STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ghent Health and Rehabilitation	3900 Llewellyn Ave Norfolk, VA 23504

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, the facility staff failed to respect residents' personal clothing and to ensure items were returned after laundering for 3 of 80 residents (Residents #20, #107, and #58) in the survey sample. The findings included: 1. The facility staff failed to protect and maintain Resident #20's personal clothing that was sent to the laundry. Resident #20 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included a stroke, hemiparesis, and aphasia. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 1/6/26, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 11 out of 15. This indicated that Resident #20's cognitive abilities for daily decision-making were moderately impaired. On 2/4/26 at approximately 9:24 AM, Resident #20 stated that he had sent clothing to the laundry over a week ago and had not been returned. The resident patted his chest and repeatedly stated that it was nasty that he had to wear the same clothing over and over, because his clothing was not returned. The resident was observed on 2/4/26 at approximately 2:18 PM asking staff for assistance in retrieving his clothing from the laundry. On 2/5/26 at approximately 11:00 AM, Resident #20 was observed asking staff to assist him in retrieving his clothing from the laundry. On 2/6/26 at approximately 11:55 AM, an interview was conducted with Resident #20 in his room with the Assistant Director of Nursing (ADON) present. The ADON assured the resident that someone would go to the laundry to retrieve her clothing. On 2/11/26 at approximately 5:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, [NAME] President of Operations, and the Corporate Nurse Consultant. The above findings were conveyed to the administrative team. The Administrator stated that the facility staff was unable to locate Resident #20's clothing; therefore, new clothing was purchased for him, and his name was added to the items to facilitate their return after laundering. 2. The facility staff failed to ensure Resident #107's personal clothing was returned to him after laundering. Resident #107 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included a stroke, diabetes, and a seizure disorder. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 1/2/26, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 13 out of 15. This indicated that Resident #107's cognitive abilities for daily decision-making were intact. On 2/4/26 at approximately 10:27 AM, the resident stated that all of his clothing was missing because his clothing was not returned from the laundry after the items were sent out for cleaning. Resident #107 stated that staff continues to bring other residents' clothing in his size, but he wants his clothing returned. Resident #107 pointed to a pair of jeans and a sweater on his bed and stated that the staff donated them to him this morning. The resident further stated that he watches other residents to see who will show up wearing his clothing. On 2/6/26 at approximately 11:55 AM, an interview was conducted with Resident #107 regarding his (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missing clothing, with the Assistant Director of Nursing (ADON) present. The ADON assured the resident that a staff member would make every effort to locate his missing clothing and return the items to him. On 2/11/26 at approximately 5:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, [NAME] President of Operations, and the Corporate Nurse Consultant. The above findings were conveyed to the administrative team, who made no comments and expressed no concerns. 3. The facility staff failed to assist Resident #58 in keeping his personal clothing in his possession after laundering. Resident #58 was admitted to the facility on [DATE]. The resident's diagnoses included a stroke, atrial fibrillation, and dementia. The annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 12/24/25, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 14 out of 15. This indicated that Resident #58's cognitive abilities for daily decision-making were intact. On 2/3/26 at approximately 3:59 PM, Resident #58 was observed seated on his bed wearing a navy blue puffer jacket. The resident stated that he and his brother were sharp dressers while growing up in [NAME], and that not having his personal clothing was extremely difficult. The resident stated that all his coats were missing, and he was afraid to remove the one he was wearing because it might be lost. On 2/6/26 at 10:15 AM, an observation was made of him having his face shaved and his hair cut in his room. At approximately 11:05 AM, the resident was observed coming out of the shower room. He stated that he had enjoyed a warm shower and was returning to his room for lunch. On 2/6/26 at approximately 11:55 AM, an interview was conducted with Resident #58 regarding his missing clothing, with the Assistant Director of Nursing (ADON) present. The ADON assured the resident that a staff member would make every effort to locate his missing coats and return the items to him. On 2/11/26 at approximately 5:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, [NAME] President of Operations, and the Corporate Nurse Consultant. The above findings were conveyed to the administrative team, who made no comments and expressed no concerns.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, a review of the clinical record, and facility documents, the facility staff failed to protect the residents' right to be free from verbal and physical abuse for 1 of 80 residents (Resident #3) in the survey sample. The findings included: Resident #3 was initially admitted to the facility on [DATE] from a community home. The residents' diagnoses included dementia, a psychotic disorder, and an anxiety disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/9/26, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 12 out of 15. This indicated Resident #3's cognitive abilities for daily decision making were intact. In section GG0130. (Self-Care), The resident was coded as requiring setup or clean-up assistance with eating, partial/moderate assistance with upper and lower body dressing, and putting on footwear, dependent on toileting, oral hygiene, and showers/baths.A review of facility documents revealed that Certified Nursing Assistant (CNA) #10 was verbally and physically abusive to Resident #3 on 4/16/25 during and after a shower. A report was filed alleging that CNA #10 called the resident a witch multiple times and, while traveling in the corridor after her shower, rolled the resident in front of a fan, causing her to yell due to discomfort from the cold air.An interview was conducted with the Resident #3 on 2/10/26 at 9:24 AM. The resident stated that no staff member mistreated her. The resident also stated she has a bad temper and is very vocal, which irritates people. On 2/10/26 at 9:53 AM, an interview was conducted with CNA #9. CNA #9 stated that Resident #3 takes showers without conflict. She stated that the resident will say I'm cold during care. CNA #9 further stated that the resident is not aggressive but becomes impatient during care.On 2/10/26 at 9:58 AM, an interview was conducted with Licensed Practical Nurse (LPN) #8. LPN #8 stated that whenever there is an allegation of abuse anywhere in the facility, all staff are educated on abuse, and at least once per year, they have to complete the abuse in-service. LPN #8 stated that the resident is often difficult to care for and that, at times, two staff members are required to provide her care. LPN #8 stated that she instructs the CNA staff that, whenever behaviors are exhibited, they should ensure the resident is safe, step away, report the behaviors to the nurse, and return later.The facility conducted the following actions after the allegation was voiced. The resident was interviewed and assessed for further abuse. The resident was referred for psychological services for her psychosocial well-being. All other residents the employee had cared for were interviewed and/or assessed for indications of abuse. Staff training on abuse was validated by signatures. The employee was suspended during the investigation and later terminated. The allegation and finding were reported to the state agency. A further review revealed the staff member had no criminal past and she had completed two abuse in-services over the year. No current findings of abuse were identified during the survey.On 2/11/26 at approximately 5:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, the Regional [NAME] President, and the Corporate Nurse Consultant. The above findings were conveyed to the administrative team, who made no comments and voiced no concerns.

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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. Based on staff interview, clinical record review, facility document review, the facility staff failed to investigate an allegation of abuse for one of 80 residents in the survey sample, Resident #170 (R170). The findings include:For Resident #170 (R170), facility staff failed to investigate an allegation of abuse. R170 was admitted to the facility with a diagnosis that included but not limited to paraplegia (1), and depression. On the most recent MDS (minimum data set), a discharge assessment with an ARD (assessment reference date) of 10/27/2023. Section C0700 Cognitive Skills for Daily Decision Making coded R170 as Independent - decisions consistent/reasonable. The facility's nursing progress note for R170 dated 10/27/2023 documented, 05:47 (5:47 a.m.) Note Text : can reported to this nurse that another resident stated that this resident (R170) pulled out a knife on him and that he was afraid for his life. DON (Director of Nursing) was called and made aware. Resident is to be 1:1 (one-to-one) and to stay in his room per DON. This nurse called 911. police arrived and spoke with both residents. officer stated that they did not have protocol to search his things. This nurse and cna (certified nursing assistant) went in resident [sic] to search his things. resident refused to let us search his bags but did allow us to search everything else. resident refused to stay in his room and went off unit. Review of facility documents failed to evidence that an incident report and investigation was conducted by the facility regarding the incident on 10/27/2023. On 02/11/2026 at approximately 8:12 a.m. an interview was conducted with the facility's Administrator (ADM) regarding the procedure for completing a facility related incident (FRI). She stated that a FRI is initiated by her when there is an incident outside of daily operations such as a resident-to-resident altercation, staff-to-resident altercation, allegations of abuse, neglect or mistreatment, injury of unknown origin, etc The ADM stated that she notifies the Ombudsman, APS (adult protective services), the state agency (office of licensure and certification) and the police if necessary of the alleged allegation and then initiates an investigation that includes interviews with the parties involved and obtains witness statements and review of the resident's clinical record if necessary. The ADM stated that she has five days to complete the investigation and send her findings to the parties listed above. She also stated that if there is an allegation of abuse the investigation needs to be initiated within two hours of being informed of the allegation. Regarding the allegation of R170 threatening a resident with a knife she stated that she could not locate a facility investigation and further stated that an investigation should have been initiated. The facility's policy Compliance with Reporting Allegations of Abuse/Neglect/Exploitation documented in part, It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. On 02/11/2026 at approximately 4:40 p.m., ASM, the DON and the Regional Director, were made aware of the above findings. No further information was provided prior to exit. References:(1) The symptom of paralysis that mainly affects your legs. This information was obtained from the website: https://my.clevelandclinic.org/health/symptoms/23984-paraplegia.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for two of 80 residents, Resident #173 and Resident #137. The findings include: 1. For Resident #173 (R173), the facility staff failed to implement the comprehensive care plan to provide pain medications per order. On the most recent minimum data set (MDS), an admission assessment with an assessment reference date (ARD) of 4/5/2024, the resident was assessed as having a surgical wound, receiving scheduled pain medication and having occasional pain. The comprehensive care plan for R173 documented in part, [R173] actual impaired skin to Lower back r/t (related to) Laminectomy. Date Initiated: 04/01/2024. Under Interventions it documented in part, Treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort. Date Initiated: 04/01/2024 . It further documented, [R173] has pain r/t Wound (surgical). Date Initiated: 04/11/2024. The emergency room discharge notes dated 3/28/2024-3/29/2024 documented in part, .Your current discharge medications are: . Hydrocodone-Acetaminophen (Norco 5) (1) 5-325mg po (by mouth) tabs take 1 tab by mouth every 4 hours for 5 days . The physician orders for R173 documented in part, Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (milligram) (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours for pain until 04/03/2024 23:59 (11:59PM). Order Date: 3/29/2024. Review of the electronic medication administration record (eMAR) for R173 dated 3/1-3/31/2024 documented the Hydrocodone-Acetaminophen scheduled to begin on 3/29/2024 at 4:00 PM. The eMAR further documented R173 not receiving the scheduled doses on 3/29/2024 at 8:00 PM, 4/30/2024 at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM and 4:00 PM. Review of the progress notes for R173 documented in part, - 3/29/2024 20:25 (8:25 PM) Note Text: New admit. Pharmacy stated did not receive fax. Called [Name of nurse practitioner] to e-scribe new order. - 3/30/2024 00:58 (12:58 AM) Note Text: Called pharmacy to check status. Stated they never received a prescription through the fax or escribe done earlier. Called on-call regarding a new e-scribe for medication. - 3/30/2024 04:05 (4:05 AM) Note Text: Spoke with on call. Informed provider would not have access to send rx (prescription) to pharmacy until 8am. Instructions to hold medicine until then. - 3/30/2024 16:31 (4:31 PM) Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG. Give 1 tablet by mouth every 4 hours for pain until 04/03/2024 23:59. Waiting pharmacy delivery. MD aware. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/2026 at approximately 2:00 PM, the director of nursing (DON) provided a list of in-house medication stock and stated that as far as she knew it was the same as what was available in March of 2024. Review of the in-house medication stock list documented a house par level of 10 Hydrocodone-Acetaminophen 5-325mg tablets available in the facility. On 2/9/2026 at 9:42 AM, an interview was conducted with registered nurse (RN) #2 who stated that medications were reconciled on admission with the discharge summary from the hospital and confirmed with the physician prior to being sent to the pharmacy. She stated that the normal turn around time to receive the medications was within 24 hours and anything needed urgently was pulled from the in-house medication stock or delivered to them from the pharmacy stat. RN #2 stated that the purpose of the care plan was to show the residents goals, treatment plan and what they needed to do for the resident. She stated that the care plan should be implemented so that everyone knew what was happening with the resident and everyone could access it. On 2/9/2026 at 2:14 PM, an interview was conducted with licensed practical nurse (LPN) #1, unit manager. LPN #1 stated that residents medications were taken from the discharge summary and verified with the physician on admission. She stated that the orders were sent to the pharmacy and any narcotic orders were escribed or a written prescription was sent by fax. LPN #1 stated that prior to the pharmacy delivering the medications they were able to pull medications from the in-house medication stock by calling the pharmacy and getting a code. On 2/9/2026 at 2:28 PM, an interview was conducted with LPN #5 who stated that when medications had not been delivered by the pharmacy they could call the pharmacy to have them send over stat or they could provide them a code to pull the medication from the in-house medication stock. She stated that she had worked at the facility for the past three years and they had the same in-house medication system for the three years. On 2/9/2026 at 3:02 PM, an interview was conducted with the DON who stated that medications were verified with the physician on admission and then were pushed through to the pharmacy. She stated that they kept the in-house medication stock due to insurance issues or issues getting medications. The DON stated that all nurses had access to the in-house medication and the nurses received a code from the pharmacy to pull out medications with a witness required to remove narcotics. The facility policy Comprehensive Care Plans revised 11/14/2025 documented in part, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality . On 2/10/2026 at 4:37 PM, the administrator and director of nursing were made aware of the concern. No further information was provided prior to exit. Reference: (1) Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	severe pain . This information was obtained from the website: Hydrocodone Combination Products: MedlinePlus Drug Information 2. The facility staff failed to develop the comprehensive care plan for fluid restriction monitoring for Resident #137 (R137). R137 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: ICH (intracranial hemorrhage) DM (diabetes mellitus) and TIA (transient ischemic attack). R137's most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 2/2/26, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as maximal assist for bed mobility, transfer, hygiene. A review of R137's comprehensive care plan dated 1/29/26 revealed, FOCUS: The resident has an ADL (activity of daily living) self-care performance deficit related to impaired mobility. INTERVENTIONS: Praise all efforts at self-care. A review of the physician's order dated 1/26/26 revealed, Fluid Restriction - 1420cc / day. A review of the January and February 2026 MAR-TAR (medication administration record-treatment administration record) did not evidence any fluid restriction monitoring. A review of R137's meal slips did not reveal any evidence of fluid restriction monitoring. An interview was conducted on 2/5/26 at 9:30 AM with R137, when asked if he is on a fluid restriction, R137 stated, not that I know of. An interview was conducted on 2/5/26 at 1:30 PM with LPN (licensed practical nurse) #3, when asked what steps are taken to monitor a fluid restriction, LPN #3 stated, we would watch what his intake was. Asked the purpose of the care plan, LPN #3 stated to identify the interventions needed to care for each resident. Asked if the fluid restriction should be on the care plan, LPN #3 stated, yes, it should. On 2/9/26 at 5:00 PM the administrator and the director of nursing, RN (registered nurse) was made aware of the concerns. No further information was provided prior to exit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to provide ADL care for six dependent residents (Resident #9, Resident #106, Resident #109, Resident #12, Resident #35, and Resident #169) in a survey sample of 80 residents. The finings include:1.The facility staff failed to ensure Activity of Daily Living (ADL) care and incontinent care was carried out appropriately. Resident #106 was originally admitted to the facility 5/12/25 after an acute care hospital stay and re-admitted on [DATE].?The current diagnoses included; Urinary Tract Infection. ? ? The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/17/2025 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #106 cognitive abilities for daily decision making were intact.??? The personal-centered care plan dated 11/19/25 reads the resident has an indwelling catheter (20Fr 10cc) r/t Urinary Retention. The Goal for the resident is that he will be/remain free from catheter-related trauma through the review date. The Intervention: Check tubing for kinks each shift, and the resident has (20 FR.) (Foley Catheter). Position the catheter bag and tubing below the level of the bladder and away from the entrance room door. In section GG(Functional Abilities Goals) the resident was coded as dependent with toileting hygiene, shower/bathe self and putting on taking off footwear. Requiring supervision or touching assistance with personal hygiene, requiring partial to moderate assistance with upper and lower body dressing and Independent with eating. requiring supervision or touch assistance with eating, oral hygiene and personal hygiene. In section H (Bladder and Bowel) the resident was coded as having an indwelling catheter. On 2/06/26 at approximately 10:00 am, permission was received from Resident #106 to observe an Activity of Daily Living (ADL), a bed bath. On 2/06/26 at approximately 10:02 am, an observation of a bed bath and incontinence care was conducted with Certified Nursing Assistant (CNA) #8. CNA #8 was observed giving the resident a bath and providing incontinent care in the following order: CNA donned gloves, removed dirty linens from the bed, and placed them in a clear bag on the floor. The resident was not provided with a bed/bath blanket or was covered with a towel during the entire bed bath (the resident remained exposed). CNA had one basin filled with water. CNA retrieved hygiene bottles from the top drawer of the dresser next to the resident's bed. CNA lathered a washcloth and began washing the resident's right upper body, back, and legs/feet. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA used a dry towel to wipe off the resident. CNA did not rinse soap off the resident's body; used lotion on the resident's back. CNA began removing dirty linens on the right side of the bed. CNA then removed the brief to perform incontinence care- no bed/bath blanket or towel was utilized. CNA placed the same washcloth used to bathe the resident in soapy water to clean up the resident after a bowel movement. CNA then placed a washcloth in the dirty linen bag. On 2/06/26 at approximately 12:06 pm., a brief interview was conducted with CNA #8 concerning not rinsing the soap off of the resident and using the same washcloth to provide incontinent care. CNA #8 said that she was taught to give bed baths like she performed them today. On 2/10/26 at approximately 4:30 pm., during the end-of-day meeting, the above concern was discussed with the Director of Nursing (DON), the Administrator, and the Regional Director. 2. The facility staff failed to ensure the residents' chin hair was removed. Resident #9 was originally admitted to the facility on [DATE] after an acute care hospital stay and re-admitted on [DATE].?The current diagnoses included a need for assistance with personal care and an overactive bladder. ? The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/27/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated that Resident #106's cognitive abilities for daily decision making were intact.??? The person-centered care plan read that Resident #9 has ADL self-care performance deficit r/t impaired gait, and generalized weakness. The Goal for Resident #9 is that the resident will maintain current level of function. Interventions for the resident is to praise resident for self-care and encourage the resident to use the call bell for assistance. In section GG(Functional Abilities Goals), the resident was coded as set up or clean up assistance with shower/bathe self, oral hygiene, and personal hygiene. Independent with eating and toileting hygiene. On 2/05/26 at approximately 8:48 am, the resident was observed ambulating in her room, and a few medium-length strands of chin hair were noted. On 2/06/26 at approximately 9:40 am, an interview was conducted with Resident #9, who indicated that she would like to get her hair cut. The resident was asked whether she wanted her chin or facial hair trimmed. She replied, Yes, both. On 2/09/26 at 3:05 pm, a brief interview was conducted with Certified Nursing Assistant (CNA) #11. CNA #11 said that when residents receive showers twice a week, other ADL care should be provided, such as removing facial hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/10/26 at approximately 1:27 pm, an interview was conducted with Licensed Practical Nurse (LPN) #4, concerning Resident #9's chin/facial hair. LPN #4 said that removing chin hair is a part of ADL care. On 2/10/26 at approximately 4:30 pm., during the end-of-day meeting, the above concern was discussed with the Director of Nursing (DON), the Administrator, and the Regional Director. 3. The facility staff failed to ensure Resident #109 received at least two (2) showers a week, including washing her hair. Resident #109 was originally admitted to the facility 05/23/25 after an acute care hospital stay. The resident had never been discharged from the facility. The current diagnoses included: need for assistance with personal care and unspecified urinary incontinence. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/25/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 4 out of a possible 15. This indicated Resident #109 cognitive abilities for daily decision making were severely impaired. Blvd In sectionGG(Functional Abilities) the resident was coded as being dependent with eating, oral hygiene, toileting, shower/bathe self and personal hygiene. The person-centered care plan dated 5/03/25 read that the resident requires assistance with toileting hygiene r/t incontinence of bowel and bladder. The Goal was that the resident would remain free from skin breakdown due to incontinence and brief use through the review date. The interventions are: clean the peri-area with each incontinence episode; monitor/document for s/sx of UTI; and monitor/document/report as needed (PRN) any possible causes of incontinence. On 02/04/2026 at approximately 12:30 pm., during the initial tour, an interview was conducted with the resident and her daughter concerning Activity of Daily Living (ADL) care. Resident #109's daughter would interpret because the resident spoke mostly Spanish. The daughter inferred from her mother that she would like more showers and to have her hair washed. The resident's daughter got up and went to the closet tacking out a bath basin that had foam taped around it. The resident's daughter said that because the facility won't wash her hair, she uses the bath basin and washes her mother's hair at bedside. A review of the ADL document for February 2026 showed that the Resident received baths/showers on Wednesday and Saturday during the 7:00 am-3:00 pm. shift. The ADL sheet did not show a breakdown of showers or bed baths; they were combined. A review of the ADL document for January 2026 showed that the Resident received missed baths/showers on Saturday January 24th 2026. A review of the ADL document for December 2025 revealed that no baths/showers were documented as given on the following days: Wednesday December 3rd and Saturday December 13th. On 2/11/26 at approximately 4:40 pm., a brief interview was conducted with CNA #12 concerning Resident #109 receiving showers. CNA #12 said that the resident is scheduled to get showers on Wednesdays and Saturdays. CNA #12 also reviewed the shower book, which showed that the resident received only (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 shower per week from December 2025 through January 2026. CNA #12 was asked if she could get the unit manager to give make a copy of the shower sheets. The Unit manager and Director of Nursing were approached on numerous occasions on 2/11/26 for a copy of the resident's bath/shower sheet, but neither provided one. On 2/11/26 at approximately 5:30 pm., during the pre-exit, the above concern was discussed with the Director of Nursing (DON), the Administrator and with the Regional Director. No comments were made. 4.The facility staff failed to provide ADL (activities of daily living) specifically incontinence care for a dependent resident, Resident #12 (R12). R12 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular attack), DM (diabetes mellitus) and epilepsy. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/1/26, coded the resident as scoring an 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers/bathing/dressing; dependent for toileting and supervision for eating. A review of the comprehensive care plan dated 5/13/24 revealed, FOCUS: Resident has an ADL self-care performance deficit related to Hemiplegia, Impaired balance, Limited Mobility, and Stroke. INTERVENTIONS: Toileting/ PERSONAL HYGIENE/ORAL CARE: The resident requires limited to extensive assistance by staff to maximize independence. A review of the ADL (activities of daily living) record revealed missing documentation for 'hygiene, bowel and bladder continence' on the following dates and shifts: December 2025-evening shift: 12/2, 12/3, night shift: 12/3, 12/28, and 12/31; January 2026-day shift: 1/23, night shift: the 4th and 1/31. An interview was conducted on 2/5/26 at 2:05 PM with CNA (certified nursing assistant) #4. Asked the incontinence care process, CNA #4 stated, we round on the residents and provide incontinence care. Asked if there are time frames for incontinence care to be provided, CNA #4 stated, about every two hours. When asked where the care is documented, CNA #4 stated, on the ADL form in PCC (point click care), we use our tablets. Asked if that is where evidence of care is documented, what does missing documentation designate, CNA #4 stated, if it was not documented, it was not done. On 2/10/26 at 5:00 PM the administrator and the director of nursing, RN (registered nurse) were made aware of the concerns. No further information was provided prior to exit. 5.The facility staff failed to provide ADL (activities of daily living) specifically incontinence care for a dependent resident, Resident #35 (R35). R35 was admitted to the facility on [DATE] with diagnosis that included but were not limited to traumatic subdural hemorrhage, syncope, falls and COPD (chronic obstructive pulmonary disease) (continued on next page)

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

R35's most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 1/23/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as maximal assist for bed mobility, transfer, hygiene.

A review of R35's comprehensive care plan dated 1/29/26 revealed, FOCUS: The resident has ADL (activities of daily living) self-care performance deficit related to impaired mobility. INTERVENTIONS: praise all self-care efforts.

A review of the ADL (activities of daily living) record revealed missing documentation for 'hygiene, bowel and bladder continence' on the following dates and shifts: January 2026-day shift: 1/21, night shift: 1/25 and 1/31.

An interview was conducted on 2/5/26 at 2:05 PM with CNA (certified nursing assistant) #4. Asked the incontinence care process, CNA #4 stated, we round on the residents and provide incontinence care. Asked if there are time frames for incontinence care to be provided, CNA #4 stated, about every two hours. When asked where the care is documented, CNA #4 stated, on the ADL form in PCC (point click care), we use our tablets. Asked if that is where evidence of care is documented, what does missing documentation designate, CNA #4 stated, if it was not documented, it was not done.

On 2/10/26 at 5:00 PM the administrator and the director of nursing, RN (registered nurse) were made aware of the concerns.

No further information was provided prior to exit.

6. For Resident #169 (R169) the facility staff failed to provide hygiene care.

For Resident #169 (R169) was admitted to the facility with a diagnosis that included but not limited to schizoaffective disorder (1), and depression.

On the most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 07/08/2022, R169 scored 6 (six) of 15 on the BIMS (brief interview for mental status), indicating R169 was severely impaired of cognition making daily decisions. Section G0110 Activities of daily Living (ADL) Assistance coded R169 as requiring one person assistance for personal hygiene (including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands).

Review of the ADL (activities of daily living) tracking sheet for R169's personal hygiene (combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands) dated November 2023 documented blanks on 11/05/2022 for the day shift (7:00 a.m. to 3:00 p.m.), evening shift (3:00 p.m. to 11:00 p.m.) and on the night shift (11:00 p.m. to 7:00 a.m.), 11/06/2022 for the day shift (7:00 a.m. to 3:00 p.m.), evening shift (3:00 p.m. to 11:00 p.m.) and Not Applicable on the night shift (11:00 p.m. to 7:00 a.m.).

Review of the ADL (activities of daily living) tracking sheet for R169's personal hygiene dated December 2023 documented blanks on 12/09/2022, 12/10/2022, 12/11/2022, 12/12/2022, 12/13/2022, 12/14/2022, 12/15/2022, 12/16/2022, 12/17/2022, 12/18/2022 and on 12/19/2022 for the day shift (7:00 a.m. to 3:00 p.m.), evening shift (3:00 p.m. to 11:00 p.m.) and on the night shift (11:00 p.m. to 7:00

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a.m.) each day. On 02/10/2026 at approximately 8:57 a.m. an interview was conducted with CNA (certified nursing assistant) #3 regarding hygiene care for R169. She stated that she did not recall R169. She also stated hygiene care included assisting the resident with washing, brushing teeth, combing their hair, dressing, providing incontinent care or toileting if needed. When asked how it is evidenced that a resident has received hygiene and ADL (activities of daily living) care she stated that it is documented in PCC (point click care) on the ADL tracking sheet. After reviewing the ADL tracking sheet for R169's personal hygiene listed above she stated that she did not know what the blanks indicated. On 02/10/2026 at approximately 9:25 a.m. an interview was conducted with RN (registered nurse) #1 regarding hygiene care for R169. When asked about providing hygiene care to a resident she stated the resident has their hair and face washed, hair combed, fingernails cleaned and trimmed if needed, showers or bed baths and incontinent care if needed. When asked how it is evidenced that a resident has received hygiene and ADL care she stated that it is documented in PCC. On 02/11/2026 at approximately 4:40 p.m., the administrator, DON and the Regional Director, were made aware of the above findings. No further information was provided prior to exit. Reference: (1) A mental condition that causes both a loss of contact with reality [psychosis] and mood problems [depression or mania]. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to provide care and services to promote healing of a surgical wound for 1 of 80 residents, Resident #173. The findings include:For Resident #173 (R173), the facility staff failed to assess and treat a surgical wound until 4/1/2024 after admission to the facility on 3/29/2024. On the most recent minimum data set (MDS), an admission assessment with an assessment reference date (ARD) of 4/5/2024, the resident was assessed as having a surgical wound and receiving surgical wound care. The emergency room discharge notes dated 3/28/2024-3/29/2024 documented in part, . here for getting placed into a rehab facility . She is also status post lumbar laminectomy done at [Name of hospital] on March 20. She was discharged home on March 22 to go home to her daughter's house with home health. Patient states that the home health nurse came out yesterday for the first time and that her daughter really cannot care for her at home and she wants to be placed in a rehab center until she can get back to normal functioning . Dressing over her laminectomy appears to be normal and was not taken down as is placed on March 23 . The nursing admission assessment for R173 dated 3/29/2024 documented no skin impairment. A skin assessment dated [DATE] documented in part, .Surgical incision to lower back. measurements 10x0.1x0.1 with one intact suture. Surgical wound 80% granulation tissue present and 20% scab. Moderate serous drainage . The assessment documented the surgical wound present on admission. The physician orders for R173 documented in part, Cleanse surgical wound of the lower back with wound cleanser and pat dry. Apply calcium alginate and a silicone foam dressing QD (every day) and prn (as needed) soilage until healed. every day shift for surgical wound care. Order Date: 04/01/2024. The physician orders failed to evidence a treatment to the surgical wound prior to 4/1/2024 or an order to not remove the dressing. Review of the electronic treatment administration record (eTAR) for R173 dated 3/1-3/31/2024 failed to evidence any treatments completed. The comprehensive care plan for R173 documented in part, [R173] actual impaired skin to Lower back r/t (related to) Laminectomy. Date Initiated: 04/01/2024. On 2/9/2026 at 9:42 AM, an interview was conducted with registered nurse (RN) #2 who stated that when a resident was admitted a full body skin assessment was completed to identify any wounds. She stated that she did not remember R173 but if they came in with a surgical wound they would remove the dressing to assess the site unless they came with an order from the physician to not remove the dressing. RN #2 stated that the wound assessment was documented in the clinical record and treatment orders were entered as sent from the surgeon or obtained from the facility physician. On 2/9/2026 at 2:14 PM, an interview was conducted with licensed practical nurse (LPN) #1, the unit manager, who stated that the admission nurse completed a head-to-toe skin assessment on each resident when they arrived. LPN #1 stated that any wounds should be identified on admission and treatment orders were obtained either from the hospital discharge summary or from the facility physician or nurse practitioner. She stated that any resident admitted with a surgical wound should have either a treatment in place or an order to not remove the dressing. On 2/9/2026 at 3:02 PM, an interview was conducted with the director of nursing (DON) who stated that normally they knew if resident had a surgical wound and treatment before they were admitted to the facility. She stated that the hospital normally advised them to leave a dressing in place or gave treatment orders and there would be orders placed in the medical record either way to alert staff. The DON stated that she would expect staff to contact the surgeons office or the case worker at the hospital to see what the treatment to the surgical wound should be and ideally have this in place prior to the resident arriving. The facility policy Skin Assessment revised 11/7/2025 documented in part, .A full body, or head to toe, skin (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment will be conducted by a licensed or registered nurse upon admission/re-admission, and weekly thereafter . On 2/10/2026 at approximately 4:37 PM, the administrator and DON were made aware of the concern. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 clinical record review, staff interview and facility document review, it was determined that the facility staff failed to provide care and services to implement a complete pain management program for 1 of 80 residents, Resident #173.The findings include:For Resident #173 (R173), the facility staff failed to provide Hydrocodone-Acetaminophen as ordered by the physician after admission to the facility. On the most recent minimum data set (MDS), an admission assessment with an assessment reference date (ARD) of 4/5/2024, the resident was assessed as having a surgical wound, receiving scheduled pain medication and having occasional pain.The emergency room discharge notes dated 3/28/2024-3/29/2024 documented in part, .Your current discharge medications are: . Hydrocodone-Acetaminophen (Norco 5) (1) 5-325mg po (by mouth) tabs take 1 tab by mouth every 4 hours for 5 days .The physician orders for R173 documented in part, Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (milligram) (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours for pain until 04/03/2024 23:59 (11:59PM). Order Date: 3/29/2024.Review of the electronic medication administration record (eMAR) for R173 dated 3/1-3/31/2024 documented the Hydrocodone-Acetaminophen scheduled to begin on 3/29/2024 at 4:00 PM. The eMAR further documented R173 missing doses on 3/29/2024 at 8:00 PM, 4/30/2024 at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM and 4:00 PM.Review of the progress notes for R173 documented in part,- 3/29/2024 20:25 (8:25 PM) Note Text: New admit. Pharmacy stated did not receive fax. Called [Name of nurse practitioner] to e-scribe new order.- 3/30/2024 00:58 (12:58 AM) Note Text: Called pharmacy to check status. Stated they never received a prescription through the fax or escribe done earlier. Called on-call regarding a new e-scribe for medication.- 3/30/2024 04:05 (4:05 AM) Note Text: Spoke with on call. Informed provider would not have access to send rx (prescription) to pharmacy until 8am. Instructions to hold medicine until then.- 3/30/2024 16:31 (4:31 PM) Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG. Give 1 tablet by mouth every 4 hours for pain until 04/03/2024 23:59. Waiting pharmacy delivery. MD aware. The comprehensive care plan for R173 documented in part, [R173] actual impaired skin to Lower back r/t (related to) Laminectomy. Date Initiated: 04/01/2024. Under Interventions it documented in part, Treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort. Date Initiated: 04/01/2024 . It further documented, [R173] has pain r/t Wound (surgical). Date Initiated: 04/11/2024. On 2/4/2026 at approximately 2:00 PM, the director of nursing (DON) provided a list of in-house medication stock and stated that as far as she knew it was the same as what was available in March of 2024.Review of the in-house medication stock list documented a house par level of 10 Hydrocodone-Acetaminophen 5-325mg tablets available in the facility.On 2/9/2026 at 2:14 PM, an interview was conducted with licensed practical nurse (LPN) #1, unit manager. LPN #1 stated that residents medications were taken from the discharge summary and verified with the physician on admission. She stated that the orders were sent to the pharmacy and any narcotic orders were escribed or a written prescription was sent by fax. LPN #1 stated that prior to the pharmacy delivering the medications they were able to pull medications from the in-house medication stock by calling the pharmacy and getting a code. On 2/9/2026 at 2:28 PM, an interview was conducted with LPN #5 who stated that when medications had not been delivered by the pharmacy they could call the pharmacy to have them send over stat or they could provide them a code to pull the medication from the in-house medication stock. She stated that she had worked at the facility for the past three years and they had the same in-house medication system for the three years. On 2/9/2026 at 3:02 PM, an interview was conducted with the director of nursing (DON) who stated that medications were verified with the physician on admission and then were pushed through to the pharmacy. She stated that they kept the in-house medication stock due to insurance issues or issues getting medications. The DON stated that (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all nurses had access to the in-house medication and the nurses received a code from the pharmacy to pull out medications with a witness required to remove narcotics.The facility policy Pain Management revised 9/24/2025 documented in part, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences .On 2/10/2026 at 4:37 PM, the administrator and director of nursing were made aware of the concern. No further information was provided prior to exit. Reference:(1) Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve severe pain . This information was obtained from the website: Hydrocodone Combination Products: MedlinePlus Drug Information

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident/staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to maintain an effective pest control program so that the facility is free of pests and rodents.The findings include: 1.Observations during the survey period of 2/3/26-2/6/26 and 2/9/26-2/11/26 revealed, observations of roaches and mice. On 2/4/2026 at 10:33 AM, an observation was made of Resident #129 in their room. A large brown roach was observed climbing up to the top of the nightstand and then proceeding to the back side of the nightstand. The roach was observed by two surveyors. On 2/4/26 no observations of pests and rodents in the kitchen. On 2/5/2026 at 6:45 AM, this surveyor observed a mouse running across hallway from the biohazard room on first floor to underneath the door of a locked room. A review of the pest control invoices revealed this number of invoices per month: 7/25-1, 9/25-6, 10/25-5, 11/25-6, 12/25-14 and 1/26-10. A review of the pest control logs for the units reveal the following: 1/25-3/25 (mice-2, roaches/ants-7), 4/25-6/25 (mice-9, roaches/ants-7), 7/25-10/25 (mice-16, roaches/ants-17), 11/25 (mice-6, roaches/ants-3), 12/25 (mice-2, roaches/ants-2), 1/26 (mice-4, roaches/ants-3), 2/26 (mice-1, roaches/ants-1). On 2/3/2026 at 12:50 PM, an interview was conducted with Resident #84, a cognitively intact resident, who stated that there was a mouse who lived in their room and he had discussed it with the assistant administrator because it came through the ventilation system. On 2/3/2026 at 2:00 PM an interview was conducted with Resident #28 (R28), a cognitively intact resident, who stated that he has had a mouse in his room that runs from under the door and goes behind the grey baseboard (baseboard is pulled up at one end). No observations of mouse in the room at the time. On 2/3/2026 at 3:33 PM, an interview was conducted with Resident #125 (R125), a cognitively intact resident, who stated that there had been roaches in the facility for quite a while and they had gotten better recently in their room. R125 stated that in December he had a roach fall out of the food dome when he opened his meal, so he had stopped eating for a while. R125 stated that there were mice at the facility and within the past week there had been a mouse coming in the room under the door with something in its mouth and was squeaking really loud. On 2/5/2026 at 10:28 AM, R125 stated that when maintenance came in to fix the motor in his heater yesterday, they found a dead mouse inside. R125 stated that he also saw a roach crawling up the wall in his room yesterday. On 2/4/2026, at 7:05 AM an interview was conducted with CNA (certified nursing assistant) #2 a night CNA. Asked about pests and rodents, CNA #2 stated, yes, we have them. Pest control comes three times a week and we keep a pest control log. You can hear something running in the ceiling at night. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ghent Health and Rehabilitation	3900 Llewellyn Ave Norfolk, VA 23504

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/2026 at 6:50 AM an interview was conducted with OSM (other staff member) #2, the maintenance director. He was informed of the mouse running across the hall into the locked room. OSM #2 went to the locked room, entered and looked for the mouse. OSM #2 stated, he must have gone behind the wall. When asked about the pest and rodents in the facility, OSM #2 stated, it has gotten better, we have a pest control company come three times a week. They review the pest logs on the units and treat those areas and any areas we are having difficulty with. I had heard about rodents in the ceiling and have put traps up there. Asked what education has been done for the residents, OSM #2 states, we tell them not to keep food out and to not have clothes on floors and stacked in chairs as rodents love to nest in them. On 2/5/2026 at 12:05 PM, an interview was conducted with Resident #7 (R7), a moderately impaired resident, who stated that he had seen some baby mice running around in his room yesterday. R7 stated that they did not get in his belongings but ran around the room. On 2/5/2026 at 1:00 PM, during resident council, Resident #34 (R34) a cognitively intact resident stated, that there was a mouse on a glue pad in his room. During observation at 4:00 PM, there was no observation of mouse on glue pad and no glue pad in room. Unable to locate any staff who may have removed mice. On 2/6/26 at 10:25 AM, an interview was conducted with OSM #3, the pest control representative. Asked about pest control for the facility, OSM #3 stated, they are on three times a week schedule. For rodent control we do traps in non-public areas and glue boards. Baiting in patient rooms and resident areas. We review the pest sighting logs and identify any other areas to treat. On 2/6/26 at 11:50 AM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. A review of the facility's Pest Control Program policy revealed, It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. No further information was provided prior to exit. 2. The facility staff failed to eradicate roaches from the environment. During the survey, observations were conducted in Unit 1B from 2/3/26 through 2/6/26 and from 2/9/26 through 2/11/26 because most interviewable residents reported roaches and mice in their rooms. On 2/4/26, a large brown roach was observed in the corridor lying on its back with its legs wiggling. On 2/6/26 at approximately 11:40 AM, while making observations of the unit with the Assistant Director of Nursing (ADON), a small dark colored roach was observed crawling quickly on the toilet seat in the bathroom of room [ROOM NUMBER]. The ADON closed the bathroom door and stated she would document the sighting on the pest control log. On 2/11/26 at approximately 5:00 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, [NAME] President of Operations, and the Corporate Nurse Consultant. The above findings were conveyed to the administrative team, who made no comments and voiced no concerns.