; Evening shift: 1/9/26, 1/24/26, 1/25/26, 2/5/26, 2/13/26, 2/20/26 and Night shift: 1/10/26, 1/11/26, 1/12/26, 1/14/26, 1/16/26, 1/24/26, 1/25/26, 1/28/26, 1/31/26, 2/6/26, 2/12/26. On 2/19/26 at 2:00 PM, CNA (certified nursing assistant) #1 showed the supply room and described that there were no bedpans in there, looking in a second room and finding no bedpans there either. Asked about the process for restocking bedpans, CNA #1 said, This is not where I normally work. I am agency and do not know where additional supplies are kept. CNA #1 verified that ADL documentation is in the ADL form in PCC (point click care). On 2/19/26 at 2:15 PM, the DON (director of nursing) was informed that no bedpans were found on the unit and of R5s concern. The DON stated, the additional bedpans are kept in P3 (parking 3) level. Supply will bring them up. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/20/26 at 6:15 AM, CNA #2 described the incontinent care process as making rounds when she comes on and then positions herself where she can see the call lights come on when residents need something such as incontinence care, water, turning. There is no every two-hour rounding on nights due to letting the residents sleep and rounds are done before end of shift. Residents are assisted to the bathroom if they need one person, if they need two, then I would need help. CNA #2 described evidence of ADL care being done, documented in the ADL form in PCC. On 2/20/26 at 10:30 AM, LPN (licensed practical nurse) #1 described the purpose of the care plan as to see how to help the resident according to the physician orders, what steps should be implemented and if those steps are not implemented, the care plan was not followed. On 2/23/26 at 5:00 PM, the Administrator and DON were informed of the concern. According to the facility's Individualized Care Plan policy, which revealed, The IDT (interdisciplinary team) develops comprehensive care plan addressing the resident's most acute problems. The comprehensive care plan will include: Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. No further information was provided prior to exit. 2.The facility staff failed to implement the comprehensive care plan for PICC (peripherally inserted central catheter) care for Resident #22 (R22). R22 was admitted to the facility on [DATE] with diagnosis that included but were not limited to intraspinal abscess, neuromuscular dysfunction of bladder and polyarthritis. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 2/6/26, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being moderate assistance for mobility/transfers/dressing, dependence for bathing and supervision for eating. A review of the comprehensive care plan dated 2/1/26 revealed, FOCUS: Parenteral - Intravenous Access (PICC), to left upper arm. INTERVENTIONS: Observe and report any changes to the access site i.e. redness, swelling and complaints or tenderness/ pain. Change Catheter site Transparent dressings/securement device every night shift every 7 day(s) for IV site Maintenance Change catheter securement device with dressing change. A review of the physician orders dated 2/9/26 revealed, Change Catheter site Transparent dressings/securement device as needed for IV Site Maintenance/loose dressing/soiled Change catheter securement device with dressing change AND every day shift every 7 day(s) for IV site Maintenance Change catheter securement device with dressing change. Observe IV site every shift for IV Site Maintenance Observe before and after administration of intermittent medications and during dressing changes. Observe for signs/symptoms infiltration/extravasation at a frequency based on therapy and patient condition. A review of the TAR (treatment administration record) for 2/26, revealed missing documentation regarding this physician order observe IV site every shift for IV Site Maintenance Observe before and after administration of intermittent medications and during dressing changes. Observe for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	signs/symptoms infiltration/extravasation at a frequency based on therapy and patient condition on following shifts and dates: Day shift: 2/21/26, 2/23/26, Evening shift: 2/23/26 and Night shift: 2/11/26, 2/13/26 and 2/14/26. On 2/20/26 at 10:30 AM, LPN (licensed practical nurse) #1 described that all documentation of PICC care is on the TAR and if documentation is not there, there was no evidence of care being provided. LPN #1 described the purpose of the care plan as to see how to help the resident according to the physician orders, what steps should be implemented and if those steps are not implemented, the care plan was not followed. On 2/23/26 at 5:00 PM, the Administrator and Director of Nursing were informed of the concern. No further information was provided prior to exit. 3. For Resident #!4 (R14), the facility staff failed to implement the comprehensive care plan for monitoring for side effects of anticoagulants. 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. A review of the comprehensive care plan dated 12/27/25 revealed, 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. A review of the Medical Administration Record and Treatment Administration Record (MAR-TAR), failed to evidence monitoring for adverse reactions to anticoagulants. 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. Reference 1. Is when blood puts too much pressure against the walls of your arteries. https://medlineplus.gov/bloodpressuremedicines.html 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. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Bleeding into the skin can occur from broken blood vessels. https://medlineplus.gov/ency/article/003235.htm 4. For Resident #36 (R36), the facility staff failed to implement the resident's comprehensive care plan for a pressure injury. A review of R36's clinical record revealed a Service Evaluation and Health assessment dated [DATE] that documented R36 presented with a stage two pressure injury (1) on the sacrum. R36's comprehensive care plan dated 11/19/24 documented, I have a pressure ulcer stage II (two) to sacrum. Re-assess wound treatment and document weekly changes and wound size /characteristics. Further review of R36's clinical record failed to reveal any further documentation regarding an assessment of the pressure injury until 1/25/25 when a weekly skin check note documented R36's skin was intact. On 2/19/26 at 1:42 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 stated a care plan tells a lot about a resident and helps staff provide care. LPN #2 stated nurses can reference a resident's care plan to ensure it is being implemented. On 2/20/26 at 12:04 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated a pressure injury assessment should consist of a measurement, color, and odor. LPN #1 stated the facility nurses do not complete full weekly pressure injury assessment because they alert the wound physician when a resident has a pressure injury and he completes the assessments. (Note-R36 was not evaluated by the wound physician until he was seen on 1/9/25 for new excoriation of the buttock). On 2/21/26 at 3:05 p.m., the Administrator and Director of Nursing were made aware of the above concern. No further information was presented prior to exit. Reference: (1) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear . Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. For Resident #24 (R24), the facility staff failed to implement the comprehensive care for the administration of diuretic medications. The comprehensive care plan dated 1/17/2026, documented in part, Focus: The resident is on diuretic therapy r/t (related to) CHF (congestive heart failure). Interventions: Administer diuretic medications as ordered by physician. The physician order dated, 1/17/2026, documented, Bumetanide Oral Tablet (1) 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 the Director of Nursing (DON), on 2/20/2026 at 12:57 p.m. The DON stated the purpose of the care plan is what the resident is in the facility for and how we are going to help them. The DON stated it should be followed. The above was reviewed with the DON and she stated the care plan was not followed. 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. 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to follow the physician's order for three of 36 current residents in the survey sample, Residents #16, #24 and #5. The findings include:1.Resident #16 (R16) was administered another resident's medications for five days; atorvastatin (1), losartan (2) and Plavix (3). R16 was admitted to the facility with diagnoses that included but were not limited to dementia (4), anemia (5), hypothyroidism (6) and embolism (7) and thrombosis (8) of left lower extremity (left lower leg) On the most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/28/2025, R16 scored 7 (seven) out of 15 on the BIMS (brief interview for mental status), indicating R16 was severely impaired of cognition for making daily decisions. The physician's order sheet dated 11/02/2025 for R16 documented in part: Atorvastatin Calcium (1) Oral Tablet 20 MG (milligrams). Give 1 (one) tablet by mouth in the evening for HLD (high cholesterol). Start Date: 11/05/2025; Losartan Potassium (2) Oral Tablet 10MG. Give 1 tablet by mouth one time a day for HTN (high blood pressure). Start Date: 11/06/2025; Plavix (3) Oral Tablet 75MG. Give 1 tablet by mouth one time a day for PAD (peripheral artery disease). Start Date: 11/06/2025. The eMAR (electronic medication administration records) for R16 dated November 2025 documented in part the physician's orders as stated above. The eMAR further documented that R16 received; atorvastatin, losartan and Plavix on 11/06/2025, 11/07/2025, 11/08/2025, 11/09/2025 and on 11/10/2025. The facility's Health Status Note dated 11/10/2025 for R16 documented, 17:05 (5:05 p.m.) Note Text: Today it has been identified that from November 5th, the medications Plavix 75 mg, Atorvastatin 20 mg, and Losartan 25 mg were mistakenly ordered for this resident. These medications were intended to be continued for another resident who had returned froma [sic] cardiology appointment. However, the medications were erroneously entered as new medications for (R16). The error was identified during chart review on Monday, November 10th with the family, and appropriate corrective actions were taken to ensure medication accuracy and resident safety. Nurse was called to confirm and clarify the medication error. Skilled Nursing Administrator, Regional Resident Care Director, PA (physician assistant) and MD (medical doctor) notified. Verbal order from PA (Name of PA) to discontinue these medications. Willfollow [sic] up with necessary steps to ensure safety and will monitor resident for any adverse reactions. The facility's Health Status Note dated 11/10/2025 for R16 documented, 23:27 (11:27 p.m.) Note Text: Patient resting in supine position, turned and reposition Q2HRS (every two hours) when family is not around, the patient is responsive to the caregivers and family who were at the bedside, she was transferred to bed safely and tolerated the transfer well, bed in 45 degrees, respirations even and unlabored, no visible signs and symptoms of pain, ADL's (activities of daily living) provided accordingly, call light within reach and bed in lowest position and locked. Night light is on, hourly rounding maintained. Vitals as follows BP (blood pressure): 111/61 mmHg millimeters of mercury) 11/10/2025 18:27 (6:27 p.m.), Temp Temperature): 98.2 degrees F (degrees Fahrenheit) 11/10/2025 18:27, Pulse:65 bpm (beats per minute) 11/10/2025 18:27, Weight:118 Lbs (pounds)11/10/2025 11:28 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:28 a.m.), Resp (respiration):18 Breaths/min (breaths per minute) 11/10/2025 18:27, BS (blood sugar):120 mg/dL (milligrams per deciliter)11/9/2025 08:35 (8:35 a.m.), O2(oxygen): 93 % (percent) 11/10/2025 18:27. On 02/24/2026 at approximately 11:45 a.m. an interview was conducted with the Director of Nursing (DON) regarding the procedure for transcribing physician's orders for a resident's medications. She stated that the medications are verified with the physician and confirmed that the medications are for the correct resident. When asked about the circumstances about R16 receiving another resident's medications the DON stated that R16's family had brought it to her attention. She stated that R16's family requested a copy of R16's medications and after reviewing them she stated the family informed her that some of the medications were not for R16. The DON stated that she then reviewed R16's medications with the physician and found the R16 was receiving another resident's medications of atorvastatin, losartan and Plavix. She further stated that when the error was identified, the physician ordered laboratory tests and assessed the resident. R16 was monitored and there was no negative outcome. On 02/24/2026 at approximately 2:00 p.m., the Administrator, and the DON, were made aware of the above findings. No further information was provided prior to exit. References: (1) Used for high cholesterol. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a600045.html. (2) Used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695008.html. (3) (Clopidogrel), used to prevent repeat heart attacks or strokes in people who have had a stroke, heart attack, severe chest pain or peripheral arterial disease. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601040.html. (4) 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. (5) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html. (6) Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html. (7)An obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the bloodstream. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/embolism. (8) Occurs when blood clots block your blood vessels. This information was obtained from the website: https://www.hopkinsmedicine.org/health/conditions-and-diseases/thrombosis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	

2. For Resident #24 (R24), the facility staff failed to administer Metoprolol Succinate when the medication was in the back up pharmacy system at the facility.

The physician order dated, 1/21/2026 documented, Metoprolol Succinate Oral Capsule ER (extended Release) 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 review of the contents of the backup pharmacy system, located in the medication room, documented Metoprolol Succinate ER 25 MG. On hand – 28.

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 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.

3. The facility failed to administer medications within recommended time frame as ordered for Resident #5 (R5).

R5 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident) with hemiparesis, hemiplegia and fibromyalgia.

The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 1/8/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers/bathing/dressing and supervision for eating.

A review of the physician's order dated 1/2/26 revealed, Clonidine HCl Oral Tablet 0.1 MG, Give 1 tablet by mouth two times a day for HTN (hypertension). Hold for SBP (systolic blood pressure) <110 and HR (heart rate) <60.

A review of R5's MAR (medication administration record) revealed, Clonidine scheduled administration time of 9 AM and 5 PM.
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Medication Administration Audit Report revealed Clonidine HCl Oral Tablet 0.1 MG, administered on the following dates and times: 2/3/26 at 10:42 AM and 6:33 PM, 2/4/26 at 11:08 AM and 5:45 PM, 2/7/26 at 11:05 AM and 7:08 PM, 2/10/26 at 2:29 PM and 5:55 PM, 2/11/26 at 10:26 AM and 5:44 PM, 2/13/26 12:05 PM and 6:09 PM, 2/14/26 at 11:20 AM and 5:38 PM, 2/15/26 10:28 AM and 5:00 PM and 2/18/26 at 10:39 PM and 6:50 PM. Time between doses (hours: minutes) is listed by date: 2/4/26 6:53, 2/10/26 3:30, 2/11/26 7:45, 2/13/26 6:00, 2/14/26 6:00 and 2/15/26 6:30. On 2/18/26 at 8:15 AM R5 described that her medications are given late specifically the Clonidine which she takes twice daily and that she has asked them to not be given them close together. On 2/18/26 at 10:10 AM LPN (licensed practical nurse) #1 described the medication administration process as administering the medication one hour before and one hour after the medication due time, it is a medication error after that time period. You go ahead and give the medication, but I do not know if there are protocols for reporting late medications to the physician. On 2/24/26 at 11:30 AM DON (director of nursing) verbalized that all staff should be calling the provider and letting them know the medication is not given on time and ask the provider when the next dose should be and that this conversation should be documented in the provider notes. On 2/23/26 at 5:00 PM, the Administrator and DON were informed of the concern. A review of the facility's Medication Administration policy which revealed, Medications are administered within 60 minutes of scheduled time. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time, the nurse shall document either in the electronic medication administration record that the dose was withheld, refused or given at other than scheduled time and enter an explanatory note in the electronic health record. No further information provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, and clinical record review, the facility staff failed to provide parenteral catheter care for four of 36 residents in the survey sample, Residents #2, #6, #25, and #22. The findings include:1. For Resident #2 (R2), the facility staff failed to obtain a physician's order for and administer PICC (peripherally inserted central catheter) line dressing changes. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/20/26, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. A review of R2's clinical record revealed a physician's order dated 1/15/26 for a PICC line in the resident's right chest. Further review of R2's clinical record (including nurses' notes, the medication administration records, and the treatment administration records for January 2026 and February 2026) failed to reveal any orders for PICC line dressing changes. On 2/17/26 at 7:31 p.m., and 2/18/26 at 2:53 p.m., R2 was observed lying in bed with a PICC line in the resident's right chest. A dressing with no date was observed covering the PICC line. On 2/18/26 at 2:53 p.m., R2 stated staff changed the PICC line dressing every two days for the first two weeks then had not changed the dressing since then. On 2/19/26 at 1:42 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 stated nurses should verify that residents with PICC lines have physician orders for dressing changes. LPN #2 stated a PICC line dressing should be changed every seven days and nurses should write a date on the dressing, so they know the dressing has been changed. LPN #2 stated nurses evidence PICC line dressing changes have been done by signing them off on the MAR (medication administration record) or TAR (treatment administration record). On 2/21/26 at 3:05 p.m., the Administrator and the Director of Nursing were made aware of the above concern. The facility policy titled, PICC LINES failed to document specific information regarding the above concern. No further information was presented prior to exit. 2. For Resident #6 (R6), the facility staff failed to obtain a physician's order for and administer PICC (peripherally inserted central catheter) line dressing changes. A review of R6's clinical record revealed a physician's order dated 1/27/26 for Vancomycin (an antibiotic medication) 500 mg (milligrams)/100 ml (milliliters)- 500mg intravenously one time a day, every other day for 28 days. Further review of R6's clinical record (including nurses' notes, the medication administration records, and the treatment administration records for January 2026 and February 2026) failed to reveal any orders for PICC line dressing changes. On 2/18/26 at 9:26 a.m., and 3:59 p.m., R6 was observed lying in bed with a PICC line in the resident's right upper arm. A dressing with no date was observed covering the PICC line. On 2/19/26 at 1:42 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated nurses should verify that residents with PICC lines have physician orders for dressing changes. LPN #2 stated a PICC line dressing should be changed every seven days and nurses should write a date on the dressing, so they know the dressing has been changed. LPN #2 stated nurses' evidence PICC line dressing changes have been done by signing them off on the MAR (medication administration record) or TAR (treatment administration record). On 2/21/26 at 3:05 p.m., the Administrator and the Director of Nursing were made aware of the above concern. No further information was presented prior to exit. 3. For Resident #25 (R25) the facility staff failed to obtain physician orders for and implement dressing changes, intravenous flush orders, and verify a stop date and removal date for an intravenous line. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/9/2026, R25 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R25 was cognitively intact for making daily decisions. A review of the clinical record demonstrated that R25 had a onetime order dated 2/13/2026 for an infusion of Sodium Chloride Intravenous Solution 0.9 % (Sodium Chloride) 100 mL (milliliters) per hour intravenously one time only for total 500 mL over five hours. On 2/18/2026 at 9:42 AM, an interview was conducted with R25 in their room. R25 was observed sitting in a wheelchair next to the bed. R25 was noted to have a peripheral IV (intravenous) site in place to their right forearm that was covered by a clear transparent dressing with a sticker that stated 2/14/26 adhered to the dressing. R25 stated the IV site was put in a few days ago and that they had a hard time getting it. A review of R25's Medication Administration Record (MAR), documents the order for Sodium Chloride was completed on 2/14/2026. A comprehensive review of the clinical record failed to include any further indications for intravenous access, orders for routine IV site maintenance/care, nor did it reflect the presence of an intravenous site to R25 from 2/15/2026-2/19/2026. An interview with LPN (Licensed Practical Nurse) #2 was conducted on 2/19/2026 at 1:42 PM. LPN #2 stated that the process for IV (intravenous) insertion was to verify the physician order, put order in system, ensure order set for dressing changes and IV flush orders, verify stop date/duration and diagnosis, and inform pharmacy when medication is needed if not readily available. Staff can call an outside service for placement; however, the facility staff is responsible for the care of the IV site following placement. The IV site should be assessed every shift for redness, leakage and flushed for patency. There is usually a physician's order for this, and it goes on the MAR or TAR (Medication Administration Record or Treatment Administration Record) and is checked off to show completion. LPN #2 was unaware if there was a duration a peripheral IV site should be left in place but could find out. On 2/19/2026 at approximately 4.00 p.m. the Administrator and the Director of Nursing were made aware of the above concern. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was presented prior to exit. 4. The facility staff failed to provide parenteral catheter care including monitoring of complications for Resident #22 (R22). R22 was admitted to the facility on [DATE] with diagnosis that included but were not limited to intraspinal abscess, neuromuscular dysfunction of bladder and polyarthritis. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 2/6/26, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being moderate assistance for mobility/transfers/dressing, dependence for bathing and supervision for eating. A review of the comprehensive care plan dated 2/1/26 revealed, FOCUS: Parenteral - Intravenous Access (PICC), to left upper arm. INTERVENTIONS: Observe and report any changes to the access site i.e. redness, swelling and complaints or tenderness/ pain. Change Catheter site Transparent dressings/securement device every night shift every 7 day(s) for IV site Maintenance Change catheter securement device with dressing change. A review of the physician orders dated 2/9/26 revealed, Change Catheter site Transparent dressings/securement device as needed for IV Site Maintenance/loose dressing/soiled Change catheter securement device with dressing change AND every day shift every 7 day(s) for IV site Maintenance Change catheter securement device with dressing change. Observe IV site every shift for IV Site Maintenance Observe before and after administration of intermittent medications and during dressing changes. Observe for signs/symptoms infiltration/extravasation at a frequency based on therapy and patient condition. A review of the TAR (treatment administration record) for February 2026, revealed missing documentation regarding this physician order Observe IV site every shift for IV Site Maintenance Observe before and after administration of intermittent medications and during dressing changes. Observe for signs/symptoms infiltration/extravasation at a frequency based on therapy and patient condition on following shifts and dates: Day shift: 2/21/26, 2/23/26, Evening shift: 2/23/26 and Night shift: 2/11/26, 2/13/26 and 2/14/26. On 2/18/26 at 8:30 AM, R22 verbalized that the staff do not always monitor her PICC line. On 2/18/26 at 10:10 AM LPN (licensed practical nurse) #1 described PICC care as being important to ensuring the resident does not have another source of infection; we monitor the site for redness, swelling, drainage and any bleeding and then sign it off on the resident's TAR. On 2/18/26 at 1:45 PM, LPN (licensed practical nurse) #2 described PICC care as including the assessment of PICC for redness, swelling, bleeding any signs of infection; it is documented on the TAR for each resident. On 2/23/26 at 5:00 PM, the Administrator and Director of Nursing were informed of the concern. No facility policy was provided. No further information was provided prior to exit.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility document review, the facility staff failed to prepare and serve food in a sanitary manner in one of one facility kitchen.The findings include:The facility staff failed to follow procedures for washing dishes in an automatic dishwasher on 2/17/26; and failed to serve food in a sanitary manner at lunch on 2/18/26.On 2/17/26 at 5:43 p.m., OSM (other staff member) #6, a dietary aide, and OSM #7, a dietary aide, were observed running loaded dish racks through the automatic dishwasher in the facility kitchen. The gauge displaying the current water temperature during the wash cycle never registered any temperature at all. Approximately 10 racks were observed being placed into the dishwasher and coming out on the other side. At no time did the wash temperature gauge fluctuate or register any temperature at all. OSM #6 stated the dishwasher was broken, but he could not say how long this had been the case. OSM #7 stated the dishwasher had not displayed an actual temperature during the wash cycle for at least two days. Neither staff member made any attempt to stop running cookware, serving pieces, plates, or utensils through the dishwasher. As the racks came through at the end of the cycle, OSM #6 and OSM #7 stacked the wet steam table pans and half steam table pans on top of each other on a drying rack. At this point, the Dietician joined the conversation and was informed by the other staff members about the wash temperature gauge on the dishwasher. She asked the surveyor if the Dietary Manager, facility chef, or dishwasher equipment company should be called. At this time, OSM #9, a dietary supervisor joined the conversation. He stated the facility staff should have been utilizing a waterproof thermometer with each dish rack to ensure the wash temperature was high enough. He stated he thought the thermometer was located in the chef's office, but he was not certain.On 2/18/26 at 7:22 a.m., the facility chef was interviewed. He stated the dishwasher had been broken since Sunday, 2/15/26, and that the repair company had been contacted. He stated that the dishwasher itself was not broken, but that the gauge that displayed the temperature of the water in the wash cycle was broken. He stated that the dishwashing staff should have been using a waterproof thermometer to determine if the wash temperature was high enough to meet the regulation. He stated the current staff were not utilizing this thermometer during the observation on 2/17/26. He stated the thermometer was in a cabinet in his office, and he had just pulled it out for use on the breakfast dishes on 2/18/26. He stated that as a backup, the repair company had recommended adding a chemical sanitizer to the rinse cycle, which the facility staff had done. He stated he did not know whether or not the dishwashing staff had been testing the ratio of water to sanitizer to make sure the sanitizer was at an effective level. He stated he could not provide any records to document any test of this kind over the past two days. He stated he had just completed an additional call to the maintenance company, and they were scheduled to make an emergency visit to the facility that morning to replace the broken gauge.On 2/18/26 at 11:48 a.m., OSM #10 was observed in the 3rd floor pantry service lunch plates for residents. She wore a pair of gloves. As she worked, she put her thumbs on the plate surfaces, served food by touching the handles of serving pieces, opened the refrigerator multiple times, opened a loaf of bread, touched the surface of the steam table multiple times, and put her gloved hands directly on sandwiches and potato chips. At no time did she change gloves or sanitize her hands.On 2/18/26 at 3:10 p.m., the Director of Dining Services was interviewed. She stated a staff member noticed the broken gauge on the facility dishwasher on Sunday, 2/15/26, and called the maintenance company. She stated that while the wash cycle water temperature gauge was broken, We have a disc thermometer that gets run through. She stated she knew this was being done on 2/17/26 at some point but was not sure if this thermometer was implemented immediately upon the discovery of the faulty gauge. She stated the wash temperature reaching the correct degree is vital to make sure all the dishware is being cleaned and sanitized properly, as this is a major component to preventing foodborne illness. She stated it was the chef or supervisor's responsibility to immediately implement measures to ensure a healthy (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water temperature as a back-up to the faulty gauge. She stated wet dishware should never be stacked directly on top of each other to avoid the formation of hazardous bacteria. She stated that staff members should change gloves and sanitize their hands whenever the gloves have a potential to have become contaminated. She added: We cannot cross contaminate just because we are wearing gloves.On 2/18/26 at 5:16 p.m., the Administrator and the Director of Nursing were informed of these concerns.A review of the facility policy, Dishwashing Procedure, revealed, in part: Air dry dirty dishes by racking or putting on single trays.If dishmachine is out of range or not working at all, use the 3-compartment sink to wash the dishes.A review of the facility policy, Recording of Dishmachine Temperatures, revealed, in part: Before each use, allow dishmachine to run 10 minutes in order to bring water temperature up to proper level by sending several empty racks through the machine.Read temperature gauges on top of machine while racks are in machine.Any inaccurate temperatures must be brought to the attention of the Dining Services Director immediately.No additional information was provided prior to exit.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on staff interviews and facility document review, the facility staff failed to follow state regulations at the time of hire for four of five staff records reviewed, LPN (licensed practical nurse) #8, LPN #9, CNA (certified nursing assistant) #10, and CNA #11.The findings include: For LPNs #8 and #9, and for CNAs #10 and #11, the facility staff failed to follow state regulations to verify professional licensure at the time of hire.According to Virginia state regulation 12VAC5-371-210 Nurse staffing, Before allowing a nurse aide to perform resident care duties, the nursing facility shall verify that the individual is.A certified nurse aide in good standing.On 2/23/26 at 9:00 a.m., facility staff were requested to provide evidence that licensure was verified at the time of hire for LPN #8, LPN #9, CNA #10, and CNA #11. According to information provided by the Director of Human Resources (HR), LPN #8 was hired 3/18/25; LPN #9 was hired 3/24/25; CNA #10 was hired 5/13/25; and CNA #11 was hired 10/10/25. Despite multiple requests for license verification at the time of hire, no such evidence was provided by the facility staff. On 2/23/26 at 5:02 p.m., the administrator and director of nursing (DON) were informed of these concerns. The director of nursing stated license verification at the time of hire is important to make sure staff members are competent and to prevent resident abuse.On 2/24/26 at 12:19 p.m., the Director of HR was interviewed. She stated that she is responsible for overall license verification. She explained that the potential employee is asked to bring a copy of their current license at the time of initial interview. Once she receives approval to move forward with the hiring process from management, she verifies the license through the state department of health professions. Once the new employee has started work with residents, the employee's manager is responsible for verifying the license one additional time. She stated her understanding that verifying a potential staff member's license at the time of hire is a part of the facility's abuse prevention program.No additional information was provided prior to exit.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on staff interview and facility document review, the facility staff failed to provide required training for five of ten staff records reviewed, CNA (certified nursing assistant) #5, RN (registered nurse) #1, OSM (other staff member) #3, a speech and language pathologist, OSM #4, a dietary aide, and OSM #5, a housekeeper.The findings include:The facility staff failed to provide evidence of required training in Quality Assurance/Performance Improvement (QAPI) for CNA #5, RN #1, OSM #3, OSM #4, and OSM #5.On 2/20/26, evidence of training in QAPI was requested for CNA #5, RN #1, OSM #3, OSM #4, and OSM #5.A review of facility records provided by the Director of Human Resources (HR) failed to reveal evidence that the training in QAPI for these staff members had been completed.On 2/23/26 at 5:02 p.m., the Administrator and Director of Nursing (DON) were informed of these concerns.On 2/24/26 at 12:19 p.m., the Director of Human Resources (HR) was interviewed. She stated that at the time of hire, new employees receive a list of required trainings through a third-party education provider. She explained that these trainings are online, and once the new employees have completed the training, she transfers the record of completion to another third-party education provider's software. She stated that she does not personally verify which trainings need to be completed by which employees, and that her role is only to receive notifications from the third party that trainings are due and then to notify the individual staff members of what they need to complete. She stated she does not keep up with specific subject matter trainings are required by regulations.A review of a document containing onboarding curriculum for all staff revealed and a document containing annual training assignments for all team members revealed no information related to training in QAPI. No additional information was provided prior to exit.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on staff interviews and facility document review, the facility staff failed to provide required training for five of five CNA (certified nursing assistant) records reviewed, CNAs #5, #6, #7, #8, and #9.The findings include:The facility staff failed to provide evidence that CNA (certified nursing assistant) regular trainings were based on the results of individual annual performance reviews for CNAs #5, #6, #7, #8, and #9.On 2/20/26, evidence of annual performance reviews and that subsequent regular trainings were based on the results of these performance reviews was requested for CNAs #5, #6, #7, #8, and #9.On 2/23/26 at 10:01 a.m., the Director of Human Resources (HR) told the survey team that she had presented all the requested information she could locate at the time. She stated she did not have the evidence requested for the trainings for the CNAs.On 2/24/26 at 11:30 a.m., the Director of Nursing (DON) was interviewed. She stated that she had not been with this company for very long, and that when she first started work, the assistant DON was in charge of all evaluations. She added: I have not done [a CNA] evaluation since I have been here. She explained that it is her plan to take on the responsibility for CNA evaluations in order to become more familiar with the staff and their strengths and needs. She stated that evaluations help point out any training or competency gaps for staff. She stated she was not sure how CNA trainings were developed from the results of the annual evaluations and she would need to check with someone else about this.On 2/24/26 at 12:19 p.m., The Director of HR was interviewed. She stated that any trainings that needed to happen after the employee's initial 30 days on the job are tracked through a software system. She stated she receives notices from this system when trainings are due for all employees, and it is her responsibility to email employees to alert them of trainings that need to be completed. She stated she does not have any role in tailoring CNA training to the results of the CNAs' annual performance reviews.On 2/23/26 at 5:02 p.m., the Administrator and Director of Nursing (DON) were informed of these concerns. A review of the facility policy, Team member Manager - Performance Reviews, revealed no information related to CNA trainings related to the outcome of annual performance reviews.No additional information was provided prior to exit.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff /resident interviews facility document review and clinical record review, it was determined the facility staff failed to promote dignity and respect for one of 36 residents, Resident #5. The findings include: The facility staff failed to promote dignity and respect for Resident #5 (R55). R5 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident) with hemiparesis, hemiplegia and fibromyalgia. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 1/8/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers/bathing/dressing and supervision for eating. A review of the comprehensive care plan dated 12/19/23 revealed, FOCUS: Toilet use, the resident has bladder incontinence related to impaired mobility. INTERVENTIONS: I am dependent with assistance of 1 helper with toilet use. The resident requires a walker for toilet use. Observe/document/report for possible causes of incontinence, such as bladder infection.Observations on 2/18/26 at 8:00 AM and 2/19/26 at 8:15 AM revealed, R5 in bed with adult brief on.On 2/19/26 at 8:15 AM R5 described that she was in an adult brief as the night shift CNAs did not want to take the time to get her out of bed to the bathroom and wanted her to use the brief instead. They do not have female urinals or bedpans for me to use. R5 said she was not being treated with dignity and respect having to urinate in this manner.On 2/19/26 at 8:15 AM and 2:00 PM, there were no bedpans in the storage room on the unit.On 2/19/26 at 2:00 PM, CNA (certified nursing assistant) #1, showed the supply room and described that there were no bedpans in there, looking in a second room and finding no bedpans there either. Asked the process for restocking bedpans, CNA #1 said, This is not where I normally work. I am agency and do not know where additional supplies are kept.On 2/19/26 at 2:15 PM, the Director of Nursing (DON) was informed that no bedpans were found on the unit and of R5s concern. DON stated, the additional bedpans are kept in P3 (parking 3) level. Supply will bring them up. On 2/23/26 at 5:00 PM, the Administrator (ADM) and DON were informed of R5's dignity issue.A review of the facility's Resident's Rights policy revealed, All residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. The facility will ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the responsibility of the facility to properly care for its residents. Training topics will be appropriate to the individual's role.No further information was provided prior to exit.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on resident interview, staff interview, and clinical record review, the facility failed to maintain an accurate MDS (Minimum Data Set) record for 1 of 36 residents in the survey sample, Resident #25.The findings include: For Resident 25 (R25), the facility staff failed to accurately code section N (medications) on the MDS admission Assessment with an ARD (assessment reference date) of 2/9/2026. According to The Centers for Medicare and Medicaid Services Resident Assessment Instrument (RAI), a facility should review MAR (medication administration records) for the 7-day look-back period to determine if the resident received insulin injections and count the number of days insulin injections were received. This number should be entered on section N-0350 of the MDS assessment.Section N-0350 of R25's admission MDS with an ARD of 2/9/2026 coded R25 as having received insulin one day of the past seven days. On the same admission MDS with an ARD of 2/9/2026, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.An interview was conducted with R25 on 2/18/2026 at 9:29 AM. During this interview, R25 stated they have never been diabetic or received insulin.A review of R25's clinical record (Medication Administration Record and Physician's Orders for February of 2026) failed to document orders for insulin and failed to document insulin administrations since R25's admission.An interview was conducted with the MDS Coordinator on 2/19/2026 at 9:20 AM. R25's MDS admission Assessment section N-0350 was reviewed with the MDS Coordinator. The MDS Coordinator stated section N-0350 was coded incorrectly and R25 should not have been coded as receiving insulin injection.The Administrator and Director of Nursing were made aware of the above concern on 2/19/26 at 5:15 PM.No further information was presented prior to exit.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement the baseline care plan for one of 36 residents in the survey sample, Resident #34. The findings include:For Resident #34 (R34), the facility staff failed to implement the resident's baseline care plan for anticoagulant therapy. R34's baseline care plan dated 2/11/26 documented, The resident receiving anticoagulant therapy Lovenox (Enoxaparin Sodium-blood thinning medication) r/t (related to) ORIF (Open Reduction and Internal Fixation surgery) to left hip. Administer medications as ordered by physician. Monitor for side effects and effectiveness daily. Observe/document/report any adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, nausea, vomiting, diarrhea, bruising, sudden changes in mental status, significant or sudden changes in v/s (vital signs). 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 a care plan tells a lot about a resident and helps staff provide care. LPN #2 stated nurses can reference a resident's care plan to ensure it is being implemented. 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 policy titled, Individualized Care Plan documented, Action Steps: 2. Within 48 hours of the resident's admission, the Interdisciplinary Team (IDT) will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. No further information was presented prior to exit.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **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 review and revise the comprehensive care plan for one of 36 residents in the survey sample, Resident #36. The findings include:For Resident #36 (R36), the facility staff failed to review and revise the resident's comprehensive care plan to include the resident's use of glasses. A review of R36's clinical record revealed a Service Evaluation and Health assessment dated [DATE] that documented R36 wore glasses. Section B 1200. of R36's admission MDS (minimum data set) assessment with an assessment reference date of 11/24/24 documented R36 wore corrective lenses. A review of R36's comprehensive care plan initiated on 11/19/24 failed to reveal documentation regarding R36's use of glasses. On 2/21/26 at 10:38 a.m., an interview was conducted with the MDS Coordinator. The MDS Coordinator stated R36 did not have a diagnosis related to vision impairment, such as glaucoma, and the resident's vision was not impaired when the resident wore glasses, so she did not review and revise the resident's care plan to include the use of glasses. The MDS Coordinator stated the care plan should reflect devices a resident needs because that was the purpose of the care plan. On 2/21/26 at 3:05 p.m., the Administrator and Director of Nursing were made aware of the above concern. The facility policy titled, ASSESSMENT AND CARE PLANNING documented, The ISP (Individualized Service Plan) is initially developed when each section of the assessment each is completed. The ISP is then opened, reviewed and customized on an ongoing basis to assure that it accurately reflects the care and services that the resident wants and needs. No further information was presented prior to exit.

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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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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, the facility staff failed to provide care and services to promote ADL (Activities of Daily Living) abilities for one of 36 residents in the survey sample, Resident #36. The findings include:For Resident #36 (R36), the facility staff failed to provide R36 with the resident's hearing aids and glasses to promote the resident's highest level of communication functioning. A review of R36's clinical record revealed a Service Evaluation and Health assessment dated [DATE] that documented the resident wore glasses and hearing aids. A physician's order dated 11/19/24 documented, Hearing aids to be charged at night time and apply in the morning one time a day and remove per schedule. Further review of R36's clinical record revealed a nurse's note dated 12/8/24 that documented, Hearing aids to be charged at night time and apply in the morning one time a day and remove per schedule. Hearing aid not found per CNA (Certified Nursing Assistant). wife [sic] is aware. A speech therapy note dated 1/13/25 documented, Pt (Patient) received upright in WC (wheelchair). SLP (Speech Language Pathologist) turned off TV and removed all distractions while making small talk about Commanders game. Pt's son came in to say goodbye. SLP presented pt w (with) task upon realizing that pt was not wearing glasses and donned pt with glasses. SLP asked pt one question and allowed processing time when pt's son came in to check if pt was wearing assistive devices. Pt was not wearing HA (hearing aids) and pt's son assisted pt in putting them on. The speech therapist who documented the above note was not available for interview during the survey. On 2/20/26 at 3:19 p.m., an interview was conducted with OSM (Other Staff Member) #2 (an Occupational Therapist). OSM #2 stated glasses and hearing aids should be used during therapy. On 2/21/26 at 11:04 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #4. LPN #4 stated glasses and hearing aids help residents maintain and increase their communication skills and ADLs. LPN #4 stated that residents who wear glasses and hearing aids are placed at a major disadvantage and risk of falls when they are not provided with those devices. LPN #4 stated residents have to see what is happening around them and if a resident who needs a hearing aid doesn't have it, he or she may be missing vital information or may be misconstrued as being cognitively impaired. 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 ADLs, hearing aids, or glasses.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident/staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide ADL (activities of daily living) care for dependent residents for one of 36 residents, Resident #5.The findings include: The facility staff failed to provide ADL (activities of daily living) specifically incontinent care for a dependent resident, Resident #5 (R5).R5 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident) with hemiparesis, hemiplegia and fibromyalgia. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 1/8/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers/bathing/dressing and supervision for eating.A review of the comprehensive care plan dated 1/8/26 revealed, FOCUS: Toilet use, the resident has bladder incontinence related to impaired mobility. INTERVENTIONS: I am dependent on the assistance of 1 helper with toilet use. The resident requires a walker for toilet use. Observe/document/report for possible causes of incontinence, such as bladder infection.Observations on 2/18/26 at 8:00 AM and 2/19/26 at 8:15 AM revealed, R5 in bed with adult brief on.On 2/19/26 at 8:15 AM R5 described that she was in an adult brief as the night shift CNAs did not want to take the time to get her out of bed to the bathroom and wanted her to use the brief instead. They do not have female urinals or bedpans for me to use. R5 said she was not being treated with dignity and respect having to urinate in this manner.On 2/19/26 at 8:15 AM and 2:00 PM, there were no bedpans in the storage room on the unit.A review of the ADL (activities of daily living) document for January and February 2026 reveals missing documentation on the following shifts and dates: Day shift: 1/2/26, 1/18/26, 1/30/26; Evening shift: 1/9/26, 1/24/26, 1/25/26, 2/5/26, 2/13/26, 2/20/26 and Night shift: 1/10/26, 1/11/26, 1/12/26, 1/14/26, 1/16/26, 1/24/26, 1/25/26, 1/28/26, 1/31/26, 2/6/26, 2/12/26.On 2/19/26 at 2:00 PM, CNA (certified nursing assistant) #1 showed the supply room and described that there were no bedpans in there, looking in a second room and finding no bedpans there either. Asked about the process for restocking bedpans, CNA #1 stated, This is not where I normally work. I am agency and do not know where additional supplies are kept. CNA #1 verified that ADL documentation is in the ADL form in PCC (point click care).On 2/20/26 at 6:15 AM, CNA #2 described the incontinent care process as making rounds when she comes on and then positions herself where she can see the call lights come on when residents need something such as incontinence care, water, turning. She stated, there is no every two-hour rounding on nights due to letting the residents sleep and rounds are done before end of shift. Residents are assisted to the bathroom if they need one person, if they need two, then she would need help. CNA #2 described evidence of ADL care being done, documented in the ADL form in PCC.On 2/23/26 at 5:00 PM, ADM (administrator) and Director of Nursing were informed of the concern.No facility policy was provided.No further information was provided prior to exit.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, and clinical record review, the facility staff failed to provide care and services for the assessment of a pressure injury for one of 36 residents in the survey sample, Resident #36. The findings include:For Resident #36 (R36), the facility staff failed to complete a thorough assessment of the resident's stage two pressure injury (1) from R36's date of admission [DATE]) until 1/25/25. A review of R36's clinical record revealed a Service Evaluation and Health assessment dated [DATE] that documented R36 presented with a stage two pressure injury on the sacrum. A nurse's note dated 11/19/24 documented R36 presented with a stage two pressure injury on the sacrum. A physician's order dated 11/19/24 documented-Desitin External Paste 40%. Apply to sacrum every shift for stage two pressure ulcer (injury). Further review of R36's clinical record failed to reveal any further documentation regarding an assessment of the pressure injury until 1/25/25 when a weekly skin check note documented R36's skin was intact. On 2/20/26 at 12:04 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated a pressure injury assessment should consist of a measurement, color, and odor. LPN #1 stated the facility nurses do not complete full weekly pressure injury assessments because they alert the wound physician when a resident has a pressure injury and he completes the assessments. (Note-R36 was not evaluated by the wound physician until he was seen on 1/9/25 for new excoriation of the buttock). 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 pressure injuries. No further information was presented prior to exit. Reference:(1) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear .Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, staff interview and clinical record review, facility staff failed to provide care and services for an indwelling catheter for one of 36 residents in the survey sample, Resident #9. The findings include:For Resident #9 (R9), the facility staff failed to keep the catheter tubing (1) from resting on the base of the over-the-bed table. R9 was admitted to the facility with diagnoses that included but were not limited to neuromuscular dysfunction of the bladder (2). On the most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/28/2026, R9 scored 12 out of 15 on the BIMS (brief interview for mental status), indicating R9 was moderately impaired of cognition for making daily decisions. On 02/17/2016 at approximately 7:00 p.m. an observation of R9 revealed she was in bed, head-of-the-bed raised with the over-the-bed table in front of her. Further observations revealed a catheter collection bag hanging on the side of the bed. Observation of the catheter tubing revealed it was going from R9 to the catheter collection bag. Further observation of the tubing reveal that a section of the tubing was resting on the base (leg)of the over-the-bed table. The physician's order for R9 documented, Indwelling Foley catheter care. Order Date: 2/5/2026. On 02/24/2026 at approximately 11:45 a.m. an interview was conducted with the Director of Nursing (DON). After informed of the above observation of R9's catheter tubing she stated that the tubing should not be in contact with anything to prevent infection. On 02/20/2026 at approximately 2:30 p.m., the Administrator, and the DON, were made aware of the above findings. No further information was provided prior to exit. References:(1) A tube placed in the body to drain and collect urine from the bladder. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm. (2) A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: https:// medlineplus.gov/ency/article/000754.htm. (3) Are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. This information was obtained from the website: https:// www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff /resident interviews facility document review and clinical record review, it was determined the facility staff failed to provide respiratory care services for one of 36 residents, Resident #22.The findings include: The facility staff failed to provide respiratory care services for Resident #22 (R22). R22 was admitted to the facility on [DATE] with diagnosis that included but were not limited to intraspinal abscess, neuromuscular dysfunction of bladder and polyarthritis.The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 2/6/26, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being moderate assistance for mobility/transfers/dressing, dependence for bathing and supervision for eating. Observations of R22's incentive spirometer on 2/17/26 at 6:45 PM and 2/18/26 at 8:30 AM revealed it was on bedside table uncovered with the mouthpiece laying on the bedside table.On 2/17/26 at 6:45 PM, R22 verbalized that the incentive spirometer had not been covered during her time in the facility. On 2/18/26 at 8:45 AM, LPN (licensed practical nurse) #3 described that the incentive spirometer should be in a plastic bag for infection control purposes. Observed a CNA (certified nursing assistant) placing it in a plastic bag.On 2/23/26 at 5:00 PM, the Administrator and Director of Nursing were informed of the concern.No facility policy was provided for the incentive spirometer.No further information was provided prior to exit.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure required physician visits for one of 36 residents in the survey sample, Resident #7. The findings include:For Resident # (R7), the facility staff failed to ensure the resident was seen by a physician between 3/12/25 and 6/19/25 (a total of 99 days), and between 6/19/25 and 9/3/25 (a total of 76 days). A review of R7's clinical record revealed the resident was seen by a physician on 3/12/25. Further review of R7's clinical record revealed the resident was not seen by a physician (or physician extender) until 6/19/25 (a total of 99 days). After 6/19/25, R7 was not seen by a physician (or physician extender) until 9/3/25 (a total of 76 days). On 2/21/26 at 10:06 a.m., an interview was conducted with the Director of Nursing. The Director of Nursing stated that most residents at this facility do not stay long term, and the facility does not really track physician visits. 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 physician visits. No further information was presented prior to exit.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. Based on staff interview and facility document review, the facility staff failed to verify licensure at the time of hire for two of three CNA (certified nursing assistant) records reviewed: CNAs #10 and #11.The findings include:The facility staff failed to verify licenses at the time of hire for CNA #10 and CNA #11.On 2/23/26 at 9:00 a.m., facility staff were requested to provide evidence that licensure was verified at the time of hire CNA #10 and CNA #11. According to information provided by the Director of Human Resources (HR), CNA #10 was hired 5/13/25, and CNA #11 was hired 10/10/25. Despite multiple requests for license verification at the time of hire, no such evidence was provided by the facility staff. On 2/23/26 at 5:02 p.m., the Administrator and Director of Nursing (DON) were informed of these concerns. The DON stated license verification at the time of hire is important to make sure staff members are competent and to prevent resident abuse.On 2/24/26 at 12:19 p.m., the Director of HR was interviewed. She stated that she is responsible for overall license verification. She explained that the potential employee is asked to bring a copy of their current license at the time of initial interview. Once she receives approval to move forward with the hiring process from management, she verifies the license through the state department of health professions. Once the new employee has started work with residents, the employee's manager is responsible for verifying the license one additional time. She stated her understanding that verifying a potential staff member's license at the time of hire is a part of the facility's abuse prevention program.A review of the facility's abuse policy revealed, in part: ABUSE POLICY: The Business Office Coordinator/designee performs background checks to screen prospective team members in accordance with state and federal law, and prior to hiring. The community must not employ or otherwise engage individuals who:a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law:b. Have a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; orHave a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment or residents or misappropriation of resident property.No additional information was provided prior to exit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure medications were 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 ensure Bumetanide was available for administration.The physician order dated, 1/17/2026, documented, Bumetanide Oral Tablet (1) 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.The review of the contents of the backup pharmacy system, located in the medication room, failed to evidence the Bumetanide Oral Tablets were in the system.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 policy, Provider Pharmacy Requirements documented in part, The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to: a. Assisting the nursing care center, as necessary, in determining the appropriate acquisition, receipt, dispensing and administration of all medications and biologicals to meet the medication needs of the residents and the nursing care center.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). 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 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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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to store medications in a safe manner for two of 36 residents in the survey sample, Residents #6, and #25. The findings include:1. For Resident #6 (R6), the facility staff failed to store heparin flushes (blood thinning medication used to prevent blood clots in intravenous catheters) in a locked compartment. The heparin flushes were observed on the dresser and over bed table in R6's room. A review of R6's clinical record revealed a physician's order dated 1/24/26 for heparin sodium lock flush intravenous solution- 10 cc (cubic centimeters) intravenous every shift for an intravenous flush. On 2/18/26 at 9:26 a.m., R6 was observed lying in bed. One heparin flush (50 USP [United States Pharmacopeia]/5 ml [milliliters]-10 USP units/ml) was observed on the resident's dresser and one heparin flush was observed on the resident's over bed table. On 2/18/26 at 3:59 a.m., R6 was observed lying in bed. Two heparin flushes were observed on the resident's dresser. On 2/19/26 at 1:42 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 stated heparin flushes should be stored in the medication room or medication cart until ready for use. LPN #2 stated heparin flushes should not be left in resident rooms because they are medication. On 2/21/26 at 3:05 p.m., the Administrator and Director of Nursing were made aware of the above concern. The facility policy titled, STORAGE OF MEDICATION documented, II. PROCEDURE A. Storage 1. Prescription medication, over-the-counter medications and syringes must be: a. Kept in an area or container that is locked. C.3. When a medication is removed from a secure storage location to be administered, the medication may not be left unattended. No further information was presented prior to exit. 2. The facility failed to ensure medications were properly stored for Resident #25 (R25). The admission care plan for R25 includes a focus dated 2/3/2026, Resident is unable to self-administer their own medication with an intervention dated 2/4/2026 stating that medications are to be administered by facility staff. On R25's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/9/2026, the resident scored 15 out of 15 on the BIMS (brief interview for mental (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status), indicating the resident was cognitively intact for making daily decisions. An interview with R25 was conducted on 2/18/2026 at 9:29 AM. During this interview, R25 opened the top drawer of the nightstand next to the bed and removed a box of medication, Ibandronate (a medication used to treat osteoporosis) 150mg (milligrams), from the bedside drawer. The pharmacy label attached to this medication included the instructions to take medication once a month. Resident #25 stated to interviewer that resident's son had brought this medication in from home, and that the doctor is aware that resident has the medication in drawer. Resident was instructed by the doctor not to take the medication and that they (doctor) would order the medication. R25 stated I am supposed to take this medicine tomorrow. It is taken once a month. It is important I take this at the same time every month. Resident was unsure what date their son brought this medication into the facility. A comprehensive review of the clinical record was performed including physician progress notes, medication administration record, and physician orders. Ibandronate 150mg monthly was not present in the record. An interview with LPN (Licensed Practical Nurse) #2 was conducted on 2/19/2026 at 1:42 PM. LPN #2 stated that if medication is brought in from home by a family member the process is to inform family that home medication is not allowed. Staff should take this medication and place it in a locked cart until it can be returned to the family. Alternatively, staff can call the physician to obtain an order for the medication, however it should still be locked up in the medication cart and not be kept at the bedside. The facility Director of Nursing and Administrator were made aware of the above findings on 2/19/2026 at 5:00 PM. No further information was presented prior to exit.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to maintain a complete and accurate clinical record for one of 11 residents in the survey sample, Resident #108.The findings include:For Resident #108 (R108), the facility staff failed to maintain a complete and accurate record regarding the resident's discharge on [DATE].A review of R108's facility census information revealed that R108 was discharged on 4/26/26. A review of R108's progress notes revealed the following activities note dated 4/27/26: Guest discharged from unit AMA (against medical advice) before assessment could be conducted. Further review of the clinical record revealed no additional information regarding R108's discharge.On 4/30/26 at 10:40 a.m., LPN (licensed practical nurse) #1 was interviewed. She stated she was on duty when R108 left the skilled nursing unit. She explained that the resident's son approached her at the nurses' station to tell her that his mother wanted to leave. She went to R108's room to find out what was going on. She stated that one of the CNAs (certified nursing assistants) had accidentally spilled some water on R108's overbed table and was trying to clean up the spill and apologizing to R108. She stated R108 told her that she no longer wanted to stay in the skilled nursing unit because of the spill. LPN #1 stated the resident's son did everything he could to keep [R108] there. LPN #1 told R108's son that the resident would have to sign out AMA, which R108 did before she left. LPN #1 stated she called the Administrator, who told her to complete a grievance form about what happened. LPN #1 agreed that the grievance form was not a part of the resident's clinical record and that the clinical record did not contain a complete description of R108's stay at the facility.On 4/30/26 at 11:56 a.m., the Director of Nursing (DON) was interviewed. She stated that when R108 made the decision to leave AMA, the Administrator instructed the nurse to complete a grievance form. She admitted that the grievance form was not a part of the clinical record and that a nurse's note should have been written in order for the clinical record to reflect accurate documentation of the events surrounding the discharge.On 4/30/26 at 1:23 p.m., the Administrator and the DON were informed of these concerns.A review of the facility policy, Clinical Records, revealed, in part: The HIC (health information coordinator) will maintain an accurate and complete clinical record for each resident that shall include.Nurses' notes written in chronological order and signed by the individual making the entry.No additional information was provided prior to exit.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on staff interview and facility document review, the facility staff failed to provide required training for three of ten staff records reviewed, OSM (other staff member) #3 (a speech and language pathologist), CNA (certified nursing assistant) #6, and LPN (licensed practical nurse) #6.The findings include:The facility staff failed to provide evidence of required training in effective communication was for OSM #3, CNA #6, and LPN #6.On 2/20/26, evidence of training in effective communication for OSM #3, CNA #6, and LPN #6 was requested.A review of facility records provided by the Director of Human Resources (HR) failed to reveal evidence that the training in effective communication for OSM #3, CNA #6, and LPN #6 had been completed.On 2/23/26 at 5:02 p.m., the Administrator and Director of Nursing (DON) were informed of these concerns.On 2/24/26 at 12:19 p.m., the Director of Human Resources (HR) was interviewed. She stated that at the time of hire, new employees receive a list of required trainings through a third-party education provider. She explained that these trainings are online, and once the new employees have completed the training, she transfers the record of completion to another third-party education provider's software. She stated that she does not personally verify which trainings need to be completed by which employees, and that her role is only to receive notifications from the third party that trainings are due and then to notify the individual staff members of what they need to complete. She stated she does not keep up with specific subject matter trainings are required by regulations.A review of a document containing annual training assignments for direct care staff for 2026 revealed, in part: January.Communicating Effectively.CNAs, Lead CNAs, LPN, LVN, Registered Nurse.No additional information was provided prior to exit.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on staff interview and facility document review, the facility staff failed to provide required training for one of ten staff records reviewed, OSM (other staff member) #3, a speech and language pathologist.The findings include:The facility staff failed to provide evidence of required training in resident rights and facility responsibilities for OSM #3.On 2/20/26, evidence of training in resident rights and facility responsibilities was requested for OSM #3.A review of facility records provided by the Director of Human Resources (HR) failed to reveal evidence that the training in resident rights and facility responsibilities for OSM #3 had been completed.On 2/23/26 at 5:02 p.m., the Administrator and Director of Nursing (DON) were informed of these concerns.On 2/24/26 at 12:19 p.m., the Director of Human Resources (HR) was interviewed. She stated that at the time of hire, new employees receive a list of required trainings through a third-party education provider. She explained that these trainings are online, and once the new employees have completed the training, she transfers the record of completion to another third-party education provider's software. She stated that she does not personally verify which trainings need to be completed by which employees, and that her role is only to receive notifications from the third party that trainings are due and then to notify the individual staff members of what they need to complete. She stated she does not keep up with specific subject matter trainings are required by regulations.A review of a document containing onboarding curriculum for all staff revealed, in part: All Community Team Members.Resident Rights.No additional information was provided prior to exit.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on staff interview and facility document review, the facility staff failed to provide required training for one of ten staff records reviewed, OSM (other staff member) #3, a speech and language pathologist.The findings include:The facility staff failed to provide evidence of required training in abuse, neglect, and exploitation for OSM #3.On 2/20/26, evidence of training in abuse, neglect, and exploitation was requested for OSM #3.A review of facility records provided by the Director of Human Resources (HR) failed to reveal evidence that the training in abuse, neglect, and exploitation for OSM #3 had been completed.On 2/23/26 at 5:02 p.m., the Administrator and Director of Nursing (DON) were informed of these concerns.On 2/24/26 at 12:19 p.m., the Director of Human Resources (HR) was interviewed. She stated that at the time of hire, new employees receive a list of required trainings through a third-party education provider. She explained that these trainings are online, and once the new employees have completed the training, she transfers the record of completion to another third-party education provider's software. She stated that she does not personally verify which trainings need to be completed by which employees, and that her role is only to receive notifications from the third party that trainings are due and then to notify the individual staff members of what they need to complete. She stated she does not keep up with specific subject matter trainings are required by regulations.A review of a document containing onboarding curriculum for all staff revealed, in part: Onboarding Required Training.Abuse and Neglect Prevention.No additional information was provided prior to exit.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on staff interview and facility document review, the facility staff failed to provide required training for one of ten staff records reviewed, OSM (other staff member) #3, a speech and language pathologist.The findings include:The facility staff failed to provide evidence of required training in infection control for OSM #3.On 2/20/26, evidence of training in infection control was requested for OSM #3.A review of facility records provided by the Director of Human Resources (HR) failed to reveal evidence that the training in infection control for OSM #3 had been completed.On 2/23/26 at 5:02 p.m., the Administrator and Director of Nursing (DON) were informed of these concerns.On 2/24/26 at 12:19 p.m., the Director of Human Resources (HR) was interviewed. She stated that at the time of hire, new employees receive a list of required trainings through a third-party education provider. She explained that these trainings are online, and once the new employees have completed the training, she transfers the record of completion to another third-party education provider's software. She stated that she does not personally verify which trainings need to be completed by which employees, and that her role is only to receive notifications from the third party that trainings are due and then to notify the individual staff members of what they need to complete. She stated she does not keep up with specific subject matter trainings are required by regulations.A review of a document containing onboarding curriculum for all staff revealed, in part: Online Required Training.Understanding Bloodborne Pathogens.A review of a document containing annual training assignments for 2026 for direct care staff revealed, in part: January.Infection Control: Essential Principles.No additional information was provided prior to exit.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on staff interview and facility document review, the facility staff failed to provide required training for one of ten staff records reviewed, OSM (other staff member) #3, a speech and language pathologist.The findings include:The facility staff failed to provide evidence of required training in compliance and ethics for OSM #3.On 2/20/26, evidence of training in compliance and ethics was requested for OSM #3.A review of facility records provided by the Director of Human Resources (HR) failed to reveal evidence that the training in compliance and ethics for OSM #3 had been completed.On 2/23/26 at 5:02 p.m., the Administrator and Director of Nursing (DON) were informed of these concerns.On 2/24/26 at 12:19 p.m., the Director of Human Resources (HR) was interviewed. She stated that at the time of hire, new employees receive a list of required trainings through a third-party education provider. She explained that these trainings are online, and once the new employees have completed the training, she transfers the record of completion to another third-party education provider's software. She stated that she does not personally verify which trainings need to be completed by which employees, and that her role is only to receive notifications from the third party that trainings are due and then to notify the individual staff members of what they need to complete. She stated she does not keep up with specific subject matter trainings are required by regulations.A review of a document containing onboarding curriculum for all staff revealed, in part: Online Required Training.Compliance and Code of Conduct.No additional information was provided prior to exit.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on staff interview and facility document review, the facility staff failed to provide required training for one of ten staff records reviewed, OSM (other staff member) #3, a speech and language pathologist.The findings include:The facility staff failed to provide evidence of required training in behavioral health for OSM #3.On 2/20/26, evidence of training in behavioral health was requested for OSM #3.A review of facility records provided by the Director of Human Resources (HR) failed to reveal evidence that the training in behavioral health for OSM #3 had been completed.On 2/23/26 at 5:02 p.m., the Administrator and Director of Nursing (DON) were informed of these concerns.On 2/24/26 at 12:19 p.m., the Director of Human Resources (HR) was interviewed. She stated that at the time of hire, new employees receive a list of required trainings through a third-party education provider. She explained that these trainings are online, and once the new employees have completed the training, she transfers the record of completion to another third-party education provider's software. She stated that she does not personally verify which trainings need to be completed by which employees, and that her role is only to receive notifications from the third party that trainings are due and then to notify the individual staff members of what they need to complete. She stated she does not keep up with specific subject matter trainings are required by regulations.A review of a document containing onboarding curriculum for all direct care staff revealed, in part: Online Required Training.Behavioral Expressions.No additional information was provided prior to exit.