STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide dignity for two of 25 residents in the survey sample, Residents #18 and #20. The findings include: 1. For Resident #18 (R18), the facility staff failed to answer the resident's call bell in a timely manner. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/11/25, R18 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 4/30/25 at 8:54 a.m., Resident #18's call bell was observed ringing. Staff did not answer the resident's call bell until 9:07 a.m. (13 minutes). During this observation, seven staff members were observed in R18's hall. On 4/30/25 at 11:24 a.m., an interview was conducted with R18. The resident stated call bell response times vary but she has waited an hour for someone to answer the call bell. On 5/1/25 at 9:36 a.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated call bells should be answered within two minutes. On 5/1/25 at 4:36 p.m., ASM (administrative staff member) #1 (the regional consultant) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Answering the Call Light documented, 1. Answer the resident call system as soon as possible . No further information was presented prior to exit. 2. For Resident #20 (R20), the facility staff failed to provide dignity and respect in the dining room. On 4/29/25 at 10:40 a.m., a sign was observed on a chalk board at the entrance of the Westham dining room. The sign documented, Any Residents After 11:45 Must Get Tray From Their Room Or Hallway! (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/24/25, R20 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 4/30/25 at 11:13 a.m., an interview was conducted with R20. R20 stated she did not like the sign at the entrance of the dining room but has to follow the rules. On 4/30/25 at 4:03 p.m., an interview was conducted with OSM (other staff member) #3 (the dietary manager). OSM #3 stated the dietary staff did not post the sign at the Westham dining room entrance and the chalk board belonged to the activities department. On 4/30/25 at 4:13 p.m., an interview was conducted with OSM #4 (the activities director). OSM #4 stated she was not sure who posted the sign at the Westham dining room entrance. On 5/1/25 at 4:36 p.m., ASM (administrative staff member) #1 (the regional consultant) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Dignity documented, 1. Residents are treated with dignity and respect at all times. No further information was presented prior to exit.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to notify the resident of a change in treatment for one of 25 residents in the survey sample, Resident #2 (R2). For R2, the facility staff failed to inform them in advance of the physician's order for the use of Percocet (1) and Xanax (2) and the risks, benefits and alternatives. The findings include: R2 was admitted to the facility with diagnoses that included but were not limited to cancer of the larynx (voice box) (3) and anxiety (4). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/06/2025, R2 scored a 14 out of 15 on the BIMS (brief interview for mental status), indicating R2 was cognitively intact for making daily decisions. The physician's order for R2 documented, Alprazolam (Xanax) Tablet 0.5 MG (milligrams) *Controlled Drug* Give 1 (one) tablet via (by) PEG-Tube (percutaneous endoscopic gastrostomy) (5) every 8 (eight) hours as needed for Anxiety for 14 Days. Order Date: 2/5/2025 and Oxycodone-Acetaminophen (Percocet)Tablet 10-325 MG *Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for Pain. Order Date: 2/5/2025. The eMAR (electronic medication administration record) for R2 dated February 2025 documented the physician order for Xanax and Percocet as stated above. Review of the eMAR revealed R2 received Xanax on 02/07/2025, 02/09/2025, 02/10/2025, 02/11/2025 and on 02/13/2025. Further review of the eMAR revealed R2 received Percocet on 02/09/2025, 02/12/2025 and on 02/13/2025. The comprehensive care plan for R2 dated 01/21/2025 documented in part Focus: I use anti-anxiety medication r/t (related to) Anxiety Disorder Date Initiated: 01/21/2025. Under Interventions it documented in part, Educate me/family/caregivers about the risks, benefits and side effects of medication being given. Date Initiated: 01/21/2025. On 04/30/2025 at approximately 10:33 a.m., an interview was conducted with ASM (administrative staff member) #6, regional clinical, regarding the notification to R2 about the use of Percocet and Xanax. ASM #6 stated there was no evidence R2 was informed of the physician's order for the administration of Percocet and Xanax. She further stated there was no evidence that R2 was informed of the risks, benefits and alternatives regarding the use of the medications. The facility's policy of Resident Rights documented in part, Policy statement. Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: p. be informed of and participate in his or her, care planning and treatment. On 05/01/2025 at approximately 4:05 p.m., ASM # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to the exit. Complaint deficiency References: (1) Is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html. (2) Used to treat anxiety disorders and panic disorders (sudden, unexpected attacks of extreme fear and worry about these attacks. Alprazolam is in a class of medications called benzodiazepines. It works by decreasing abnormal excitement in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684001.html. (3) Located in the neck and performs several important functions in the body. The larynx is involved in swallowing, breathing, and voice production. Sound is produced when the air which passes through the vocal cords causes them to vibrate and create sound waves in the pharynx, nose and mouth. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19708.htm. (4) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (5) The placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000900.htm.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, resident interview, staff interview and facility document review, it was determined that facility staff failed to respect a resident's personal possessions for one of 25 residents in the survey sample, Resident #17. For R17, the facility staff failed to assure all clothing was within their possession and accessible. The findings include: On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 04/14/2025, R17 scored 12 out of 15 on the BIMS (brief interview for mental status), indicating R17 was moderately impaired of cognition for making daily decisions. On 04/29/2025 at approximately 2:00 p.m. an observation of a room on the facility's Grove Unit revealed no resident names posted outside the door. Observations of the inside of the room revealed two dressers, one on the A-side and one on the B-side of the room. At approximately 2:10 p.m., an interview and observation of the room was conducted with LPN (licensed practical nurse) #3, unit manager. When asked if the room was vacant, she stated yes and that R17 was assigned to the room but never occupied it. An observation of the inside of the closet in the room revealed two men's undershirts/T-shirts hanging on the clothes rack. LPN #3 stated that the shirts belonged to a resident who was discharged from the facility. An observation of the top drawer of the dresser on the A-side of the room, revealed a pressure reducing boot. Observation of the boot failed to evidence a resident's name. LPN #3 stated the boot was trash. Observation of the dresser on the B-side revealed the following: top drawer revealed six pairs of pajama sleep pants, second drawer revealed sweatshirt and lined shirt-jacket (lined shirt), third drawer revealed 11- eight-ounce bottles of water, the bottom drawer revealed a clear plastic bag with the top of the bag tied closed. When asked about the contents of the bag LPN #X stated the bag contained linens but could not determine if the linens were clean or soiled. Regarding the clothing and water bottles found in the dresser, LPN #3 stated the clothing belongs to R17. When asked if R17 resided in the room she stated R17 currently resided in (Room Number) and had room been moved from (Previous Room Number). When asked about R17's clothing in the room she stated that all R17's clothing should have been relocated to each room R17 was moved to. On 04/30 2025 at approximately 2:20 p.m., an interview was conducted with R17. When asked about his clothing being in (Room Number of Vacant Resident Room) he stated he wanted his clothes. R17 further stated the clothes should be in (Current Room Number) and that someone must have taken his clothes. The facility's policy of Resident Rights documented in part, Policy statement. Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: c. be free from abuse, neglect, misappropriation of property and exploitation. On 05/01/2025 at approximately 4:05 p.m., ASM (administrative staff member) # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to the exit. Complaint deficiency

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, staff interview, and facility document review, the facility staff failed to provide privacy for two of 25 residents in the survey sample, Residents #19 and #20. The findings include: 1. For Resident #19 (R19), ASM (administrative staff member) #5 (the nurse practitioner) failed to assess the resident in a private setting. On 4/30/25 at 11:17 a.m., ASM #5 was observed listening to R19's chest, back, and abdomen with a stethoscope in the dining room while other residents were present in the room. On 4/30/25 at 4:41 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated she assesses residents in private settings and would not assess residents in the dining room unless there was an emergency. On 5/1/25 at 1:12 p.m., an interview was conducted with ASM #5. ASM #5 stated she typically assesses residents in their rooms but sometimes for timing purposes, she assesses residents in therapy, in the dining room, and at the nurses' station. On 5/1/25 at 4:36 p.m., ASM #1 (the regional consultant) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Dignity documented, 11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. No further information was presented prior to exit. 2. For Resident #20 (R20), ASM (administrative staff member) #5 (the nurse practitioner) failed to assess the resident in a private setting. On 4/30/25 at 11:15 a.m., ASM #5 was observed palpating the resident's neck and listening to the resident's chest and back with a stethoscope in the dining room while other residents were present in the room. On 4/30/25 at 4:41 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated she assesses residents in private settings and would not assess residents in the dining room unless there was an emergency. On 5/1/25 at 1:12 p.m., an interview was conducted with ASM #5. ASM #5 stated she typically assesses residents in their rooms but sometimes for timing purposes, she assesses residents in therapy, in the dining room, and at the nurses' station. On 5/1/25 at 4:36 p.m., ASM #1 (the regional consultant) and ASM #2 (the director of nursing) were made aware of the above concern. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was presented prior to exit.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 5. The facility staff failed to maintain a homelike environment for A) two of three nursing units and B) one of three common hallways. A) On 4/29/25 at 10:48 a.m., an observation of the Westham nursing station area and the three hallways of the Westham unit revealed a strong urine odor present. Housekeeping staff were observed on the unit cleaning resident rooms. On 4/29/25 at 11:12 a.m., an observation of the Grove unit revealed a strong urine odor immediately upon exiting the elevator in the common resident area, nurses station area and three hallways on the unit. Housekeeping staff were observed mopping the floors at that time. Additional observations of the Westham unit and Grove unit were made on 4/29/25 at approximately 3:39 p. m., 4/30/25 at approximately 8:19 a.m., 4/30/25 at approximately 2:12 p.m. and 5/1/25 at approximately 8:22 a.m. The observations all revealed housekeeping staff on the unit cleaning, however the urine odors remained. B) On 4/29/25 at 10:30 a.m., upon entrance to the facility a strong urine odor was noted in the hallway from the Westham dining room to the Westham nurse's station. Additional observations of the common hallway from the Westham dining room to the Westham nurses' station were made on 4/29/25 at approximately 3:37 p.m., 4/30/25 at approximately 8:16 a.m., 4/30/25 at approximately 2:10 p.m. and 5/1/25 at approximately 8:20 a.m. The observations all revealed housekeeping staff on the unit cleaning, however the strong urine odors remained. On 5/1/25 at 9:47 a.m., an interview was conducted with OSM (other staff member) #1, the director of housekeeping. OSM #1 stated that her staff cleaned the common areas first including the lobby, guest bathrooms, hallways, therapy department and then the offices. She stated that she tried to staff each unit with two housekeepers and had two housekeepers staffed to clean discharged rooms. OSM #1 stated that they cleaned the nurses' stations, soiled utility rooms and resident rooms daily and each housekeeper deep-cleaned one room daily. She stated that they used an odor laminator in water for mopping the floors and a cdiff tablet that was dissolved in water to clean surfaces. She stated that she was aware that sometimes there was an odor on the Westham unit in the mornings which came from the residents being changed and on the Grove unit it was a problem due to the dementia residents. She stated that they cleaned the walls, rooms and touch areas and it was hard to control the odors when they came from the residents needing to be changed. On 5/1/25 at approximately 9:55 a.m., observations were made of the hallway from the Westham dining room to the Westham nurses' station where OSM #1 noted the urine odor was present. At approximately 9:58 a.m., OSM #1 observed the Westham unit and noted the urine odor was present. She stated that they had a hard time on that unit due to a lack of ventilation and was not sure what could be done. When asked if the urine odor was homelike, she stated that it was not. At approximately 10:05 a.m., OSM #1 observed the Grove unit and noted the urine odor was present. She stated that they wiped down the walls, high and low touch surfaces and tried to wipe down everything that would help with the odors. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Homelike Environment documented in part, .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: .f. pleasant, neutral scents . The facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include: . b. institutional odors . On 5/1/25 at 4:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #6, the regional clinical nurse were made aware of the findings. No further information was provided prior to exit. 4. For Resident #13 (R13), the facility staff failed to change a bloody pillowcase on 4/29/25 and 4/30/25. A review of R13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/4/25, R13 was coded as being totally dependent on facility staff for turning and positioning. He was admitted with a diagnosis of paraplegia. He was coded as being cognitively intact for making daily decisions. On the following dates and times, R13 was observed sitting up in bed. At each observation, R13's right foot was propped on a pillow which had a moderate amount of blood on the pillowcase. The blood was in contact with R13's left leg: 4/9/25 at 1:43 p.m. and 4:55 p.m.; 4/30/25 at 7:50 a.m. and 10:15 a.m. On 4/30/25 at 10:17 a.m., R13 was interviewed. He stated no staff member offered to change the pillowcase all night the previous night. On 5/1/25 at 9:20 a.m., LPN (licensed practical nurse) #1 was interviewed. He stated a resident should not have to have a bloody pillowcase in contact with any part of his body. He stated this was not a clean or homelike environment for the resident. On 5/1/25 at 12:52 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated a resident should not have to have a bloody pillowcase in contact with any part of his body. She stated this was not a clean or homelike environment for the resident. She stated if she had provided evening care for R13 on 4/29/25, she would have removed all of the sheets and blankets covering him to give him a bed bath. She would have noticed the soiled pillowcase and changed it. On 5/1/25 at 4:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #6, the regional clinician, were informed of these concerns. No additional information was provided prior to exit. Based on observations, resident interview and staff interview, it was determined that facility staff failed to maintain a clean, homelike environment for four of 25 residents in the survey sample, Residents #24 (R24), R25, R11, R13, on two of three nursing units and in one of three common hallways. The findings include: 1. For R24, facility staff failed to maintain the privacy curtain in a clean manner. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At the time of the survey, R24's admission MDS (minimum data set), was not due. The facility's admission assessment for R24 dated 04/28/2025 documented R24 was orientated to person and place. On 4/29/25 at approximately 11:06 am an observation R24's room revealed a portion of the A-side privacy curtain was hanging off track and resident touching floor. On 4/30/25 at approximately 8:40 a.m. an observation R24's bed privacy curtain was partially hanging off tracks, resting on the floor. Further observations revealed a CNA (certified nursing assistant) entering R24's room to deliver meal trays and an LPN (licensed practical nurse) entered R24's room to give medications. On 05/01/2025 at approximately 9:35 a.m., an interview and observations of resident rooms was conducted with OSM (other staff member) #1, director of environmental services. When asked to describe the procedure for cleaning and maintaining resident's privacy curtains she stated that all the resident's privacy curtains throughout the facility are taken down, washed or replaced. She further she checks resident's rooms throughout the day and while housekeeping cleans the resident's rooms they check the privacy curtains. She also stated nursing will notify her if they find a privacy curtain in need of repair or need to be cleaned. At 9:55 a.m. OSM #1 observed the privacy curtain in R24's room with two surveyors. The observation revealed the privacy curtain as described above on 04/29/25 at 11:06 a.m. and on 04/30/2025 8:40 a.m. OSM #1 stated she was notified this morning of the condition of the privacy curtain. When informed that the condition of the curtain as described above was observed since 04/29/2025, OSM #1 did not have a response. The facility's policy Homelike Environment documented in part, 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment; f. pleasant, neutral scents; 3. The facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include: b. institutional odors. On 05/01/2025 at approximately 4:05 p.m., ASM (administrative staff member) # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. No further information was provided prior to the exit. 2. For R25, facility staff failed to maintain the privacy curtain in a clean manner. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/09/2025, R25 scored three out of 15 on the BIMS (brief interview for mental status), indicating R1 was severely impaired of cognition for making daily decisions. On 4/29/25 at approximately 11:11 a.m. an observation of the privacy curtain in R25's room between the A-side and B-side of the room revealed two small brownish colored stains in center of the curtain measuring approximately two and four inches. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/25 at approximately 9:30 p.m. an observation of the privacy curtain in R25's room between the A-side and B-side of the room revealed two small brownish colored stains in center of the curtain measuring approximately two and four inches. On 05/01/2025 at approximately 9:35 a.m., an interview and observations of resident rooms was conducted with OSM (other staff member) #1, director of environmental services. When asked to describe the procedure for cleaning and maintaining resident's privacy curtains she stated that all the resident's privacy curtains throughout the facility are taken down, washed or replaced. She further she checks resident's rooms throughout the day and while housekeeping cleans the resident's rooms they check the privacy curtains. She also stated nursing will notify her if they find a privacy curtain in need of repair or need to be cleaned. At 10:00 a.m., OSM #1 observed the privacy curtain in R25's room with two surveyors. The observation revealed the privacy curtain as described above on 04/29/25 at 11:11 a.m. and on 04/30/2025 at 9:30 a.m. OSM #1 stated the curtains were not clean and had them removed. On 05/01/2025 at approximately 4:05 p.m., ASM # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. No further information was provided prior to the exit. 3. For R11, facility staff failed to maintain the privacy curtain in a clean manner. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/07/2025, R11 scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating R11 was severely impaired of cognition for making daily decisions. On 04/29/2025 at approximately 8:20 a.m., an observation of R11's privacy curtain between the A-side and B-side of the room revealed brown debris at approximately the middle of the curtain on approximately the bottom third of it. On 04/29/2025 at approximately 1:50 p.m., an observation of R11's privacy curtain between the A-side and B-side of the room revealed brown debris at approximately the middle of the curtain on approximately the bottom third of it. On 04/30/2025 at 7:50 a.m. an observation of R11's privacy curtain between the A-side and B-side of the room revealed brown debris at approximately the middle of the curtain on approximately the bottom third of it. On 04/30/2025 at 11:06 a.m. an observation of R11's privacy curtain between the A-side and B-side of the room revealed brown debris at approximately the middle of the curtain on approximately the bottom third of it. (continued on next page)

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Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/01/2025 at approximately 9:35 a.m., an interview and observations of resident rooms was conducted with OSM (other staff member) #1, director of environmental services. When asked to describe the procedure for cleaning and maintaining resident's privacy curtains she stated that all the resident's privacy curtains throughout the facility are taken down, washed or replaced. She further she checks resident's rooms throughout the day and while housekeeping cleans the resident's rooms they check the privacy curtains. She also stated nursing will notify her if they find a privacy curtain in need of repair or need to be cleaned. At 10:05 a.m., OSM #1 observed the privacy curtain in R11's room with two surveyors. The observation revealed the privacy curtain as described above on 04/29/25 at 8:20 a.m. and at 1:50 p.m. and on 04/30/2025 7:50 a.m. and at 11:06 a.m. OSM #1 stated the curtains were not clean and had them removed. On 05/01/2025 at approximately 4:05 p.m., ASM # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. No further information was provided prior to the 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to assure a resident was free of a chemical restraint for one of 25 residents in the survey sample, Resident #2 (R2). For R2, the facility staff failed to evidence attempts of alternate interventions prior to the administration of Xanax (1). The findings include: R2 was admitted to the facility with diagnoses that included but were not limited to anxiety (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/06/2025, R2 scored a 14 out of 15 on the BIMS (brief interview for mental status), indicating R2 was cognitively intact for making daily decisions. The physician's order for R2 documented, Alprazolam (Xanax) Tablet 0.5 MG (milligrams) *Controlled Drug* Give 1 (one) tablet via (by) PEG-Tube (percutaneous endoscopic gastrostomy) (5) every 8 (eight) hours as needed for Anxiety for 14 Days. Order Date: 2/5/2025 The eMAR (electronic medication administration record) for R2 dated February 2025 documented the physician order for Xanax as stated above. Further review of the eMAR revealed R2 received Xanax on 02/07/2025, 02/09/2025, 02/10/2025, 02/11/2025 and on 02/13/2025. On 04/30/2025 at approximately 10:33 a.m., an interview was conducted with ASM (administrative staff member) #6, regional clinical, regarding alternate interventions prior to the administration of Xanax. ASM #6 stated there was no evidence of attempts at alternate interventions prior to the administration of Xanax. On 05/01/2025 at approximately 4:05 p.m., ASM # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. No further information was provided prior to the exit. Complaint deficiency References: (1) Used to treat anxiety disorders and panic disorders (sudden, unexpected attacks of extreme fear and worry about these attacks. Alprazolam is in a class of medications called benzodiazepines. It works by decreasing abnormal excitement in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684001.html. (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

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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 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** 3. For Resident #12 (R12), the facility staff failed to implement the abuse policy for reporting an injury of unknown origin (IUO) in a timely manner. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/22/25, the resident was assessed as being severely impaired for making daily decisions. The progress notes for R12 documented in part, - 04/18/2025 14:46 (2:46 p.m.) Note Text: Resident has been in the dining room all morning outside of therapy. She was found with a large bruise on her left hand in the dining room by activities. Resident does not have any pain or discomfort. MD (medical doctor) notified. RP (responsible party) was called and a message was left. - 04/18/2025 08:51 (8:51 a.m.) Nurse Practitioner Note: LATE ENTRY Note Text : X-ray ordered to rule out acute pathology. - 04/18/2025 08:48 (8:48 a.m.) Nurse Practitioner Note: LATE ENTRY .Hematoma noted to left hand Patient had ben [sic] in dining room in wheelchair, possibly hit against table . A skin assessment for R12 dated 4/18/25 documented a new large bruise on the back of the left hand on the pinky knuckle. Review of the facility synopsis of events documented a report for an injury of unknown origin reported to the state agency on 4/21/25. It documented in part, .Brusie [sic] of unknown origin noted to back of left hand being investigated by facility . Review of the investigation folder documented an incident report which documented an unwitnessed bruise to the left hand observed on 4/18/25 at 2:45 p.m. It documented the resident unable to give a statement due to dementia. On 4/30/25 at 4:28 p.m., an interview was conducted with LPN (licensed practical nurse) #3 who stated that the nurse had called her when the bruise was first observed on 4/18/25 and she thought that the staff knew what had happened by what they told her. She stated that once they investigated the bruise further, they found out that no one had witnessed any incident happen and everything was just speculation, so they had reported the bruise as an injury of unknown origin at that time. LPN #3 stated that staff had told her that R12 had gotten her hand stuck in between the tables in the dining room and when she found out that no one saw anything happen she had gotten the order for the x-ray and investigated further. She stated that she had reported the bruise to the administrator and the director of nursing on 4/18/25 when it was first reported to her. LPN #3 stated when there was an injury of unknown origin, they had two hours to report it, and it was important for them to follow their policy. She stated that all staff were mandated reporters, and they had to report the injury and investigate it to rule out abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/25 at 9:36 a.m., an interview was conducted with LPN #1 who stated that another staff member reported the bruise on R12's hand to him. He stated that no one had witnessed anything happen to cause the bruise and he had documented the note in the medical record and contacted the physician, responsible party and LPN #3, unit manager. LPN #1 stated that R12 was not complaining of any pain, and he had given her medication that morning and had not seen any bruising at that time. He stated that there was a large purple bruise on the side of the pinky finger and she was able to move it fully with no complaints of pain. LPN #1 stated that after he had reported the bruise to LPN #3 that she and the director of nursing had come to the floor and asked him about the bruise. He stated that he told them both that the bruise was unwitnessed and that a staff member had reported it while R12 was in the dining room, and he did not know what had happened. He stated that he told LPN #3 possible causes but that he did not know for sure. On 5/1/25 at 4:10 p.m., an interview was conducted with ASM (administrative staff member) #1, acting administrator. ASM #1 stated that when there was an injury of unknown origin it was reported. He stated that if they were not sure how an injury occurred, they went ahead and reported it if they felt the injury was unknown origin. He stated that the proper way was to report the injury of unknown origin and investigate it. On 5/2/25 at 9:23 a.m., ASM #1, acting administrator, ASM #2, director of nursing and ASM #6, regional clinical nurse were made aware of the findings. No further information was provided prior to exit. 4. For Resident #6 (R6), the facility staff failed to implement a policy to report an injury of unknown origin (IUO) discovered 12/31/24 to the state agency in a timely manner. A review of R6's clinical record revealed the following progress note dated 12/31/24: Received to [room number] from [name of unit]. Resident responds to questions. Disoriented to place and time .Large discolored bruised area LUE (left upper extremity). Resident has no recall of injury or trauma. Call light in reach. A review of a facility synopsis of events dated 1/5/25 revealed, in part: Report date: 1/5/25, Incident date: 1/4/25 .Injuries: Yes .bruising to the left breast and arm .Investigation launched. A review of the facility's investigation of this IUO revealed the following employee statement dated 12-31-24: What happened? I just moved her from upstairs to downstairs .She didn't hit herself or nothing (sic) .She was in bed: Didn't touch me at all, just moved the bed. On 5/1/25 at 9:20 a.m., LPN (licensed practical nurse) #1 was interviewed. He stated if any IUO is discovered on a resident, it should be immediately reported to the unit manager, then to the director of nursing (DON) or administrator immediately. If the origin of the bruise/IUO cannot be immediately identified, it should be reported to management and an investigation should be started. On 5/1/25 at 3:02 p.m., ASM (administrative staff member) #7, the regional clinician, was interviewed. She stated if an IUO is discovered, the staff member should call the nursing supervisor, and the administrator should be notified immediately. She explained that the administrator should submit a report to the state agency and initiate an investigation. She stated this should happen within two hours of discovery of the IUO. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/25 at 4:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #6, the regional clinician, were informed of these concerns. No additional information was provided prior to exit. Based on staff interview, clinical record review, facility document review, it was determined that the facility staff failed implement their abuse policy for four of 25 residents in the survey sample, Resident #2 (R2), R11, R12 and R6. The findings include: 1. For R2, facility staff failed to implement their policy regarding an allegation of neglect. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/06/2025, R2 scored a 14 out of 15 on the BIMS (brief interview for mental status), indicating R2 was cognitively intact for making daily decisions. The facility's incident report for R2 documented, Incident Date: 02/18/2025. Incident type: Allegation of neglect. Describe the incident, including location and action taken: facility received a report of neglect on (Name of R2). Review of the facility's fax confirmation sheets and incident file failed to evidence documentation of the facility's final investigative report was sent to state agency. On 05/01/2025 at approximately 10:30 a.m., an interview was conducted with LPN (licensed practical nurse) #3, unit manager. When asked to describe the procedure for submitting the final investigative report to the state agency she stated it should be submitted withing five days of the incident. After reviewing the incident file for R2 with an incident date of 02/18/2025 she stated there was evidence of the final investigative report being sent to the state agency. On 05/01/2025 at approximately 3:00 p.m., an interview was conducted with ASM 9administrative staff member) # 6, regional clinical. When asked to describe the procedure for submitting the final investigative report to the state agency she stated it should be submitted withing five days of the incident. On 05/01/2025 at approximately 4:00 p.m., ASM #1, administrator, stated there was no evidence the final investigative report for R2 with an incident date of 02/18/2025 was sent to the state agency. On 05/01/2025 at approximately 4:05 p.m., ASM # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. No further information was provided prior to the exit. 2. For R11, facility staff failed to implement their policy regarding an injury of unknown origin. R11 was admitted to the facility with diagnoses that included but not limited to Alzheimer's disease (1). (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/07/2025, R11 scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating R11 was severely impaired of cognition for making daily decisions. The facility's incident report for R11 documented, Incident Date: 04/02/2025. Incident type: Other. Describe the incident, including location and action taken: Bruise of unknown origin. The facility's Health Status Note for R11 dated 03/30/2025 documented in part, Note Text: CNA (certified nursing assistant) alerted writer that the resident had a bruise on her upper left side of her forehead. The bruise seems to be old as it had a yellow ring around it signifying healing has begun. Asked the other staff about any potential falls or injuries there was no confirmation in the system or in the 24-hour report book . The facility's fax confirmation sheet dated 04/03/2025 for R11 documented in part, Date, Time: 04/03, 04:47 (4:47 p.m.). Fax No. (number), / Name: (Fax Number of State Agency). The facility's fax confirmation sheet dated 04/08/2025 for R11 documented in part, Name: (Fax Number of State Agency). Date and Time: Tuesday, April 08, 2025 at 11:34 AM (a.m.). Result: Sent. Further review of the fax confirmation sheet failed to evidence the document(s) faxed to the state agency. On 05/01/2025 at approximately 10:30 a.m., an interview was conducted with LPN (licensed practical nurse) #3, unit manager. When asked to describe the procedure for reporting an injury of unknown origin she stated it should be report withing two hours of the findings. After reviewing the health status note and the fax confirmation sheet for R11 dated 04/03/32025 she stated the incident was not reported withing two hours. The facility's policy abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating documented in part, Reporting Allegations to the Administrator and Authorities. 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury. Follow-Up Report. 1. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report. On 05/01/2025 at approximately 4:05 p.m., ASM (administrative staff member) # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. No further information was provided prior to the exit. References: (1) A brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. For Resident #12 (R12), the facility staff failed to report an injury of unknown origin (IUO) in a timely manner. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/22/25, the resident was assessed as being severely impaired for making daily decisions. The progress notes for R12 documented in part, - 04/18/2025 14:46 (2:46 p.m.) Note Text: Resident has been in the dining room all morning outside of therapy. She was found with a large bruise on her left hand in the dining room by activities. Resident does not have any pain or discomfort. MD (medical doctor) notified. RP (responsible party) was called and a message was left. - 04/18/2025 08:51 (8:51 a.m.) Nurse Practitioner Note: LATE ENTRY Note Text : X-ray ordered to rule out acute pathology. - 04/18/2025 08:48 (8:48 a.m.) Nurse Practitioner Note: LATE ENTRY .Hematoma noted to left hand Patient had ben [sic] in dining room in wheelchair, possibly hit against table . A skin assessment for R12 dated 4/18/25 documented a new large bruise on the back of the left hand on the pinky knuckle. Review of the facility synopsis of events documented a report for an injury of unknown origin reported to the state agency on 4/21/25. It documented in part, .Brusie [sic] of unknown origin noted to back of left hand being investigated by facility . Review of the investigation folder documented an incident report which documented an unwitnessed bruise to the left hand observed on 4/18/25 at 2:45 p.m. It documented the resident unable to give a statement due to dementia. On 4/30/25 at 4:28 p.m., an interview was conducted with LPN (licensed practical nurse) #3 who stated that the nurse had called her when the bruise was first observed on 4/18/25 and she thought that the staff knew what had happened by what they told her. She stated that once they investigated the bruise further, they found out that no one had witnessed any incident happen and everything was just speculation, so they had reported the bruise as an injury of unknown origin at that time. LPN #3 stated that staff had told her that R12 had gotten her hand stuck in between the tables in the dining room and when she found out that no one saw anything happen she had gotten the order for the x-ray and investigated further. She stated that she had reported the bruise to the administrator and the director of nursing on 4/18/25 when it was first reported to her. LPN #3 stated when there was an injury of unknown origin, they had two hours to report it, and it was important for them to follow their policy. She stated that all staff were mandated reporters, and they had to report the injury and investigate it to rule out abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/25 at 9:36 a.m., an interview was conducted with LPN #1 who stated that another staff member reported the bruise on R12's hand to him. He stated that no one had witnessed anything happen to cause the bruise and he had documented the note in the medical record and contacted the physician, responsible party and LPN #3, unit manager. LPN #1 stated that R12 was not complaining of any pain, and he had given her medication that morning and had not seen any bruising at that time. He stated that there was a large purple bruise on the side of the pinky finger and she was able to move it fully with no complaints of pain. LPN #1 stated that after he had reported the bruise to LPN #3 that she and the director of nursing had come to the floor and asked him about the bruise. He stated that he told them both that the bruise was unwitnessed and that a staff member had reported it while R12 was in the dining room, and he did not know what had happened. He stated that he told LPN #3 possible causes but that he did not know for sure. On 5/1/25 at 4:10 p.m., an interview was conducted with ASM (administrative staff member) #1, acting administrator. ASM #1 stated that when there was an injury of unknown origin it was reported. He stated that if they were not sure how an injury occurred, they went ahead and reported it if they felt the injury, was unknown origin. He stated that the proper way was to report the injury of unknown origin and investigate it. On 5/2/25 at 9:23 a.m., ASM #1, acting administrator, ASM #2, director of nursing and ASM #6, regional clinical nurse were made aware of the findings. No further information was provided prior to exit. 4. For Resident #6 (R6), the facility staff failed to report an injury of unknown origin (IUO) discovered 12/31/24 to the state agency in a timely manner. A review of R6's clinical record revealed the following progress note dated 12/31/24: Received to [room number] from [name of unit]. Resident responds to questions. Disoriented to place and time .Large discolored bruised area LUE (left upper extremity). Resident has no recall of injury or trauma. Call light in reach. A review of a facility synopsis of events dated 1/5/25 revealed, in part: Report date: 1/5/25, Incident date: 1/4/25 .Injuries: Yes .bruising to the left breast and arm .Investigation launched. A review of the facility's investigation of this IUO revealed the following employee statement dated 12-31-24: What happened? I just moved her from upstairs to downstairs .She didn't hit herself or nothing (sic) .She was in bed: Didn't touch me at all, just moved the bed. On 5/1/25 at 9:20 a.m., LPN (licensed practical nurse) #1 was interviewed. He stated if any IUO is discovered on a resident, it should be immediately reported to the unit manager, then to the director of nursing (DON) or administrator immediately. If the origin of the bruise/IUO cannot be immediately identified, it should be reported to management and an investigation should be started. On 5/1/25 at 3:02 p.m., ASM (administrative staff member) #7, the regional clinician, was interviewed. She stated if an IUO is discovered, the staff member should call the nursing supervisor, and the administrator should be notified immediately. She explained that the administrator should submit a report to the state agency and initiate an investigation. She stated this should happen within two hours of discovery of the IUO. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/25 at 4:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #6, the regional clinician, were informed of these concerns. No additional information was provided prior to exit. Based on staff interview, clinical record review, facility document review, it was determined that the facility staff failed to report an allegation of abuse and an injury of unknown origin to the state agency for three of 25 residents in the survey sample, Resident #11 (R11), R12 and R6. The findings include: 1. For R11, facility staff failed to report an injury of unknown origin in a timely manner. R11 was admitted to the facility with diagnoses that included but not limited to Alzheimer's disease (1). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/07/2025, R11 scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating R11 was severely impaired of cognition for making daily decisions. The facility's incident report for R11 documented, Incident Date: 04/02/2025. Incident type: Other. Describe the incident, including location and action taken: Bruise of unknown origin. The facility's Health Status Note for R11 dated 03/30/2025 documented in part, Note Text: CNA (certified nursing assistant) alerted writer that the resident had a bruise on her upper left side of her forehead. The bruise seems to be old as it had a yellow ring around it signifying healing has begun. Asked the other staff about any potential falls or injuries there was no confirmation in the system or in the 24-hour report book . The facility's fax confirmation sheet for R11 documented in part, Date, Time: 04/03. 04:47 (4:47 p.m.). Fax No. (number), / Name: (Fax Number of State Agency). On 05/01/2025 at approximately 10:30 a.m., an interview was conducted with LPN (licensed practical nurse) #3, unit manager. When asked to describe the procedure for reporting an injury of unknown origin she stated it should be report withing two hours of the findings. After reviewing the health status note and the fax confirmation sheet for R11 dated 04/03/32025 she stated the incident was not reported within two hours. The facility's policy abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating documented in part, Reporting Allegations to the Administrator and Authorities. 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury. On 05/01/2025 at approximately 4:05 p.m., ASM (administrative staff member) # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to the exit. References: (1) A brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on staff interview, clinical record review, facility document review, it was determined that the facility staff failed to submit the follow-up report of an investigation for two of 25 residents in the survey sample, Resident #2 (R2) and R11. The findings include: 1. For R2, facility staff failed to submit a follow-up report to the state agency regarding an allegation of neglect. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/06/2025, R2 scored a 14 out of 15 on the BIMS (brief interview for mental status), indicating R2 was cognitively intact for making daily decisions. The facility's incident report for R2 documented, Incident Date: 02/18/2025. Incident type: Allegation of neglect. Describe the incident, including location and action taken: facility received a report of neglect on (Name of R2). Review of the facility's fax confirmation sheets and incident file failed to evidence documentation of the facility's final investigative report was sent to state agency. On 05/01/2025 at approximately 10:30 a.m., an interview was conducted with LPN (licensed practical nurse) #3, unit manager. When asked to describe the procedure for submitting the final investigative report to the state agency she stated it should be submitted withing five days of the incident. After reviewing the incident file for R2 with an incident date of 02/18/2025 she stated there was evidence of the final investigative report being sent to the state agency. On 05/01/2025 at approximately 3:00 p.m., an interview was conducted with ASM 9administrative staff member) # 6, regional clinical. When asked to describe the procedure for submitting the final investigative report to the state agency she stated it should be submitted withing five days of the incident. On 05/01/2025 at approximately 4:00 p.m., ASM #1, administrator, stated there was no evidence the final investigative report for R2 with an incident date of 02/18/2025 was sent to the state agency. The facility's policy abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating documented in part, Follow-Up report. 1. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report. On 05/01/2025 at approximately 4:05 p.m., ASM # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. No further information was provided prior to exit. 2. For R11, facility staff failed to submit a follow-up report to the state agency regarding an allegation of unknown origin within five business days. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11 was admitted to the facility with diagnoses that included but not limited to Alzheimer's disease (1). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/07/2025, R11 scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating R11 was severely impaired of cognition for making daily decisions. The facility's incident report for R11 documented, Incident Date: 04/02/2025. Incident type: Other. Describe the incident, including location and action taken: Bruise of unknown origin. The facility's Health Status Note for R11 dated 03/30/2025 documented in part, Note Text: CNA (certified nursing assistant) alerted writer that the resident had a bruise on her upper left side of her forehead. The bruise seems to be old as it had a yellow ring around it signifying healing has begun. Asked the other staff about any potential falls or injuries there was no confirmation in the system or in the 24-hour report book . The facility's fax confirmation sheet dated 04/03/2025 for R11 documented in part, Date, Time: 04/03, 04:47 (4:47 p.m.). Fax No. (number), / Name: (Fax Number of State Agency). The facility's fax confirmation sheet dated 04/08/2025 for R11 documented in part, Name: (Fax Number of State Agency). Date and Time: Tuesday, April 08, 2025 at 11:34 AM (a.m.). Result: Sent. Further review of the fax confirmation sheet failed to evidence the document(s) faxed to the state agency. On 05/01/2025 at approximately 10:30 a.m., an interview was conducted with LPN (licensed practical nurse) #3, unit manager. When asked to describe the procedure for reporting an injury of unknown origin she stated it should be report withing two hours of the findings. After reviewing the health status note and the fax confirmation sheet for R11 dated 04/03/32025 she stated the follow-up investigation was sent to the state agency withing five business days. On 05/01/2025 at approximately 4:05 p.m., ASM (administrative staff member) # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. No further information was provided prior to the 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. 2. For Resident #22 (R22), the facility staff failed to implement the comprehensive care plan to provide treatment as recommended by the wound nurse practitioner for A) the right heel and B) the right anterior lower leg pressure injury (1). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/20/25, the resident was assessed as severely impaired for making daily decisions. R22 was assessed as being non-verbal, totally dependent for personal hygiene, bed mobility, toileting and bathing. It further documented R22 always incontinent of bowel and bladder and at risk for pressure injuries but not having any unhealed pressure injuries at the time of the assessment. The comprehensive care plan for R22 documented in part, The resident has a pressure ulcer or has the potential for pressure ulcer development r/t immobility, diabetes. Right anterior Lower Leg Pressure. Date Initiated: 03/18/2024. Under Interventions/Tasks it documented in part, Administer treatments as ordered and monitor for effectiveness. Date Initiated: 03/18/2024 . A) Review of the skin and wound progress note for R22 dated 3/24/2025 by the wound nurse practitioner documented a comprehensive skin assessment completed. It documented in part, . On assessment today right heel noted to be boggy with blanchable redness, recommend skin prep and continue heel booties . Review of the physician orders failed to evidence an order for skin prep to the right heel. Review of the eTAR (electronic treatment administration record) for R22 dated 3/1/25-3/31/25 failed to evidence an order for skin prep to the right heel. Review of the eTAR for R22 dated 4/1/25-4/30/25 failed to evidence an order for skin prep to the right heel. On 5/1/25 at 9:07 a.m., an observation was made of LPN (licensed practical nurse) #4 performing wound care to R22's right anterior lower leg pressure injury. At that time an observation was made of R22's right heel. Observation revealed the skin intact, boggy with blanchable redness. When asked if there were any treatments in place for R22's right heel, LPN #4 stated that he was not aware of any treatment in place. B) Review of the nurse practitioners wound assessment report for R22 dated 3/24/2025 documented a full thickness in house acquired wound to the right anterior lower leg. The description of the wound was 100% eschar with attached wound edges, periwound: intact, dryness, fragile with scant serosanguineous exudate. The treatment recommendations documented were to clean with wound cleanser, treat with calcium alginate, apply bordered gauze daily and as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurse practitioners wound assessment report for R22 dated 4/1/25 documented two wounds, a right lower leg skin tear and a right anterior lower leg pressure injury. The right anterior lower leg wound was documented as an unstageable pressure injury acquired on 3/24/25 that was improving without complications with 20% granulation, 80% slough and 0% eschar. The treatment recommendations were to cleanse with wound cleanser, apply silver alginate, cover with bordered gauze daily and as needed. The nurse practitioners wound assessment report for R22 dated 4/8/25 documented two wounds, a right lower leg skin tear and a right anterior lower leg pressure injury. The right anterior lower leg wound was described as an unstageable pressure injury acquired on 3/24/25 that was improving without complications with 40% granulation, 60% slough and 0% eschar. The treatment recommendations were to cleanse with wound cleanser, apply Manuka HD alginate, cover with bordered gauze daily and as needed. Review of the eTAR for R22 dated 3/1/25-3/31/25 failed to evidence a treatment to the right anterior lower leg. Review of the eTAR for R22 dated 4/1/25-4/30/25 documented treatment to the right lower leg skin tear with xeroform and dry dressing completed from 4/2/25-4/9/25, right anterior lower leg pressure injury treatment of Manuka Alginate and dry dressing from 4/11/25-4/22/25 and calcium alginate and dry dressing from 4/23/25-4/29/25. The eTAR failed to evidence the treatment recommended by the wound nurse practitioner until 4/11/25 for the pressure injury. The physician orders for R22 documented in part, - Cleanse skin tear to the right lower leg with wound wash apply xeroform and a dry dressing change daily one time a day for wound care. Start Date: 4/2/2025. - Right Anterior Lower Leg: Cleanse with wound cleanser apply Manuka Alginate and cover with dressing Q (every) day one time a day for wound care. Start Date: 4/11/2025. - Right Anterior Lower Leg: Cleanse with wound cleanser apply Calcium Alginate and cover with dressing Q day one time a day for wound care. Start Date: 4/23/2025. The physician orders failed to evidence a treatment to the right anterior lower leg pressure injury prior to 4/11/2025 other than the skin tear treatment starting 4/2/25. On 4/30/35 at 12:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the acting wound nurse. He stated that if a resident had an established wound that was already being followed by the wound NP (nurse practitioner), the facility's wound nurse accompanied them on them on weekly rounds to assess each resident with a wound. He stated that usually the wound NP gave a verbal order for any new orders needed after the wound NP assessment. LPN #4 stated it was the wound nurse's responsibility to get approval for the new order from the resident's PCP (primary care physician) and then put the order into the computer system. He stated as a backup, the wound NP sent a summary of all visits and new orders after each visit to the facility and the summary was usually reviewed by the DON (director of nursing). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/25 at 1:16 p.m., an interview was conducted with ASM (administrative staff member) # 4, a wound NP. ASM #4 stated that they assessed each resident at least once a week and communicated treatment changes to the facility's wound nurse. She stated the wound NP also completes a report at the end of each visit to the facility listing all residents/wounds assessed, and including all treatment orders and that this report was sent to the facility's DON. She stated that as far as she knew, the facility nurse communicates the wound NP's recommendation to the resident's PCP and gets approval before implementation. She stated she believes that if a PCP declined a recommendation, the facility staff would communicate this with the wound NP. She stated nothing like this had ever been communicated to her or to any of the NPs employed by her company. She stated the wound NPs did not directly input orders into the facility's EMR (electronic medical record). On 4/30/25 at 1:34 p.m. an interview was conducted with ASM # 3, the regional mobile director of nursing, and ASM #7, the regional clinician. ASM #3 stated the wound NP was always accompanied by a member of the facility's wound team on their weekly rounds. Once the wound NP had completed rounds, they usually talked with the DON and always sent a written report containing a list of residents seen that day and all wound treatments. She stated the facility's wound nurse who had accompanied the wound NP was responsible for reaching out to the PCP to get approval for the wound NP's recommendations. Once the approval was obtained, the facility's wound nurse was responsible for entering the order accurately into the EMR. On 5/1/25 at 10:28 a.m., an interview was conducted with LPN #8 who stated that the purpose of the care plan was to tell them about the resident and sum up what was going on with them. She stated that they should all follow the care plan and implement it to show what they were doing to care for the resident. On 5/1/25 at 4:10 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #6, the regional clinician, were made aware of the concern. No further information was provided prior to exit. Reference: (1) Pressure sores appear as ulcers (open wounds) or crater-like areas on your skin. They can happen when a part of your body experiences a long period of excessive pressure that reduces blood flow and leads to skin damage. The medical name for pressure sores is decubitus ulcers. Pressure sores are also called pressure injuries or pressure wounds. This information was obtained from the website: https://www.cancer.org/cancer/managing-cancer/side-effects/hair-skin-nails/pressure-sores.html Based on observation, resident interview, staff interview, and facility document review, the facility staff failed to implement the comprehensive care plan for six of 25 residents in the survey sample, Residents #13, #22, #23, #2, #7, and #9. The findings include: 1. For Resident #13 (R13), the facility staff failed to follow the care plan to turn and reposition the resident to prevent worsening of pressure injuries (1). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R13's most recent wound NP note dated 4/29/25 revealed R13 had three current pressure injuries at the time of the survey. All three pressure injuries were located on the resident's buttocks. This note contained the following instructions: The patient has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol. On 4/30/25 at 7:45 a.m., R13 was observed sitting up in his bed watching television. This observation continued until 10:15 a.m. No staff member attempted or offered to turn and reposition R13 during this time. On 4/20/25 at 10:17 a.m., R13 was interviewed. He stated no staff member offered to turn and reposition him all night the previous night. A review of R13's care plan dated 5/3/23 revealed, in part: The resident has a pressure ulcer and has the potential for further pressure ulcer development .is not always compliant with turning and positioning (he understands the risks and benefits) .Follow facility policies/protocols for the prevention and treatment of skin breakdown .I require monitoring, reminding, and assistance to turn and reposition at least every 2 hours, more often as needed or requested. On 5/1/25 at 9:20 a.m., LPN (licensed practical nurse) #1 was interviewed. LPN #1 stated each resident has a care plan to ensure they get what they need. He explained that the care plan elements must be communicated to each member of the interdisciplinary team. He stated all staff members are involved in making sure the care plan is implemented for each resident. On 5/1/25 at 4:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #6, the regional clinician, were informed of these concerns. A review of the facility policy, Comprehensive Person-Centered Care Plans, revealed, in part: A comprehensive, person-centered care plan .to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident .The comprehensive person-centered care plan . reflects currently recognized standards of practice for problem areas and conditions. No additional information was provided 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. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf. 5. For Resident #7 (R7), the facility staff failed to implement the resident's comprehensive care plan for isolation. R7's comprehensive care plan dated 4/23/25 documented, I have shingles; isolation as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R7's clinical record revealed a physician's order dated 4/24/25 for contact precautions for seven days for a diagnosis of shingles. On 4/29/25 at 3:25 p.m., an observation of CNA (certified nursing assistant) #5, CNA #6, and CNA #7 transferring R7 from the wheelchair to the bed with a mechanical lift was conducted. The CNAs wore gloves but did not wear gowns. A sign for enhanced barrier precautions (not contact precautions) was posted on the room door. On 4/29/25 at 3:25 p.m., an interview was conducted with CNA #5, CNA #6, and CNA #7. CNA #5, CNA #6, and CNA #7 stated they transferred R7 to bed and checked to make sure the resident did not have an incontinent episode. CNA #5, CNA #6, and CNA #7 stated they wore gloves but did not wear gowns and R7 was not on isolation precautions. On 5/1/25 at 9:19 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated each individual has a carefully choreographed care plan that is set so they get what they need. LPN #1 stated residents have requirements specific to their own unique needs and staff have access to look at residents' care plans to ensure they are being implemented. On 5/1/25 at 4:36 p.m., ASM (administrative staff member) #1 (the regional consultant) and ASM #2 (the director of nursing) were made aware of the above concern. The CDC (Centers for Disease Control and Prevention) documented Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. This information was obtained from the website: https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html The CDC further documented, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO (multidrug-resistent organism) colonization status Infection or colonization with an MDRO. This information was obtained from the website: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html No further information was presented prior to exit. 6. For Resident #9 (R9), the facility staff failed to implement the resident's comprehensive care plan for tracheostomy care. R9's comprehensive care plan dated 3/20/25 documented, I have a tracheostomy r/t (related to) Impaired breathing mechanics, Respiratory Failure. Provide tracheostomy care as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R9's clinical record revealed a physician's order dated 3/19/25 for tracheostomy care every shift and as needed. Further review of R9's clinical record failed to reveal tracheostomy care was provided on the following days (as evidenced by blank spaces on the respiratory administration record): 3/25/25 during the night shift, 3/29/25 during the night shift, 4/4/25 during the day shift, 4/11/25 during the day shift, 4/13/25 during the day shift and night shift, 4/18/25 during the day shift, and 4/27/25 during the day shift. On 4/30/25 at 4:41 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated tracheostomy care consists of cleaning around the tracheostomy stoma, changing the gauze around the stoma, and changing the inner cannula. LPN #3 stated nurses evidence tracheostomy care was provided by signing off on the respiratory administration record. On 5/1/25 at 9:19 a.m., an interview was conducted with LPN #1. LPN #1 stated each individual has a carefully choreographed care plan that is set so they get what they need. LPN #1 stated residents have requirements specific to their own unique needs and staff have access to look at residents' care plans to ensure they are being implemented. On 5/1/25 at 4:36 p.m., ASM (administrative staff member) #1 (the regional consultant) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 3. For R23, the facility staff failed to follow the comprehensive care plan for the treatment of a pressure injury. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/10/2025, R23 resident was coded as having both short- and long-term memory difficulties and was coded as being severely impaired of cognition for making daily decisions. Section M Skin Conditions coded R23 as having a stage four pressure injury. The Wound Assessment Report for 23 dated 02/4/2025 documented in part, TREATMENT. Dressing Change Frequency: Daily, and PRN (as needed) Clean Wound With: Cleanse with 0.125% Dakins (2) solution Primary Treatment: Silver alginate (3), Zinc Oxide Paste to periwound (skin around the wound) Other Dressings: silicone bordered superabsorb (5). The eTAR (electronic treatment record) for R23 dated February 2025 documented in part, SACRAL WOUND: clean wound with normal saline, apply skin prep (6) around periwound, apply extra fluffed gauze to fill in wound, cover with collagen (7) and cover with bordered gauze everyday shift for wound care-Start Date 02/07/2025 0700-D/C (discharge) Date 02/20/2025. Review of the eTAR revealed R23 received the pressure injury treatment as stated on the February 2025 eTAR from 02/03/2025 through 02/20/2025. Further review of the eTAR failed to evidence pressure injury treatments to R23 as recommended from the wound assessment report dated 02/04/2025. The Wound Assessment Report for R23 dated 02/18/2025 documented in part, TREATMENT Dressing Change Frequency: Daily, and PRN Clean Wound With: Cleanse with wound cleanser Primary Treatment: Silver alginate, Zinc Oxide Paste to periwound Other Dressings: silicone bordered superabsorb. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The eTAR for R23 dated February 2025 documented in part, SACRAL WOUND: Cleanse with silver alginate, zinc oxide paste to periwound and cover with silicone dressing QDAY (every day) one time a day for wound care-Start Date 02/21/2025 0700-D/C Date 03/17/2025. Review of the eTAR revealed R23 received the pressure injury treatment as stated on the February 2025 eTAR from 02/21/2025 through 02/28/2025. Further review of the eTAR failed to evidence pressure injury treatments to R23 as recommended from the wound assessment report dated 02/18/2025. The comprehensive care plan for R23 dated documented in part, Focus. The resident has a pressure ulcer or has the potential for pressure ulcer development r/t disease process., immobility. Under Interventions it documented in part, Treatments as indicated. Date Initiated: 11/27/2024. On 5/1/25 at 9:19 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated each individual has a carefully choreographed care plan that is set so they get what they need. LPN #1 stated residents have requirements specific to their own unique needs and staff have access to look at residents' care plans to ensure they are being implemented. On 05/01/2025 at approximately 4:05 p.m., ASM # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. No further information was provided prior to the exit. 4. For R2, the facility staff failed to follow the comprehensive care plan for informing of the risks and benefits of Xanax (1). R2 was admitted to the facility with diagnoses that included but were not limited to cancer. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/06/2025, R2 scored a 14 out of 15 on the BIMS (brief interview for mental status), indicating R2 was cognitively intact for making daily decisions. The physician's order for R2 documented, Alprazolam (Xanax) Tablet 0.5 MG (milligrams) *Controlled Drug* Give 1 (one) tablet via (by) PEG-Tube (percutaneous endoscopic gastrostomy) (3) every 8 (eight) hours as needed for Anxiety for 14 Days. Order Date: 2/5/2025 The eMAR (electronic medication administration record) for R2 dated February 2025 documented the physician order for Xanax and Percocet as stated above. Review of the eMAR revealed R2 received Xanax on 02/07/2025, 02/09/2025, 02/10/2025, 02/11/2025 and on 02/13/2025. The comprehensive care plan for R2 dated 01/21/2025 documented in part Focus: I use anti-anxiety medication r/t (related to) Anxiety Disorder Date Initiated: 01/21/2025. Under Interventions it documented in part, Educate me/family/caregivers about the risks, benefits and side effects of medication being given. Date Initiated: 01/21/2025. On 5/1/25 at 9:19 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated each individual has a carefully choreographed care plan that is set so they get what they need. LPN #1 stated residents have requirements specific to their own unique needs and staff have access to look at residents' care plans to ensure they are being implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/01/2025 at approximately 4:05 p.m., ASM # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. No further information was provided prior to the exit. References: (1) Used to treat anxiety disorders and panic disorders (sudden, unexpected attacks of extreme fear and worry about these attacks. Alprazolam is in a class of medications called benzodiazepines. It works by decreasing abnormal excitement in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684001.html. (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (3) The placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000900.htm.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to follow professional standards of practice for one of 25 residents in the survey sample, Resident #2. The findings include: For Resident #2 (R2), the facility staff failed to follow professional standards of practice for monitoring a resident after an unwitnessed fall on 2/13/25. Facility staff failed to evidence neuro checks (1) completed after the unwitnessed fall. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/6/25, the resident was assessed as taking anticoagulant medication and having no falls since readmission. The progress notes for R2 documented in part, - 2/12/2025 03:37 (3:37 a.m.) Note Text: During walking rounds the writer found the resident on the floor in his room. The resident was found on the left side of his bed, lying on his left side with his back against the bed. The writer had another staff member to assist with getting the resident from the floor and into his bed. Completed skin assessment done by the writer. No apparent injuries. The writer medicated for pain, and anxiety. Neurological assessment in place. The writer notified [Name of responsible party], [Name of nurse practitioner] and ADON (assistant director of nursing). - 2/14/2025 03:51 (3:51 a.m.) Note Text: At approximately 2100 (9:00 p.m.), writer was notified by a visitor that patient was on the floor in [Room number]. Writer performed an assessment. VWNL (vital signs within normal limits). PERRLA (pupils round, reactive to light and accommodation). Patient denied pain. Full ROM (range of motion) noted in all extremities. Skin intact. No injuries noted. Writer noted hematuria (2) in the foley bag. NP (nurse practitioner) was notified about the situation. NP ordered a UA&CS (urinalysis and culture and sensitivity) and to see the patient in the morning. patient's son is aware of the situation. - 2/14/2025 11:56 (11:56 a.m.) Nurse Practitioner Note. Note Text: Skill Visit. Suffered fall over night. PMH (past medical history): reviewed. Allergies: reviewed. ROS (review of systems): Denies headache, blurred vision, dizziness, CP (chest pain), SOB (shortness of breath), N/V/D (nausea/vomiting/diarrhea), or pain . No injury from fall. UA ordered after fall overnight . - 2/14/2025 16:32 (4:32 p.m.) Note Text: The resident left the facility for an appointment at the [Name of facility] at around 9:30 AM via stretcher for a follow up with his general surgeon. - 2/14/2025 16:39 (4:39 p.m.) Note Text: A call was received from the resident's son informing that the resident had been admitted . [Name of staff] from the [Name of facility] also called to request a report on the resident ' s medications taken in the morning and the previous night prior to his appointment and admission. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to evidence additional neurological monitoring between 2/13/25 9:00 p.m. and 2/14/25 9:30 a.m. Review of the facility fall investigation dated 2/13/25 documented neuro checks initiated however failed to evidence documentation of the checks. A fall risk assessment for R2 dated 1/21/25 documented a moderate risk for falls. The comprehensive care plan for R2 documented in part, I am at risk for falls r/t impaired mobility, Respiratory failure with hypoxia, Tracheostomy, MRSA (methicillin resistant staphylococcus aureus), Pneumonia Due to Pseudomonas. Date Initiated: 01/21/2025. On 4/29/25 at 3:57 p.m., an interview was conducted with LPN (licensed practical nurse) #7 who stated that they did not remember R2 but had documented the progress note regarding the fall on 2/13/25. He stated that when a resident had an unwitnessed fall, they assessed the resident for any injury prior to getting them back in the bed. LPN #7 stated that they notified the doctor and the responsible party and sent the resident to the hospital if needed. LPN #7 stated that neuro checks were started because the fall was unwitnessed, and they were not able to determine if they had hit their head or not. He stated that the neuro checks were completed according to a schedule after the fall for hours after the fall to assess any change in the resident's level of consciousness and they were either documented in the electronic medical record or on a paper document. On 4/30/25 at 11:46 a.m., ASM (administrative staff member) #6, regional clinical staff, stated that they did not have any neuro check evidence to provide for R2. The facility policy, Assessing Falls and Their Causes dated March 2018, documented in part, .If a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities . Observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall, and will document findings in the medical record. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings . On 5/1/25 at 4:10 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #6, the regional clinical staff were made aware of the concern. No further information was provided prior to exit. Reference: (1) Healthcare providers use different tests and measures to diagnose TBI. Often, multiple measures are used together to diagnose TBI and to map out a path for treatment and recovery. Some of these tests are described in the following sections. In addition to neuro-checks-a series of quick questions and tasks that help healthcare providers assess how well a TBI patient's brain and body are working-some in-depth tests help reveal levels of injury or damage in TBI patients . This information was obtained from the website: https://www.nichd.nih.gov/health/topics/tbi/conditioninfo/diagnose (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(2) Blood in your urine is called hematuria . This information was obtained from the website: https://medlineplus.gov/ency/article/003138.htm

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F 0686 Level of Harm - 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** 3. For Resident #22 (R22), the facility staff failed to provide treatment as recommended by the wound nurse practitioner for A) the right heel and B) the right anterior lower leg pressure injury (1). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/20/25, the resident was assessed as severely impaired for making daily decisions. R22 was assessed as being non-verbal, totally dependent for personal hygiene, bed mobility, toileting and bathing. It further documented R22 always incontinent of bowel and bladder and at risk for pressure injuries but not having any unhealed pressure injuries at the time of the assessment. A) Review of the skin and wound progress note for R22 dated 3/24/2025 by the wound nurse practitioner documented a comprehensive skin assessment completed. It documented in part, . On assessment today right heel noted to be boggy with blanchable redness, recommend skin prep and continue heel booties . Review of the physician orders failed to evidence an order for skin prep to the right heel. Review of the eTAR (electronic treatment administration record) for R22 dated 3/1/25-3/31/25 failed to evidence an order for skin prep to the right heel. Review of the eTAR for R22 dated 4/1/25-4/30/25 failed to evidence an order for skin prep to the right heel. On 5/1/25 at 9:07 a.m., an observation was made of LPN (licensed practical nurse) #4 performing wound care to R22's right anterior lower leg pressure injury. At that time an observation was made of R22's right heel. Observation revealed the skin intact, boggy with blanchable redness. When asked if there were any treatments in place for R22's right heel, LPN #4 stated that he was not aware of any treatment in place. B) Review of the nurse practitioners wound assessment report for R22 dated 3/24/2025 documented a full thickness in house acquired wound to the right anterior lower leg. The description of the wound was 100% eschar with attached wound edges, periwound: intact, dryness, fragile with scant serosanguineous exudate. The treatment recommendations documented were to clean with wound cleanser, treat with calcium alginate, apply bordered gauze daily and as needed. The nurse practitioners wound assessment report for R22 dated 4/1/25 documented two wounds, a right lower leg skin tear and a right anterior lower leg pressure injury. The right anterior lower leg wound was documented as an unstageable pressure injury acquired on 3/24/25 that was improving without complications with 20% granulation, 80% slough and 0% eschar. The treatment recommendations were to cleanse with wound cleanser, apply silver alginate, cover with bordered gauze daily and as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The nurse practitioners wound assessment report for R22 dated 4/8/25 documented two wounds, a right lower leg skin tear and a right anterior lower leg pressure injury. The right anterior lower leg wound was described as an unstageable pressure injury acquired on 3/24/25 that was improving without complications with 40% granulation, 60% slough and 0% eschar. The treatment recommendations were to cleanse with wound cleanser, apply Manuka HD alginate, cover with bordered gauze daily and as needed. Review of the eTAR for R22 dated 3/1/25-3/31/25 failed to evidence a treatment to the right anterior lower leg. Review of the eTAR for R22 dated 4/1/25-4/30/25 documented treatment to the right lower leg skin tear with xeroform and dry dressing completed from 4/2/25-4/9/25, right anterior lower leg pressure injury treatment of Manuka Alginate and dry dressing from 4/11/25-4/22/25 and calcium alginate and dry dressing from 4/23/25-4/29/25. The eTAR failed to evidence the treatment recommended by the wound nurse practitioner until 4/11/25 for the pressure injury. The physician orders for R22 documented in part, - Cleanse skin tear to the right lower leg with wound wash apply xeroform and a dry dressing change daily one time a day for wound care. Start Date: 4/2/2025. - Right Anterior Lower Leg: Cleanse with wound cleanser apply Manuka Alginate and cover with dressing Q (every) day one time a day for wound care. Start Date: 4/11/2025. - Right Anterior Lower Leg: Cleanse with wound cleanser apply Calcium Alginate and cover with dressing Q day one time a day for wound care. Start Date: 4/23/2025. The physician orders failed to evidence a treatment to the right anterior lower leg pressure injury prior to 4/11/2025 other than the skin tear treatment starting 4/2/25. The comprehensive care plan for R22 documented in part, The resident has a pressure ulcer or has the potential for pressure ulcer development r/t immobility, diabetes. Right anterior Lower Leg Pressure. Date Initiated: 03/18/2024. Under Interventions/Tasks it documented in part, Administer treatments as ordered and monitor for effectiveness. Date Initiated: 03/18/2024 . On 4/30/35 at 12:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the acting wound nurse. He stated that if a resident had an established wound that was already being followed by the wound NP (nurse practitioner), the facility's wound nurse accompanied them on them on weekly rounds to assess each resident with a wound. He stated that usually the wound NP gave a verbal order for any new orders needed after the wound NP assessment. LPN #4 stated it was the wound nurse's responsibility to get approval for the new order from the resident's PCP (primary care physician) and then put the order into the computer system. He stated as a backup, the wound NP sent a summary of all visits and new orders after each visit to the facility and the summary was usually reviewed by the DON (director of nursing). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/30/25 at 1:16 p.m., an interview was conducted with ASM (administrative staff member) # 4, a wound NP. ASM #4 stated that they assessed each resident at least once a week and communicated treatment changes to the facility's wound nurse. She stated the wound NP also completes a report at the end of each visit to the facility listing all residents/wounds assessed, and including all treatment orders and that this report was sent to the facility's DON. She stated that as far as she knew, the facility nurse communicates the wound NP's recommendation to the resident's PCP and gets approval before implementation. She stated she believes that if a PCP declined a recommendation, the facility staff would communicate this with the wound NP. She stated nothing like this had ever been communicated to her or to any of the NPs employed by her company. She stated the wound NPs did not directly input orders into the facility's EMR (electronic medical record). On 4/30/25 at 1:34 p.m. an interview was conducted with ASM # 3, the regional mobile director of nursing, and ASM #7, the regional clinician. ASM #3 stated the wound NP was always accompanied by a member of the facility's wound team on their weekly rounds. Once the wound NP had completed rounds, they usually talked with the DON and always sent a written report containing a list of residents seen that day and all wound treatments. She stated the facility's wound nurse who had accompanied the wound NP was responsible for reaching out to the PCP to get approval for the wound NP's recommendations. Once the approval was obtained, the facility's wound nurse was responsible for entering the order accurately into the EMR. On 5/1/25 at 4:10 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #6, the regional clinician, were made aware of the concern. No further information was provided prior to exit. Reference: (1) Pressure sores appear as ulcers (open wounds) or crater-like areas on your skin. They can happen when a part of your body experiences a long period of excessive pressure that reduces blood flow and leads to skin damage. The medical name for pressure sores is decubitus ulcers. Pressure sores are also called pressure injuries or pressure wounds. This information was obtained from the website: https://www.cancer.org/cancer/managing-cancer/side-effects/hair-skin-nails/pressure-sores.html Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services to prevent and treat pressure injuries (1) for six of 25 residents in the survey sample, Residents #13, #6, #22, #23, #1, and #21. For Residents #13 and #6, the facility staff failed to implement treatments as recommended by the wound nurse practitioner (NP), causing the residents' pressure injuries to worsen. This failure resulted in harm to both Residents #13 and #6. The findings include: 1.a. For Resident #13 (R13), the facility staff failed to change a pressure injury treatment according to the wound nurse practitioner's (NP's) recommendation between 5/23/24 and 7/23/24. During this time, the wound worsened by increasing in length. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of R13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/4/25, R13 was coded as being totally dependent on facility staff for turning and positioning. He was admitted with a diagnosis of paraplegia. He was coded as being cognitively intact for making daily decisions. A review of R13's weekly skin assessment dated [DATE] revealed, in part: Head to Toe Skin Check and Evaluation .Are there any skin impairments noted? yes .Site .penis. A review of R13's wound NP note dated 5/23/24 revealed, in part: Wound Assessment Report . Measurements: length 2 cm (centimeters) X (by) width 0.8 cm X depth 0.7 cm .Location: penile shaft . Etiology: Pressure .100% granulation (2) .0% slough (3) .0% eschar (4) .Treatment: Dressing Change Frequence: Daily and PRN (as needed), Clean Wound With: Cleanse with wound cleanser, Primary Treatment: Silver alginate. A review of R13's May 2024 TAR (treatment administration record) revealed no treatment was implemented for the penile shaft wound. A review of R13's wound NP note dated 5/28/24 revealed, in part: Wound Assessment Report . Measurements: length 1.5 cm X width 0.8 cm X depth 0.7 cm .Location: penile shaft .Etiology: Pressure . 100% granulation .0% slough .0% eschar .Treatment: Dressing Change Frequence: Daily and PRN (as needed), Clean Wound With: Cleanse with wound cleanser, Primary Treatment: Silver alginate .Other Dressings: Rolled gauze, THIN layer. A review of R13's May 2024 TAR (treatment administration record) revealed no evidence that treatment was implemented for the penile shaft wound. A review of R13's wound NP note dated 6/20/24 revealed, in part: Wound Assessment Report . Measurements: length 1.5 cm X width 0.8 cm X depth 0.7 cm .Location: penile shaft .Etiology: Pressure . 100% granulation .0% slough .0% eschar .Treatment: Dressing Change Frequence: Daily and PRN (as needed), Clean Wound With: Cleanse with wound cleanser. A review of R13's June 2024 TAR revealed no evidence that treatment was implemented for R13's penile shaft wound until 6/25/24. On 6/25/24, the wound cleanser and Venelex were implemented, but only once a day, instead of twice A review of R13's wound NP note dated 6/25/24 revealed, in part: Wound Assessment Report . Measurements: length 1.5 cm X width 0.8 cm X depth 0.7 cm .Location: penile shaft .Etiology: Mucosal Membrane Pressure Injury .100% granulation .0% slough .0% eschar .Treatment: Dressing Change Frequence: BID (twice a day) .Clean Wound With: Cleanse with wound cleanser, Primary Treatment: Venelex (5) .Other Dressings: Leave open to air. A review of R13's June TAR revealed on 6/25/24, the wound cleanser and Venelex were implemented, but only once a day, instead of twice a day as recommended. A review of R13's wound NP note dated 7/2/24 revealed, in part: Wound Assessment Report . Measurements: length 2.5 cm, an increase in size, X width 0.8 cm X depth 0.7 cm .Location: penile shaft . Etiology: Mucosal Membrane Pressure Injury .100% granulation .0% slough .0% eschar .Treatment: Dressing Change Frequence: BID .Clean Wound With: Cleanse with wound cleanser, Primary Treatment: Venelex .Other Dressings: Leave open to air. A review of R13's July TAR revealed the wound cleanser and Venelex were implemented, but only once a day, instead of twice a day as recommended. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of R13's wound NP note dated 7/9/24 revealed, in part: Wound Assessment Report . Measurements: length 2.5 cm X width 0.8 cm X depth 0.7 cm .Location: penile shaft .Etiology: Mucosal Membrane Pressure Injury .100% granulation .0% slough .0% eschar .Treatment: Dressing Change Frequence: BID .Clean Wound With: Cleanse with wound cleanser, Primary Treatment: Venelex .Other Dressings: Leave open to air. A review of R13's July TAR revealed the wound cleanser and Venelex were implemented, but only once a day, instead of twice a day as recommended. A review of R13's wound NP note dated 7/16/24 revealed, in part: Wound Assessment Report . Measurements: length 2.5 cm X width 0.8 cm X depth 0.7 cm .Location: penile shaft .Etiology: Mucosal Membrane Pressure Injury .100% granulation .0% slough .0% eschar .Treatment: Dressing Change Frequence: BID .Clean Wound With: Cleanse with wound cleanser, Primary Treatment: Venelex .Other Dressings: Leave open to air. A review of R13's July TAR revealed the wound cleanser and Venelex were implemented, but only once a day, instead of twice a day as recommended. A review of R13's wound NP note dated 7/23/24 revealed, in part: Wound Assessment Report . Measurements: length 2.5 cm X width 0.8 cm X depth 0.7 cm .Location: penile shaft .Etiology: Mucosal Membrane Pressure Injury .100% granulation .0% slough .0% eschar .Treatment: Dressing Change Frequence: BID .Clean Wound With: Cleanse with wound cleanser, Primary Treatment: Venelex .Other Dressings: Leave open to air. A review of R13's July TAR revealed the wound cleanser and Venelex were implemented, but only once a day, instead of twice a day as recommended. A review of R13's wound NP note dated 7/30/24 revealed, in part: Wound Assessment Report . Measurements: length 2.5 cm X width 0.8 cm X depth 0.7 cm .Location: penile shaft .Etiology: Mucosal Membrane Pressure Injury .100% granulation .0% slough .0% eschar .Treatment: Dressing Change Frequence: BID .Clean Wound With: Cleanse with wound cleanser, Primary Treatment: Venelex .Other Dressings: Leave open to air. A review of R13's July TAR revealed the wound cleanser and Venelex were implemented, but only once a day, instead of twice a day as recommended. A review of R13's wound NP note dated 8/6/24 revealed, in part: Wound Assessment Report . Measurements: length 2.4 cm X width 0.8 cm X depth 0.7 cm .Location: penile shaft .Etiology: Mucosal Membrane Pressure Injury .100% granulation .0% slough .0% eschar .Treatment: Dressing Change Frequence: BID .Clean Wound With: Cleanse with wound cleanser, Primary Treatment: Venelex .Other Dressings: Leave open to air. A review of R13's August TAR revealed the wound cleanser and Venelex were implemented, but only once a day, instead of twice a day as recommended. R13 was discharged to the hospital on 8/10/24. On 4/30/35 at 12:20 p.m., LPN (licensed practical nurse) #4, the acting wound nurse, was interviewed. He stated if a resident comes in with a wound, the facility gets orders from either the PCP (primary care physician) or the wound NP. If a resident has an established wound that is already being followed by the wound NP, the facility's wound nurse accompanies the wound NP on weekly rounds to assess each resident with a wound. He stated usually the wound NP gives a verbal order for any new orders needed after the wound NP assessment. LPN #4 stated it is the wound nurse's responsibility to get approval for the new order from the resident's PCP and then enters the order into the computer system. He stated as a backup, the wound NP sends a summary of all visits and new orders after each visit to the facility. This summary is usually reviewed by the DON (director of nursing). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/30/25 at 1:16 p.m., ASM (administrative staff member) # 4, a wound NP, was interviewed. She stated if a resident is admitted with a new wound or develops a new wound while in the facility, her company's nurse practitioner performs a head to toe evaluation for each resident. Once the assessment is complete, the wound NP makes a verbal recommendation to the facility's wound nurse for treatments for all wounds. She stated the wound NP also completes a report at the end of each visit to the facility listing all residents/wounds assessed, and including all treatment orders. She stated the wound NPs do not directly input orders into the facility's EMR (electronic medical record). She stated if a resident has an established wound, the wound NP follows the same process. This includes assessing each resident at least once a week and communicating treatment changes to the facility's wound nurse. The process remains the same for the report generated after each facility visit. This report is sent to the facility's DON. She stated that as far as she knows, the facility nurse communicates the wound NP's recommendation to the resident's PCP and gets approval before implementation. She stated she believes that if a PCP declined a recommendation, the facility staff would communicate this with the wound NP. She stated nothing like this had ever been communicated to her or to any of the NPs employed by her company. On 4/30/25 at 1:34 p.m. ASM # 3, the regional mobile director of nursing, and ASM #6, the regional clinician, were interviewed. ASM #3 stated if a new wound is identified, either on a current or newly admitted resident, the PCP is called and the PCP gives an order for treatment for the first 24 hours. The following day, the resident is seen by someone on the facility's wound team. The facility's wound nurse assesses, measures, and stages the wound, and makes a recommendation to the PCP for treatment until the wound NP can evaluate the wound. She explained: Something should be in place for each wound within 24 hours of identification. She stated the wound NP is always accompanied by a member of the facility's wound team on their weekly rounds. Once the wound NP has completed rounds, they usually talk with the DON and always send a written report containing a list of residents seen that day and all wound treatments. She stated the facility's wound nurse who has accompanied the wound NP is responsible for reaching out to the PCP to get approval for the wound NP's recommendations. Once the approval is obtained, the facility's wound nurse is responsible for entering the order accurately into the EMR. On 4/30/25 at 2:56 p.m., ASM #7, a primary care physician, was interviewed. He stated he oversees the whole medical process for residents under his care, and this includes wound care. He states he talks clearly to the wound NPs about his expectations. He stated unless the contract wound NP is ordering an unnecessary wound culture for someone who has an underlying systemic infection, he follows their recommendations. He stated: If we have the products, we are going to follow their recommendation. On 4/30/25 at 5:36 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #6 were informed of the concern for harm for R13. These staff members were requested to present any evidence that would indicate R13 was not harmed by the facility's lack of implementation of the wound NP's recommendations. A review of the facility policy, No additional information was provided prior to exit. References: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	(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. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf. (2) Granulation tissue is an important component in the wound healing process. Wounds can heal by primary intention (wound edges approximate easily) and secondary intention (wound edges do not approximate). The granulation tissue matrix fills wounds that heal by the second intention. This information is taken from the website https://pubmed.ncbi.nlm.nih.gov/32119289/. (3) 'The wound bed may be covered with necrotic tissue (non-viable tissue due to reduced blood supply), slough (dead tissue, usually cream or yellow in color), or eschar (dry, black, hard necrotic tissue). Such tissue impedes healing. This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360405/ (4) The wound bed may be covered with necrotic tissue (non-viable tissue due to reduced blood supply), slough (dead tissue, usually cream or yellow in color), or eschar (dry, black, hard necrotic tissue). Such tissue impedes healing. This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360405/ (5) VENELEX (Trademark) OINTMENT helps to deodorize and protectively cover pressure wounds (ulcers). VENELEX (Trademark) OINTMENT provides a moist wound environment. The moisturizing properties of VENELEX (Trademark) OINTMENT may also help in the prevention of cracking around the edges of sores. This information is taken from the website https://dailymed.[NAME].nih.gov. 1.b. On 4/30/24 between 7:45 a.m. and 10:15 a.m., the facility staff failed to turn and position the resident to prevent worsening of pressure injuries. A review of R13's most recent wound NP note dated 4/29/25 revealed R13 had three current pressure injuries at the time of the survey. All three pressure injuries were located on the resident's buttocks. This note contained the following instructions: The patient has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol. On 4/30/25 at 7:45 a.m., R13 was observed sitting up in his bed watching television. This observation continued until 10:15 a.m. No staff member attempted or offered to turn and reposition R13 during this time. On 4/30/25 at 10:17 a.m., R13 was interviewed. He stated no staff member offered to turn and reposition him all night the previous night. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of R13's care plan dated 5/3/23 revealed, in part: The resident has a pressure ulcer and has the potential for further pressure ulcer development .is not always compliant with turning and positioning (he understands the risks and benefits) .Follow facility policies/protocols for the prevention and treatment of skin breakdown .I require monitoring, reminding, and assistance to turn and reposition at least every 2 hours, more often as needed or requested. On 4/30/25 at 4:20 p.m., (certified nursing assistant) #2 was interviewed. CNA #2 stated residents should be turned and repositioned every two hours and this is evidenced by signing off on the ADL (activities of daily living) records. On 4/30/25 at 4:35 p.m., CNA #3 was interviewed. She stated all dependent residents should be encouraged and assisted to turn at least every two hours. She stated she turns her patients on a rotation as best she can and keeps resident in the same order throughout her shift. On 5/1/25 at 9:20 a.m., LPN (licensed practical nurse) #1 was interviewed. He stated dependent residents should be turned at a minimum of every two hours to prevent pressure injury development and/or worsening. He stated even if a resident is known to have refused turning in the past, the CNA should still offer it to the resident each and every time. On 5/1/25 at 12:52 p.m., CNA #1 was interviewed. She stated that dependent residents should be turned at least every two hours to prevent pressure injuries. She stated if a resident has refused turning in the past, she still offers to assist in turning every single time. She added: If they have refused before, I'm going to ask anyway. I try to encourage them. On 4/30/25 at 5:36 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #6, the regional clinician, were informed of these concerns. A review of the facility policy, Repositioning, revealed, in part: The purpose of this procedure is to .prevent skin breakdown, promote circulation and provide pressure relief for residents .Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief . Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning .Residents who are in bed should be on at least an every-two-hour .repositioning schedule .For residents with a Stage 1 or above pressure ulcer, and every-two-hour .repositioning schedule is inadequate. No additional information was provided prior to exit. 2. For Resident #6 (R6), the facility staff failed to change a pressure injury (1) treatment according to the wound nurse practitioner's (NP's) recommendation between 12/5/24 and 12/24/24. During this time, the wound worsened by increasing in depth and increasing in slough (2), resulting in harm to the resident. In December 2024, on multiple dates, the facility staff failed to provide evidence that resident was turned and positioned through the night. The facility staff failed to follow the wound NP's recommendation to initiate dual antibiotic coverage for a suspected wound infection on 1/2/25. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/2/25, R6 was coded as being completely dependent on facility staff for turning and repositioning. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of R6's clinical record revealed she was admitted [DATE] with an existing pressure injury on her sacrum. Further review of the record revealed the following treatment was initiated for the pressure injury on 11/28/24: Sacrum wound, every day shift .Cleanse with Dakins (a wound cleanser with antimicrobial properties), pack with Dakins moist gauze, cover with border gauze. A review of R6's TARs (treatment administration record) for November and December 2024 and January 2025 revealed R6 received this treatment from 11/28/24 through 1/6/25 when she was discharged to the hospital. A review of R6's wound NP note dated 12/5/24 revealed, in part: Stage 4 (3) Sacrum 7.5 cm (centimeters) length X (by) 7.5 cm width X 1 cm depth. 80% granulation (4), 20% slough. Moderate serosanguinous (partially bloody) drainage .Cleanse with wound cleanser .Apply medical grade honey fiber to base of the wound .secure with bordered gauze .change daily and prn (as needed). A review of R6's December 2024 TAR revealed this recommendation was never implemented. A review of R6's wound NP note dated 12/12/24 revealed, in part: Stage 4 Sacrum 4 cm length X 4 cm width X 1 cm depth. Cleanse with wound cleanser .Apply medical grade honey fiber to base of the wound .secure with bordered gauze .change daily and prn (as needed). A review of R6's December 2024 TAR revealed this recommendation was never implemented. A review of R6's wound NP note dated 12/19/24 revealed, in part: Follow up assessment for stage 4 sacral pressure ulcer, wound improving .Continue current treatment with honey fiber and preventative measures . Cleanse with wound cleanser .Apply medical grade honey fiber to base of the wound .secure with bordered gauze .change daily and prn (as needed). A review of R6's December 2024 TAR revealed this recommendation was never implemented. A review of R6's wound NP note dated 12/24/24 revealed, in part: Sacrum stage 4 pressure ulcer is worsening with increased measurements and hyperpigmentation noted to wound bed. Treatment changed . Monitor closely for signs/symptoms of infection .Stage 4 Sacrum 3.4 cm length X 3 cm width X 2 cm depth (an increase in depth) .Wound base 80% granulation, 20% slough .Treatment changed to cleanse with Dakins and Apply Dakins fluffed gauze. A review of R6's December 2024 TAR revealed this had been the facility's treatment for this pressure injury since 11/28/24, with none of the changes recommended by the wound NP. A review of R6's wound NP note dated 1/2/25 revealed, in part: Sacrum stage 4 pressure ulcer continues to worsen with increased measurements and hyperpigmentation to wound bed. Recommendation for wound culture and dual coverage antibiotic. Monitor closely for signs/symptoms of worsening infection .Stage 4 Sacrum Worsening .4 cm length (an increase in length) X 3.5 cm width (an increase in width) X 4.2 cm depth (an increase in depth) .Wound base 10% granulation, 90% slough) .Cleanse with 0.125% Dakins solution . apply Dakins moistened fluffed gauze to base of the wound .secure with silicone bordered superabsorb . change daily and prn. A review of the January 2025 TAR (treatment administration record) revealed the facility never ordered or impleneted the dual coverage antibiotic as recommended by the wound NP. A review of R6's point of care records revealed the task of turning and positioning by CNAs was not performed on the following nights in December 2024: 12/1, 12/3, 12/6, 12/13, 12/22, 12/26, and 12/31. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of R6's comprehensive care plan dated 11/27/24 revealed, in part: The resident has a pressure ulcer .r/t (related to) disease process, immobility. Often refuses treatments/care, refuses to be turned and positioned .Administer treatments as ordered and monitor for effectiveness .I require monitoring, reminding, and assistance to turn and reposition every 2 hours, more often as needed or requested. On 4/30/35 at 12:20 p.m., LPN (licensed practical nurse) #4, the acting wound nurse, was interviewed. He stated if a resident comes in with a wound, the facility gets orders from either the PCP (primary care physician) or the wound NP. If a resident has an established wound that is already being followed by the wound NP, the facility's wound nurse accompanies the wound NP on weekly rounds to assess each resident with a wound. He stated usually the wound NP gives a verbal order for any new orders needed after the wound NP assessment. LPN #4 stated it is the wound nurse's responsibility to get approval for the new order from the resident's PCP and then enters the order into the computer system. He stated as a backup, the wound NP sends a summary of all visits and new orders after each visit to the facility. This summary is usually reviewed by the DON (director of nursing). On 4/30/25 at 1:16 p.m., ASM (administrative staff member) # 4, a wound NP, was interviewed. She stated if a resident is admitted with a new wound or develops a new wound while in the facility, her company's nurse practitioner performs a head to toe evaluation for each resident. Once the assessment is complete, the wound NP makes a verbal recommendation to the facility's wound nurse for treatments for all wounds. She stated the wound NP also completes a report at the end of each visit to the facility listing all residents/wounds assessed, and including all treatment orders. She stated the wound NPs do not directly input orders into the facility's EMR (electronic medical record). She stated if a resident has an established wound, the wound NP follows the same process. This includes assessing each resident at least once a week and communicating treatment changes to the facility's wound nurse. The process remains the same for the report generated after each facility visit. This report is sent to the facility's DON. She stated that as[TRUNCATED]

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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, facility document review, and clinical record review, the facility staff failed to position an indwelling urinary catheter collection bag in a sanitary manner for one of 25 residents in the survey sample, Resident #13. The findings include: For Resident #13 (R13), the facility staff failed to position his indwelling urinary catheter collection bag off the floor on 4/29/25 and 4/30/25. A review of R13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/4/25, R13 was coded as being totally dependent on facility staff for turning and positioning. He was admitted with a diagnosis of paraplegia. He was coded as being cognitively intact for making daily decisions. On the following dates and times, R13 was observed sitting up in bed. At each observation an indwelling urinary catheter collection bag was lying completely on the floor: 4/9/25 at 1:43 p.m. and 4:55 p.m.; 4/30/25 at 7:50 a.m. A review of R13's physician's orders revealed the following order, dated 8/16/24: Urinary Catheter .maintain #16/10 coude catheter to straight drain. DX (diagnosis) obstructive uropathy. On 5/1/25 at 9:20 a.m., LPN (licensed practical nurse) #1 was interviewed. He stated a urinary catheter collection bag should never be in contact at all with the floor. He explained there is a risk of infection, as well as a risk of the bag snagging on something sharp and bursting, also exposing the resident to infection. On 5/1/25 at 12:52 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated a catheter bag should not be lying on the floor because of the risk of a resident developing an infection. On 5/1/25 at 4:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #6, the regional clinician, were informed of these concerns. A review of the facility policy, Urinary Catheter Care, revealed, in part: The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections .Infection Control Be sure the catheter tubing and drainage bag are kept off the floor. No additional information was provided prior to exit.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide respiratory care and services for two of 25 residents in the survey sample, Residents #1 and #9. The findings include: 1. For Resident #1 (R1), the facility staff failed to provide tracheostomy care on multiple days in January 2025 and February 2025. A review of R1's clinical record revealed a physician's order dated 1/6/25 for tracheostomy care every shift and as needed. Further review of R1's clinical record failed to reveal tracheostomy care was provided on the following days during the night shift (as evidenced by blank spaces on the respiratory administration record): 1/9/25, 1/11/25, 1/13/25, 1/23/25, and 2/1/25. On 4/30/25 at 4:41 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated tracheostomy care consists of cleaning around the tracheostomy stoma, changing the gauze around the stoma, and changing the inner cannula. LPN #3 stated nurses evidence tracheostomy care was provided by signing off on the respiratory administration record. On 5/1/25 at 4:36 p.m., ASM (administrative staff member) #1 (the regional consultant) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Tracheostomy Care documented, General Guidelines: 5. Tracheostomy care should be provided as often as needed, at least once daily for old, established tracheostomies, and at least every eight hours for residents with unhealed tracheostomies. No further information was presented prior to exit. 2. For Resident #9 (R9), the facility staff failed to provide tracheostomy care on multiple days in March 2025 and April 2025. A review of R9's clinical record revealed a physician's order dated 3/19/25 for tracheostomy care every shift and as needed. Further review of R9's clinical record failed to reveal tracheostomy care was provided on the following days (as evidenced by blank spaces on the respiratory administration record): 3/25/25 during the night shift, 3/29/25 during the night shift, 4/4/25 during the day shift, 4/11/25 during the day shift, 4/13/25 during the day shift and night shift, 4/18/25 during the day shift, and 4/27/25 during the day shift. On 4/30/25 at 4:41 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated tracheostomy care consists of cleaning around the tracheostomy stoma, changing the gauze around the stoma, and changing the inner cannula. LPN #3 stated nurses evidence tracheostomy care was provided by signing off on the respiratory administration record. On 5/1/25 at 4:36 p.m., ASM (administrative staff member) #1 (the regional consultant) and ASM #2 (the director of nursing) were made aware of the above concern. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was presented prior to exit.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement a complete pain management program for one of 25 residents in the survey sample, Resident #2 (R2). The findings include: 1. For R2, the facility staff failed to attempt non-pharmacological interventions prior to the administration of the prn (as needed) pain medication of Percocet (1) 10-325MG (milligrams). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/06/2025, R2 scored a 14 out of 15 on the BIMS (brief interview for mental status), indicating R2 was cognitively intact for making daily decisions. The physician's order for R2 documented, Oxycodone-Acetaminophen (Percocet)Tablet 10-325 MG *Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for Pain. Order Date: 2/5/2025. The eMAR (electronic medication administration record) for R2 dated February 2025 documented the physician order for Percocet as stated above. Review of the eMAR revealed R2 received Percocet on 02/09/2025, 02/12/2025 and on 02/13/2025. Further review of the eMAR failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of Percocet on the dates listed above. The facility's progress notes for R2 for the times listed above on the eMARs dated 02/09/2025 through 02/13/2025 failed to evidence documentation of non-pharmacological interventions prior to the administration of Percocet on 02/09/2025 and 02/12/2025. On 05/01/2025 at approximately 1:43 p.m., an interview was conducted with LPN (licensed practical nurse) #5. When asked to describe the procedure for administering prn pain medications LPN #5 stated she would assess the resident, ask where the pain is located, try non-pharmacological interventions, and if the interventions were not effective, administer the medication that was prescribed. LPN #5 further stated that non-pharmacological interventions should always be attempted before administering the prn pain medication. When asked where it would be documented that the non-pharmacological interventions were attempted, she stated in the nursing notes or on the eMAR. LPN #5 was asked to review the eMAR and progress notes for R2 for documented evidence of non-pharmacological interventions being attempted on the above dates. She stated there was no evidence that non-pharmacological interventions were attempted on 02/09/2025 and 02/12/2025. The facility's policy Administering Pain Medications it documented in part, general Guidelines. 3. Pain management is a multidisciplinary care process that includes the following: 3g. Monitoring for the effectiveness of intervention. Under Steps in the procedure. It documented in part, 5. Evaluate and document the effectiveness of non-pharmacological interventions (e.g., repositioning, warm or cold compresses, etc.). On 05/01/2025 at approximately 4:05 p.m., ASM # 1, administrator, ASM #2, director of nursing, ASM #6, regional clinical, were made aware of the above findings. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to the exit. References: (1) Is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to provide complete dialysis services for one of 25 residents, Resident #5. The findings include: For Resident #5 (R5), the facility staff failed to evidence complete dialysis communication on multiple dates in November, December 2024 and January 2025. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/9/24, the resident was assessed as receiving dialysis while a resident at the facility. The physician orders for R5 documented in part, - Complete Dialysis Communication form prior to transporting residents to Dialysis. Vital signs prior to transport. every day shift every Mon, Wed, Fri. Order Date: 11/04/2024. Start Date: 11/04/2024. Review of the Hemodialysis Communication Records for R5 from 11/3/24-1/19/25 documented the following: - 11/15/24 No pre-dialysis communication completed. - 11/18/24 No dialysis communication completed. - 11/20/24 No pre-dialysis communication completed. - 11/22/24 No pre-dialysis communication completed. - 11/27/24 No dialysis communication completed. - 11/29/24 No dialysis communication completed. - 12/6/24 No pre-dialysis communication completed. - 12/9/24 No pre-dialysis communication completed. - 1/15/25 No dialysis communication completed. - 1/17/25 No dialysis communication completed. The comprehensive care plan for R5 documented in part, I need Hemodialysis r/t ESRD (end stage renal disease), left arm AV fistula. Date Initiated: 11/03/2024. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/25 at 10:28 a.m., an interview was conducted with LPN (licensed practical nurse) #8 who stated that they worked with R5 at the facility. She stated that when residents went to dialysis, they filled out the dialysis communication record prior to sending them to the dialysis unit for the treatment. She stated that the form was placed in the dialysis communication book and sent with the resident to dialysis where they filled out the middle section and returned it with the resident after the treatment. LPN #8 stated that upon return to the unit, the nurse reviewed the communication book for any updates from dialysis. She stated that the dialysis communication forms were completed for each dialysis treatment and were kept in the book and sent to medical records at the end of each month. The facility policy Dialysis Communication dated 6/2021, documented in part, The facility and dialysis center will establish a communication and reporting mechanism to promote situational awareness between both facilities. Policy Interpretation and Implementation. 1. Routine communication of relevant information will be provided by the facility to the dialysis center on treatment days, and more frequently as necessary . On 5/1/25 at 4:10 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #6, the regional clinical staff were made aware of the concern. No further information was provided prior to exit.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide physician services for one of 25 residents in the survey sample, Resident #7. The findings include: For Resident #7 (R7), ASM (administrative staff member) #10 (the resident's physician) failed to address the resident's refusal of medications prior to dialysis. A review of R7's clinical record revealed the following physician's orders: 2/19/25-Amiodarone 200mg (milligrams)- one tablet once a day for antiarrhythmic (an irregular heartbeat) 2/19/25-Clopidogrel Bisulfate 75mg- one tablet once a day for anticoagulant (to prevent blood clots, heart attacks, and strokes) 2/19/25-Cymbalta 30mg- one capsule once a day for depression 2/19/25-Esomeprazole Magnesium 40mg- one capsule once a day gastroesophageal reflux disease 2/24/25-Eliquis 2.5mg- one tablet every 12 hours for atrial fibrillation (a heart condition) 2/25/25-Gabapentin 100mg- one capsule every 12 hours for neuropathy (nerve pain) 3/17/25-Bumetanide 2mg- one tablet twice a day for fluid retention A review of R7's April 2025 medication administration record revealed the morning doses of the above medications were not administered to R7 on 4/7/25, 4/9/25, 4/11/25, 4/14/25, 4/16/25, 4/21/25, and 4/23/25. Multiple nurses' notes for April 2025 documented no by mouth medications were given to R7 prior to dialysis, per the resident's request. A nurse's note dated 4/21/25 documented R7's physician was aware, and no new orders were given. A review of physician's notes for the duration of R7's stay at the facility failed to reveal R7's physician addressed the resident's refusal of medications prior to dialysis. On 5/1/25 at 10:34 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated R7 does not take his prescribed medications prior to dialysis. LPN #2 stated R7 says, What's the purpose if it's going to be flushed out. LPN #2 stated, I told the doctor. He is aware the resident does not take his morning medications on dialysis days, and he basically said, 'okay.' On 5/1/25 at 1:34 p.m. an interview was conducted with ASM #10. ASM #10 stated he was aware R7 frequently does not take his morning medications. ASM #10 stated he has talked to the resident about the risks but has not documented the conversation. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the most recent MDS (minimum data set), a five-day Medicare assessment with an ARD (assessment reference date) of 3/5/25, R7 scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 5/1/25 at 1:45 p.m., an interview was conducted with R7. R7 stated someone at the dialysis center told him all medications are flushed out during dialysis, so he does not take his morning medications on dialysis days. R7 stated no staff at the facility, including his physician, has talked to him and addressed his refusal of medications on dialysis days. On 5/1/25 at 2:28 p.m., an interview was conducted with ASM #9 (the divisional medical director). ASM #9 stated some medications are dialyzed (removed from the body during dialysis) and some medications are not dialyzed. ASM #9 stated if a resident is refusing medications on dialysis days because he believes the medications are flushed out during dialysis, the physician should educate the resident on the risks, educate the resident on the medications that are dialyzed versus the medications that are not, and possibly consult with the nephrologist (kidney doctor). ASM #9 stated that the physician who has this conversation with the resident should document the conversation. On 5/1/25 at 4:36 p.m., ASM (administrative staff member) #1 (the regional consultant) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Physician Services documented, The medical care of each resident is supervised by a licensed physician .3. Supervising the medical care of residents includes (but is not limited to): a. participating in the resident's assessment and care planning; b. monitoring changes in resident's medical status; c. providing consultation or treatment when called by the facility No further information was presented prior to exit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to evidence monitoring of anticoagulant medication use for one of 25 residents in the survey sample, Resident #2. The findings include: For Resident #2 (R2), the facility staff failed to evidence anticoagulant medication monitoring from 2/1/25-2/11/25. R2 was readmitted to the facility on [DATE]. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/6/25, the resident was assessed as taking anticoagulant medication. The physician orders for R2 documented in part, - Apixaban Oral Tablet 5 MG (Apixaban) (1) Give 5 mg via PEG (percutaneous endoscopic gastrostomy)-Tube two times a day for blood thinner. Order Date: 01/31/2025. The eMAR for R2 dated 2/1/25-2/28/25 documented the Apixaban administered on 2/1/25-2/14/25. The eMAR documented anti-coagulant monitoring beginning on night shift 2/12/25. It failed to evidence monitoring from 2/1/25-2/11/25. The comprehensive care plan for R2 documented in part, I am on anticoagulant therapy r/t PE (pulmonary embolism), Other Pulmonary Embolism without Acute Cor Pulmonale. Date Initiated: 01/21/2025. Under Interventions/Tasks it documented in part, Monitor/record/report PRN (as needed) s/sx (signs/symptoms) of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, bruising, sudden severe headaches, nausea, vomiting, muscle joint pain, lethargy, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Date Initiated: 01/21/2025 . On 5/1/25 at 10:28 a.m., an interview was conducted with LPN (licensed practical nurse) #8 who stated that residents who took anticoagulants were monitored for any adverse effects every shift. She stated that they watched for any bruising or bleeding and it was evidenced by their documentation on the eMAR normally. The facility policy, Anticoagulation-Clinical Protocol documented in part, .The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems . The facility policy Medication and Treatment Orders documented in part, .Orders for anti-coagulants will be prescribed only with appropriate clinical and laboratory monitoring . On 5/1/25 at 4:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #6, the regional clinical staff were made aware of the concern. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit. Reference (1) Apixaban is used to help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease . This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a613032.html

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to prevent significant medication errors for one of 25 residents, Resident #5. The findings include: For Resident #5 (R5), the facility staff failed to administer Midodrine (1) as ordered prior to dialysis when the blood pressure was in the parameters set for administration. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/9/24, the resident was assessed as receiving dialysis while a resident at the facility. The physician orders for R5 documented in part, - Midodrine HCl Oral Tablet 10 MG (Midodrine HCl) Give 1 tablet by mouth as needed for hypotension before dialysis 3 days a week Hold for systolic of 140 or more. Order Date: 11/04/2024. Start Date: 11/04/2024. End Date: 01/21/2025. Review of the Hemodialysis Communication Records for R5 from 11/3/24-1/19/25 documented the following dates and pre-dialysis blood pressures. - 11/4/24 blood pressure 135/72, no medication documented as administered before going to dialysis. - 11/6/24 blood pressure 126/70, no medication documented as administered before going to dialysis. - 11/8/24 blood pressure 120/68, no medication documented as administered before going to dialysis. - 11/11/24 blood pressure 118/70, no medication documented as administered before going to dialysis. - 11/25/24 blood pressure 130/72, no medication documented as administered before going to dialysis. - 12/2/24 blood pressure 130/68, no medication documented as administered before going to dialysis. - 12/4/24 blood pressure 122/68, no medication documented as administered before going to dialysis. - 12/11/24 blood pressure 128/62, no medication documented as administered before going to dialysis. - 12/16/24 blood pressure 127/51, no medication documented as administered before going to dialysis. - 12/18/24 blood pressure 134/72, no medication documented as administered before going to dialysis. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 12/20/24 blood pressure 128/72, no medication documented as administered before going to dialysis. - 12/23/24 blood pressure 133/68, no medication documented as administered before going to dialysis. - 1/1/25 blood pressure 129/71, no medication documented as administered before going to dialysis. - 1/6/25 blood pressure 138/78, no medication documented as administered before going to dialysis. - 1/10/25 blood pressure 138/68, no medication documented as administered before going to dialysis. - 1/13/25 blood pressure 122/68, no medication documented as administered before going to dialysis. The eMARs (electronic medication administration records) for R5 dated 11/1/24-11/30/24, 12/1/24-12/31/24 and 1/1/25-1/31/25 documented the Midodrine order but failed to evidence administration of the medication to R5 when they were a resident at the facility. The comprehensive care plan for R5 documented in part, I need Hemodialysis r/t ESRD (end stage renal disease), left arm AV fistula. Date Initiated: 11/03/2024. It further documented, I have a behavior problem due to refusal or care, Dialysis, medications, being combative, and yelling out frequently. Date Initiated: 11/04/2024. Under Interventions/Tasks it documented in part, Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 11/04/2024 . On 5/1/25 at 10:28 a.m., an interview was conducted with LPN (licensed practical nurse) #8 who stated that they worked with R5 at the facility. She stated that when residents went to dialysis, they filled out the dialysis communication record prior to sending them to the dialysis unit for the treatment. She stated that the vital signs documented on the dialysis communication would be the ones taken prior to them leaving the unit and would be the ones they used to determine if any as needed Midodrine would be administered. LPN #8 reviewed the order for Midodrine for R5 and stated that the medication should have been administered as needed on the dialysis days when the blood pressure was below 140 prior to sending them to the dialysis unit. On 5/1/25 at 1:17 p.m., an interview was conducted with ASM (administrative staff member) #11, medical doctor. ASM #11 stated that they followed the recommendations that the nephrologist gave them for dialysis residents and his expectation when he wrote the order listed above was for the staff to check the blood pressure prior to sending R5 to dialysis and give them the medication unless the blood pressure was over 140. ASM #11 stated that these parameters were set by the nephrologist because often the residents' blood pressures would drop during dialysis, and he had seen residents with blood pressures in the 170-180's drop to the 70-80's. The facility policy Administering Medications documented in part, Medications are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescriber orders, including any required time frame . On 5/1/25 at 4:10 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #6, the regional clinical nurse were made aware of the concern. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit. Reference: (1) Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine is in a class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a616030.html

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to follow infection control practices for three of 25 residents in the survey sample, Residents #10, #7 and #13. The findings include: 1. For Resident #10 (R10), the facility staff failed to follow infection control practices during tracheostomy care observed on 5/1/25. The MDS (minimum data set) assessment was not due at the time of the survey. On the admission assessment dated [DATE], R10 was assessed as having a tracheostomy and being alert and oriented to person, place, time and situation. The baseline care plan for R10 documented in part, I have a tracheostomy r/t Dependence on mechanical ventilator, Impaired breathing mechanics, Respiratory Failure. Date Initiated: 04/24/2025. On 5/1/25 at 8:33 a.m., an observation was made of OSM (other staff member) #10, respiratory therapist performing tracheostomy care for R10. OSM #10 was observed to don a gown and clean gloves prior to placing supplies on the overbed table, positioning and raising the overbed table, picking the bed remote off the floor and elevating the bed, and adjusting the bed covers. After preparing the resident, OSM #10 continued to remove the oxygen collar, inner cannula and soiled split gauze from around the tracheostomy tube. While still wearing the soiled gloves, OSM #10 opened the tracheostomy care supplies and set up the sterile field, donned sterile gloves over the contaminated gloves and proceeded to provide tracheostomy care to the outer cannula and stoma. After cleaning the stoma and outer cannula, OSM #10 removed the sterile gloves and continued to wear the contaminated gloves to insert a new inner cannula, place a new split gauze and new tracheostomy tie. She then removed the gloves and washed her hands. On 5/1/25 at 8:57 a.m., an interview was conducted with OSM #10. When asked about double gloving, OSM #10 stated that they were taught that way in school and were told when you put the sterile gloves on you were in a sterile field and the other parts were not part of the sterile process. When asked if the gloves that the sterile gloves were placed over were contaminated after touching the blanket, overbed table, bed control and then removing the soiled split gauze, inner cannula and oxygen mask, she stated that they were, and she should have removed the gloves prior to donning the sterile gloves. She stated that she should have had new gloves on when replacing the inner cannula, trach tie and split gauze. The facility policy Tracheostomy Care documented in part, . 4. Apply clean gloves . 8. Remove old dressings. Pull soiled glove over dressing and discard into appropriate receptacle. 9. Perform hand hygiene . Clean the Stoma and Surrounding Site: 1. Apply clean gloves. 2. Clean the stoma . 3. Apply a fenestrated gauze pad around the insertion site, touching only the outer edges. 4. Replace neck ties . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the CDC's (Centers for Disease Control) clinical safety: Hand hygiene for healthcare workers dated 2/27/24, it documented in part, .Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings. Always clean your hands after removing gloves . When to change gloves and clean hands. If gloves become damaged. If gloves become soiled with blood or body fluids after a task. If moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurs. If moving from care on one patient to another patient. If they look dirty or have blood or body fluids on them after completing a task. Before exiting a patient room . This information was obtained from the website: https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html On 5/1/25 at 4:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #6, the regional nurse were made aware of the findings. No further information was provided prior to exit. 3. For Resident #13 (R13) the facility staff failed to provide a clean pillowcase to replace one with potentially infectious bodily fluids on it during observations on 4/29/25 and 4/20/25. A review of R13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/4/25, R13 was coded as being totally dependent on facility staff for turning and positioning. He was admitted with a diagnosis of paraplegia. He was coded as being cognitively intact for making daily decisions. On the following dates and times, R13 was observed sitting up in bed. At each observation, R13's right foot was propped on a pillow which had a moderate amount of blood on the pillowcase. The blood was in contact with R13's left leg: 4/9/25 at 1:43 p.m. and 4:55 p.m.; 4/30/25 at 7:50 a.m. and 10:15 a.m. On 4/30/25 at 10:17 a.m., R13 was interviewed. He stated no staff member offered to change the pillowcase all night the previous night. On 5/1/25 at 9:20 a.m., LPN (licensed practical nurse) #1 was interviewed. He stated a resident should not have to have a bloody pillowcase in contact with any part of his body. He stated this was an infection control concern. On 5/1/25 at 12:52 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated a resident should not have to have a bloody pillowcase in contact with any part of his body. She added: This is infection control. She stated if she had provided evening care for R13 on 4/29/25, she would have removed all of the sheets and blankets covering him to give him a bed bath. She would have noticed the soiled pillowcase and changed it. On 5/1/25 at 4:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #6, the regional clinician, were informed of these concerns. No additional information was provided prior to exit. 2. For Resident #7 (R7), the facility staff failed to implement transmission-based precautions per a physician's order. (continued on next page)

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	495272	A. Building B. Wing	05/02/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R7's clinical record revealed a physician's order dated 4/24/25 for contact precautions for seven days for a diagnosis of shingles. On 4/29/25 at 3:25 p.m., an observation of CNA (certified nursing assistant) #5, CNA #6, and CNA #7 transferring R7 from the wheelchair to the bed with a mechanical lift was conducted. The CNAs wore gloves but did not wear gowns. A sign for enhanced barrier precautions (not contact precautions) was posted on the room door. On 4/29/25 at 3:25 p.m., an interview was conducted with CNA #5, CNA #6, and CNA #7. CNA #5, CNA #6, and CNA #7 stated they transferred R7 to bed and checked to make sure the resident did not have an incontinent episode. CNA #5, CNA #6, and CNA #7 stated they wore gloves but did not wear gowns and R7 was not on isolation precautions. On 5/1/25 at 4:36 p.m., ASM (administrative staff member) #1 (the regional consultant) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Isolation-Categories of Transmission-Based Precautions documented, Contact Precautions: 8. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room . The CDC (Centers for Disease Control and Prevention) documented Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. This information was obtained from the website: https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html The CDC further documented, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO (multidrug-resistent organism) colonization status Infection or colonization with an MDRO. This information was obtained from the website: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html No further information was presented prior to exit.