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

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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 - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, facility document review, and clinical record review, it was determined that the facility staff failed to maintain a clean and homelike environment for residents across four of the facility's four units, which constituted substandard quality of care (SQC). The findings include: 1. The facility staff failed to maintain a clean and homelike environment for Resident #35 (R35). Observation of the bathroom for room [ROOM NUMBER] on 2/3/26 evidenced no hot water. Water was left running for 4 minutes without it getting warm. 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) 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. During interview with R35 on 2/3/26 at approximately 1:00 PM, R35 stated that we do not have hot water, R35's daughter was present and verified she was unable to obtain hot water from bathroom sink. On 2/3/26 at 1:05 PM, an interview was conducted with CNA (certified nursing assistant) #1. Asked if the water was hot in the bathroom for room [ROOM NUMBER], CNA #1 stated, no, it is not getting warm. On 2/6/26 at 11:50, the administrator and Director of Nursing (DON) were made aware of the findings. A review of the facility's Safe and Homelike Environment policy which reveals, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Comfortable and safe temperature levels means that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia/ hyperthermia and is comfortable for the residents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	No further information was provided prior to exit. 2. The facility staff failed to maintain a clean and home-like environment for R47. Observation of the bathroom for room [ROOM NUMBER] on 2/3/26 evidenced no hot water and the toilet was on half to three fourths full of urine and did not flush. Water was left running for 4 minutes without it getting warm. Observation of bathroom form room [ROOM NUMBER] on 2/4/26 revealed, no hot water and toilet was approximately three fourths full and did not flush R47 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: OSA (obstructive sleep apnea), acute cystitis and malignant neoplasm of prostate. R47's most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 1/28/26, 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 moderate assist for bed mobility, transfer, hygiene. A review of R47's comprehensive care plan dated 1/22/26 revealed, FOCUS: The resident has a Urinary Tract Infection related to acute cystitis with hematuria. INTERVENTIONS: Encourage fluid intake and monitor/document/report to physician as needed signs/symptoms of UTI (urinary tract infection). During interview with Resident #47 on 2/3/26 at approximately 12:40 PM, R47 stated, we do not have hot water, the toilet does not flush and the heat went off last night 2/2/26. On 2/3/26 at 12:42 PM, an interview was conducted with CNA (certified nursing assistant) #1. Asked if the water was hot in the bathroom for room [ROOM NUMBER], CNA #1 stated, no, it is not getting warm. Asked if she was able to flush the toilet, CNA #1 stated, no, it does not flush. On 2/6/26 at 11:50 AM, the administrator and DON were made aware of the findings. No further information was provided prior to exit. 3. The facility staff failed to maintain a clean and homelike environment for Resident #137 (R137). Observation of the bathroom for room [ROOM NUMBER] on 2/3/26 evidenced no hot water and the toilet was on half to three fourths full of urine and did not flush. Water was left running for 4 minutes without it getting warm. Observation of bathroom form room [ROOM NUMBER] on 2/4/26 revealed, no hot water and toilet was approximately three fourths full and did not flush and the heat went off last night 2/2/26. On 2/9/26 R137 stated, the heat went off Saturday night into Sunday morning, it was cold and they had to reset it 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). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. During interview with R137 on 2/3/26 at approximately 12:40 PM, R137 stated, we do not have hot water, the toilet does not flush and the heat went off last night 2/2/26. On 2/3/26 at 12:42 PM, an interview was conducted with CNA (certified nursing assistant) #1. Asked if the water was hot in the bathroom for room [ROOM NUMBER], CNA #1 stated, no, it is not getting warm. Asked if she was able to flush the toilet, CNA #1 stated, no, it does not flush. On 2/4/26 at 7:20 AM R137 stated the heat went off again last night, they restarted it about 10 minutes ago. On 2/4/26 at 9:15 AM an interview was conducted with LPN (licensed practical nurse) #1, when asked about the lack of hot water in 135 and 139 and toilet not flushing in room [ROOM NUMBER], LPN #1 stated, let me check, was unable to flush toilet or have hot water. On 2/4/26 at approximately 12:00 PM, the maintenance director stated, we have fixed the toilet in room [ROOM NUMBER] and when I came in this morning at 7:00 AM, I saw the heat in TELS (electronic work order system) and reset it about 7:10 AM. 2/6/26 at 10:00 AM an interview was conducted with the administrator. Asked about the heating in room [ROOM NUMBER] on Unit 1-B, ASM #1 stated, that unit was the first area we renovated. When we replaced the old heating units, there was a duct to the outside with a vent for air intake. After we put the new heating units in each resident room, we found that with the cold weather, the cold air was coming in through the outside vents and trips the heating unit causing it to turn off. We have been working with STR-our contractor to fix this issue. They are fabricating metal plates that will place on the outside of the vent so cold air will not trip the system requiring a manual reset. As we are renovating the rest of the building, we are insulating the vent from the inside to keep it from tripping the heating system. The issue with the no hot water on 2/3 and 2/4 was due to STR shutting it off on the area they were working in on the first floor.the other end of the hall from 1B. On 2/6/26 at 11:50 AM, the administrator and DON were made aware of the findings. No further information was provided prior to exit. - 4.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 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 2/5/2026 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 living in their room and that he had discussed it with the assistant administrator because it had come 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). 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. CNA #2 described there are pests and rodents, it is documented in the pest control log and pest control comes three times a week. You can hear something running in the ceiling at night. On 2/5/2026 at 6:50 AM an interview was conducted with the maintenance director. He was informed of the mouse running across the hall into the locked room. The maintenance director went to the locked room, entered and looked for the mouse and said he must have gone behind the wall; 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. We tell them not to keep food out and not to 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 some baby mice were seen 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 described that there was a mouse on a glue pad in his room. During observation at 4:00 PM, there was (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 the pest control representative who described his treatment schedule of three times a week; 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, the administrator and the DONwere 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. 5. The facility staff failed to provide a safe, clean, comfortable, and homelike environment for Resident #58. 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 stated that every night he saw roaches and many mice in his bedroom, including pregnant mice. The resident stated that there are far more mice than roaches. Several glue traps and pest-control boxes were observed throughout the room, and no pests were observed. On 2/4/26 at 10:12 AM, the resident stated that his bathroom was dirty. An observation of the bathroom revealed that all the water in the commode was dark brown and odorous. On 2/5/26 at 2:10 PM, an observation of the resident's commode revealed that it still contained the dark brown, odorous liquid. An interview was conducted with the Maintenance Director. The Maintenance Director stated that a resident on the hall places eating utensils in the toilet, which backs up the system and prevents the toilets from flushing. The Maintenance Director further stated that the company comes out every two weeks to get the system running again. The Maintenance Director showed the intervention in place to prevent the resident from flushing items that should not be flushed. The Maintenance Director stated that it had not prevented the problem. On 2/6/26 at approximately 11:55 AM, an inspection of Resident #58's bathroom was completed with the Assistant Director of Nursing (ADON). 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. 6. The facility staff failed to provide a safe, clean, comfortable, and homelike environment for Resident #107. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 was observed walking quickly in the corridor. He was observed entering the shower room. After toileting in the shower room, the resident returned to his room. He stated that the commode in his room had been out of order for weeks. He also said that the maintenance man removed the old commode and installed a new one, but it doesn't work. An observation of the resident's toilet in his room revealed a commode half-filled with a dark brown liquid and wads of toilet paper. It would not flush when the handle was activated. On 2/6/26 at 12:20 PM, the resident was seen in the corridor, very upset. He stated that while he was eating his lunch, the maintenance man entered and began working on the commode, and that they should have waited until after lunch. On 2/6/26 at approximately 11:55 AM, an inspection of Resident #107's bathroom was completed with the Assistant Director of Nursing (ADON). 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. 7. The facility staff failed to provide a safe, clean, comfortable, and homelike environment for Resident #64. Resident #64 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included diabetes and dementia. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 12/2/25, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 10 out of 15. This indicated that Resident #64's cognitive abilities for daily decision-making were moderately impaired. On 2/4/26 at approximately 10:12 AM, an interview was conducted with Resident #64. The resident stated he had moved to another room for two days and regretted agreeing to return to room [ROOM NUMBER]. Resident #64 stated that the commode in the other room flushed, but the toilet in the current room did not. It hadn't flushed for over 30 days when he left two days ago, and it still does not. The resident further stated that the only difference is that when he left, it was full, and now it is only a quarter full. The resident stated that having a dirty bathroom for so long was unhealthy, and it made him sick. The resident stated he had to walk to the end of the hall to use the toilet in the shower room because the toilet was flushed. On 2/4/26 at 10:16 AM, an observation was made of the commode in room [ROOM NUMBER]. It was partially filled with dark brown liquid and had a strong urine odor. Feces and toilet paper were in the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	commode, and the odor was extremely foul. On 2/6/26 at approximately 11:55 AM, an inspection of Resident #107's bathroom was completed with the Assistant Director of Nursing (ADON). 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. 8. For Resident #125 (R125), the facility staff failed to secure a portable air conditioner to the window to maintain a homelike environment. On the most recent minimum data set (MDS), a significant change assessment with an assessment reference date of 1/29/2026, the resident scored 15 out of 15 on the brief interview for mental status (BIMS) assessment, indicating they were cognitively intact for making daily decisions. On 2/3/2026 at 3:33 PM, an observation was made of R125's room. Observation revealed a portable air conditioning unit on the floor beside R125's bed. The unit was connected to a hose, and a window panel was attached to the window in the room, partially secured with tan masking tape. Observation of the window revealed that the tape had peeled off the plastic panel on the underside and the left side, exposing a gap between the window and the panel to the facility exterior, approximately 4 inches wide. The gap exposed the brick on the outside of the building. At that time, an interview was conducted with R125, who stated that the unit had been in place since the end of summer, when the air conditioner had broken, and that he had requested it be left in place because the room became hot even in winter. R125 stated that the tape had been coming off for a while and he had issues in the past with flies and gnats getting in, but it was too cold for them right now. On 2/3/2026 at 4:50 PM, an interview was conducted with the director of plant operations. He stated that R125 was the only resident left who had wanted to keep the portable air conditioning unit in their room for the winter, and they checked it monthly. The director of plant operations stated that the windows open 4 inches for the hose to stick out, and they use window insulation and tape around the window to keep it sealed. He observed R125's window and stated that he could see the outside and that it looked like it had been blown loose by the wind, and it needed to be retaped. The facility policy Safe and Homelike Environment revised 10/14/2025, documented in part, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility, both inside and outside, maximizes resident independence and does not pose a safety risk . Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment . On 2/4/2026 at approximately 5:00 PM, the administrator and the director of nursing were made aware of the concern. No further information was provided prior to exit. 9. The facility staff failed to maintain a clean and homelike environment for Resident #127. Resident #127 was originally admitted to the facility on [DATE] after an acute care hospital stay. The (continued on next page)

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Ghent Health and Rehabilitation	3900 Llewellyn Ave Norfolk, VA 23504

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to provide COVID-19 vaccinations to residents 2025 and failed to maintain COVID-19 staff vaccination status. The findings include:During the facility task of Infection Prevention and review of facility documents, on 2/10/26 and 2/11/26, there was no evidence of resident COVID-19 vaccination for 2025 and no evidence of maintenance of staff COVID-19 vaccination status.On 2/11/26 at 9:00 AM an interview was conducted with LPN (licensed practical nurse) #4, the Infection Preventionist. LPN #4 stated, this role is new for me as of June of 2025. In regard to the COVID vaccinations for 2025, our pharmacy OMNICARE initially told us they did not have the vaccine; not sure who would have contacted them or another pharmacy to get the COVID vaccine. In regard to the staff COVID-19 vaccination status logs, they are not here, have checked my file cabinets and other file cabinets and they are not here. On 2/11/26 at 2:30 PM, the administrator and the director of nursing were made aware of the findings. A review of the facility's COVID-19 Vaccination policy revealed, It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine. The facility will maintain documentation related to staff COVID-19 vaccination and include at a minimum: the COVID-19 vaccine status of staff and related information as indicated by NHSN.No further information was provided prior to exit.

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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 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 (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. CNA used a dry towel to wipe off the resident. CNA did not rinse soap off the resident's body; used (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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].ˆThe current diagnoses included a need for assistance with personal care and an overactive bladder. ˆ 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.ˆˆˆ 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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received only 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) R35's most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(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 a.m.) each day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to monitor fluid intake for one of 80 residents, Resident #137 (R137). The findings include:The facility failed to evidence monitoring of fluid restriction for 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 monitoringA 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 who had no knowledge of fluid restrictions.An interview was conducted on 2/5/26 at 1:30 PM with LPN (licensed practical nurse) #3. In describing the fluid restriction process, LPN #3 described that fluid intake is monitored. On 2/10/26, the director of nursing, asked what evidence we were looking for. Described that evidence of monitoring fluid intake totals by shift including nursing and dietary, the director of nursing stated, fluid restrictions are not tracked that way.On 2/9/26 at 5:00 PM, the administrator and the director of nursing, were made aware of the concerns.A review of the facility's Fluid Restriction policy reveals It is the policy of this facility to ensure that fluid restrictions will be followed in accordance with physician's orders. The nurse will obtain and verify the physician's order for the fluid restriction and an order written to include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department and will be recorded on the medication record or other format as per facility protocol.No further information was provided prior to exit.

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Ghent Health and Rehabilitation	3900 Llewellyn Ave Norfolk, VA 23504

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide dialysis care and services for one of 80 residents in the survey sample, Resident #53 (R53).The findings include:The facility failed to provide evidence of monitoring fistula for bruit/thrill/bleeding and communication with dialysis facility for R53.R53 was admitted to the facility on [DATE] with diagnosis that included but were not limited to chronic kidney disease, diabetes mellitus and neuromuscular dysfunction of bladderThe most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/31/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being independent for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 5/24/23 revealed, FOCUS: Resident needs dialysis related to renal failure, has AV shunt Left arm. INTERVENTIONS: Check and change dressing daily at access site. Document as indicated. Hemodialysis: Pickup 0530. Monday-Wednesday-Friday.A review of the physician's order dated 5/9/25 revealed, Hemodialysis- Assess Left Forearm Fistula for bleeding /symptoms of infection every shift for dialysis. Dialysis Midtown- [NAME]- [PHONE NUMBER], Monday, Wednesday, Friday.On 2/05/2026 at 8:30 AM review of dialysis communication book from 12/1/25 to 2/4/26. Missing communication sheet documentation on 12/15, 12/19, 12/22, 12/24, 12/31, 1/12, 1/14, 1/16, 1/19, 1/21, 1/28, 1/30. A review of the December 2025 TAR (treatment administration record) revealed, Hemodialysis- Assess Left Forearm Fistula for bleeding /symptoms of infection every shift for dialysis documented day/evening/night 12/1-12/9/25. Was discontinued on 12/9/25.An interview was conducted with R53 on 2/5/26 at 8:40 AM, who described his dialysis care as, the facility staff do not check his fistula for bleeding, bruit and thrill (showed fistula in left arm) but they do at the dialysis center and he takes his communication book with him to appointments.An interview was conducted on 2/5/26 at 8:50 AM with LPN (licensed practical nurse) #2. LPN #2 described the purpose of the dialysis communication book as providing information of the resident's vital signs, weight and any other pertinent information. Checking the fistula for bruit/thrill and check for bleeding is documented on the MAR-TAR (medication administration record-treatment administration record).On 2/9/26 at 5:00 PM, the administrator and the director of nursing, were made aware of the concerns.Facility did not provide a policy regarding dialysis care. A review of the dialysis contract reveals The nursing facility shall ensure that there is documented evidence of collaboration of care and communication between the nursing facility and the ESRD (end stage renal disease) facility.No further information was provided prior to exit.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and review of facility documents, the facility staff failed to provide leadership and oversight to ensure effective systems were in place to assure the quality of life for the residents in the area of Safe/Clean/Comfortable/ Homelike Environment.The findings included:During the recertification survey completed on 2/11/26 the facility failed to: provide hot water in two resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) on Unit 2A; address current observations of mice and roaches on all units: 1A, 1B, 2A, 2B; have operable toilets that are able to flush on unit 2A and unit 1B; provide a safe, functional, sanitary, and comfortable environment for the residents to shower on units 1A and 1B; and provide heat in two resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) on Unit 2A.On 2/26/26 at 12:08 PM an interview was conducted with the Administrator regarding the issues identified during the recertification survey in the area of Safe/Clean/Comfortable/Homelike Environment. The Administrator stated that the Quality Assurance and Performance Improvement (QAPI) committee did not discuss the issues regarding pest control management, heat issues, hot water issues, inoperable toilets, and the unsanitary shower rooms. The Administrator also stated, I don't have the time regarding developing and implementing data collection systems, feedback, monitoring, analysis, and action plans in the areas identified. The Administrator further stated that the Administrator is responsible and accountable for the QAPI program. The facility's Administration of Facility policy with a date reviewed/revised of 10/14/2025 reads, Policy: This facility will provide policies and systems to ensure that it is administered in a manner that will focus on attaining and maintaining the highest practicable physical, mental, and psychosocial well-being of each resident. 7. The facility must have a governing body that is legally responsible for establishing and implementing policies regarding management and operation of the facility as well as QAPI. On 2/26/26 at approximately 2:55 PM, a final interview was conducted with the Administrator, Assistant Director of Nursing, Regional Minimum Data Set Consultant, and Regional Nursing Consultant. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and review of facility documents, the facility's Governing Body failed to ensure facility policies were implemented regarding management and operation of the facility to ensure effective systems were in place to assure the quality of life for the residents in the area of Safe/Clean/Comfortable/ Homelike Environment.The findings included:During the recertification survey completed on 2/11/26 the facility failed to: provide hot water in two resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) on Unit 2A; address current observations of mice and roaches on all units: 1A, 1B, 2A, 2B; have operable toilets that are able to flush on unit 2A and unit 1B; provide a safe, functional, sanitary, and comfortable environment for the residents to shower on units 1A and 1B; and provide heat in two resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) on Unit 2A.On 2/26/26 at 12:08 PM an interview was conducted with the Administrator regarding the issues identified during the recertification survey in the area of Safe/Clean/Comfortable/Homelike Environment. The Administrator stated that the Quality Assurance and Performance Improvement (QAPI) committee did not discuss the issues regarding pest control management, heat issues, hot water issues, inoperable toilets, and the unsanitary shower rooms. The Administrator also stated, I don't have the time regarding developing and implementing data collection systems, feedback, monitoring, analysis, and action plans in the areas identified. The Administrator further stated that the Administrator is responsible and accountable for the QAPI program. The facility's Governing Body policy with a date reviewed/revised of 10/15/2025 reads, Policy: The facility will have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. 2. The governing body is responsible and accountable for the QAPI program. On 2/26/26 at approximately 2:55 PM, a final interview was conducted with the Administrator, Assistant Director of Nursing, Regional Minimum Data Set Consultant, and Regional Nursing Consultant. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and review of facility documents, the facility staff failed to adequately identify, keep systems functioning properly, and implement necessary action plans to assure the quality of life for the residents using the Quality Assurance and Performance Improvement (QAPI) committee to identify deficiencies if the area of Safe/Clean/Comfortable/Homelike Environment.The findings included:During the recertification survey completed on 2/11/26 the facility failed to: provide hot water in two resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) on Unit 2A; address current observations of mice and roaches on all units: 1A, 1B, 2A, 2B; have operable toilets that are able to flush on unit 2A and unit 1B; provide a safe, functional, sanitary, and comfortable environment for the residents to shower on units 1A and 1B; and provide heat in two resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) on Unit 2A.On 2/26/26 at 12:08 PM an interview was conducted with the Administrator regarding the issues identified during the recertification survey in the area of Safe/Clean/Comfortable/Homelike Environment. The Administrator stated that the QAPI committee did not discuss the issues regarding pest control management, heat issues, hot water issues, inoperable toilets, and the unsanitary shower rooms. The Administrator also stated, I don't have the time regarding developing and implementing data collection systems, feedback, monitoring, analysis, and action plans in the areas identified. The facility's Quality Assurance and Performance Improvement (QAPI) policy with a date reviewed/revised of 10/22/2025 reads, Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. 4. The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include, but is not limited to: b. Systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events. On 2/26/26 at approximately 2:55 PM, a final interview was conducted with the Administrator, Assistant Director of Nursing, Regional Minimum Data Set Consultant, and Regional Nursing Consultant. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations and staff interviews, the facility staff failed to follow infection control practices, increasing the chances of infection, illnesses, and diseases, and the facility staff failed to follow enhanced barrier precautions (EBP) during an observation of wound care on 2/4/26 having the potential to infect others in the facility and specific to 1 of 80 residents (Resident #129) in the survey sample.The findings include: 1. The facility staff failed to ensure the commode seat in the community shower room was clean. On 2/5/26 at 3:26 pm, a small to moderate amount of brown substance was observed on the commode seat. On 2/5/26, an observation of the shower room on unit 1A was conducted at 3:26 pm with the unit manager and Licensed Practical Nurse (LPN) #6. The observation revealed a small to moderate brown substance on the commode seat. LPN #6 said that she will make sure the area is cleaned. LPN #6 was asked who was responsible for cleaning the commode. LPN #6 said that once the nursing staff cleans off the toilet seat, they should contact housekeeping to get the commode sanitized. On 2/09/26 at 4:40 pm, the end-of-day meeting was conducted with the administrator, the Director of Nursing, and the Regional Director. 2. For Resident #129 (R129), the facility staff failed to follow enhanced barrier precautions (EBP) during an observation of wound care on 2/4/26. On the most recent minimum data set (MDS), an admission assessment with an assessment reference date (ARD) of 1/14/2026, the resident was assessed as being moderately impaired for making daily decisions, under hospice care and not having a pressure injury. The physician orders for R129 documented in part, Clean area to R (right) hip with DWC (Dakin's wound cleanser), pat dry, apply calcium alginate. Cover with dry dressing. one time a day for wound tx (treatment). Order Date: 02/03/2026. The comprehensive care plan for R129 documented in part, [R129] has a wound to Right trochanter. Date Initiated: 02/03/2026. On 2/3/2026 at 4:07 PM, an observation was made of R129 in their room. Observation of the outside of R129's room revealed a sign with a red stop sign which documented, Enhanced Barrier Precautions- Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and gowns for the following High-Contact Resident Activities: .Wound care: any skin opening requiring a dressing . On 2/4/2026 at 10:33 AM, an observation was made of licensed practical nurse (LPN) #1 providing wound care to R129's pressure injury. Registered nurse (RN) #1 was observed assisting LPN #1 with positioning R129 and holding the resident in place during wound care. Neither staff member was observed to wear a gown during the wound care procedure. On 2/4/2026 at 11:05 AM, an interview was conducted with LPN #1 who stated that residents were placed on EBP when they had an open skin area, wound, intravenous line, dialysis site, feeding tube or catheter. She stated that the staff wore gowns and gloves when providing care to protect the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident and themselves from spreading any infection. LPN #1 stated that she should have had a gown on during the wound care for R129 and it had been overlooked. On 2/9/2026 at 3:50 PM, an interview was conducted with LPN #4, the infection preventionist. LPN #4 stated that when a resident had a wound, they were placed on EBP, and a sign was placed outside the door which instructed the staff to wear a gown and gloves during high-contact activities, including wound care. The facility policy Enhanced Barrier Precautions effective 9/1/2022 documented in part, Enhanced Barrier Precautions (EBP) is used to reduce the spread of Multidrug-resistant organisms (MDROs) among residents by utilizing gloves and gowns for high contact resident care activities . Identify residents who are appropriate for EBP including: .Residents who have a wound and/or indwelling medical devices . On 2/6/2026 at 11:54 AM, the administrator and director of nursing were made aware of the concern. No further information was provided prior to exit.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, facility document review, and clinical record review, it was determined that the facility staff failed to maintain a safe, functional, and comfortable environment in the facility's shower rooms.The findings include: 1.The facility staff failed to provide a safe, functional, sanitary, and comfortable environment for the residents to shower On 2/05/2026 an observation of the shower room on unit 1A was conducted at 3:26 pm, with the unit manager, Licensed Practical Nurse (LPN) #6. The observation revealed a small to moderate brown substance on the commode seat. LPN #6 said that she will make sure the area is cleaned. LPN #6 was asked who's responsible for cleaning the commode. LPN #6 said that once the nursing staff clean off the toilet seat, they will contact housekeeping to get the commode sanitized. On 2/09/26 at 4:40 pm., End of day meeting with the administrator, the Director of Nursing and Regional Director. 2. The facility staff failed to provide a safe, functional, sanitary, and comfortable environment for the residents to shower. On 2/6/26 at 11:40 AM, an inspection of the Unit 1B shower room was completed with the Assistant Director of Nursing. Upon entering the shower room, it smelled of stale water. A green bottle of [NAME] Spring shower gel and a disposable razor were on the shower chair seat. Beneath the chair was a worn and soiled area in which the resident's naked foot would touch. In the shower room, approximately 21 shower chairs were cluttered throughout, and in the area where the resident showered, the individual had to face them. There was no privacy when others entered the shower room, and the door was left unlocked because this room was frequently used by others whose in-room toilets were out of order. Around the base of the toilet was brown dirt and debris, along with dingy floor stains. An interview was conducted with the ADON on 2/6/26 at approximately 12:04 PM. The ADON stated she was unaware of the clutter and appearance of the shower room. 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.

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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)

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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.

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide a call bell accessible from the floor in the bathroom for one of 80 residents in the survey sample, Resident #6. The findings include:For Resident #6 (R6), the facility staff failed to ensure the bathroom call bell was accessible to the resident from the floor. On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 1/6/2026, the resident scored 14 out of 15 on the brief interview for mental status (BIMS) assessment, indicating they were cognitively intact for making daily decisions. The assessment further documented R6 not having any upper or lower extremity functional limitations in range of motion, using a wheelchair and requiring setup or clean-up assistance for toilet transfers and toileting hygiene. R6 was assessed as being occasionally incontinent of urine and frequently incontinent of bowel. On 2/5/2026 at 9:08 AM, R6 was not in their room, an observation of the shared bathroom for R6 revealed a bathroom approximately 10 feet wide by six feet depth with a toilet located on the right wall with approximately eight-inches space between the wall and the toilet. On the wall beside the toilet was a small grab bar, toilet paper holder and a call bell cord located just below the seat level of the toilet. The call bell cord was observed coming from the wall approximately 12-inches hanging towards the floor. The space on the left side of the toilet was approximately six feet to the opposite wall with no call bell access from that side of the room if the resident were to fall onto the floor. On 2/5/2026 at 2:05 PM, an interview was conducted with R6 in their room. R6 was observed lying in bed on top of the sheets fully dressed with a fall mat down to the left side of the bed. When asked about the fall mat, R6 stated that it had been a while since they fell but the staff kept the mat down just in case. R6 stated that they ambulated around in the room and bathroom by themselves. R6 further stated that they used the bathroom independently and they were not sure if they were able to reach the call bell in the bathroom or not because they had never needed to use it. Fall risk evaluations for R6 documented a high fall risk on 11/2/2025. Review of the clinical record for R6 documented a fall without injury in the residents room on 11/14/2025 and another fall without injury on 12/6/2025. The activities of daily living (ADL) documentation for R6 dated 1/1/26-1/31/26 and 2/1/26-2/28/26 documented R6 independently toileting during 58 shifts in January and 14 shifts in February. On 2/9/2026 at 2:21 PM, an interview was conducted with certified nursing assistant (CNA) #6 who stated that in the bathrooms the residents had call bells that they used to alert the staff when they needed assistance. She stated that the resident pulled on the string which cut the light on outside of the room to let them know to go check on them. On 2/9/2026 at 2:28 PM, an interview was conducted with licensed practical nurse (LPN) #5 who stated that there were emergency call bells in the bathrooms and they sounded when the resident pulled the cord. She stated that the staff were able to see the light outside of the room and on the board at the nurses station. LPN #5 stated that R6 used the bathroom by themselves and she was not sure what type of call bell was in the bathroom. On 2/9/2026 at approximately 2:35 PM, an observation was conducted with LPN #5 of R6's bathroom. LPN #5 observed the call bell located to the right of the toilet on the wall with the approximately 12-inch cord hanging towards the floor. When asked if the resident would be able to reach the cord if they were in the floor on the space to the left of the toilet, LPN #5 stated, No, she could not get to it. On 2/9/2026 at 2:37 PM, an interview was conducted with CNA #5 who stated that R6 was independent when toileting. She stated that there were call bells in the bathroom and if any assistance was needed the residents would pull the cords on the call lights to alert them to come to assist. The facility policy Call Lights: Accessibility and Timely Response revised 11/7/2025 documented in part, The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response . The call system must be accessible to the resident at each toilet and bath or (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower facility. The call system should be accessible to a resident lying on the floor . On 2/9/2026 at approximately 4:37 PM, the administrator and the director of nursing were made aware of the concern. No further information was provided prior to exit.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide reasonable access to private use of the telephone to one of 80 residents in the survey sample, Resident #84.The findings include:For Resident #84 (R84), the facility staff failed to provide private access to a telephone for resident use.On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date of 1/15/2026, the resident scored 13 out of 15 on the brief interview for mental status (BIMS), indicating they were cognitively intact for making daily decisions. On 2/3/2026 at 12:50 PM, an interview was conducted with R84 who stated that they did not have access to a telephone to speak to anyone privately. R84 stated that they had to go to the nurses station and beg to use the phone. On 2/5/2026 at 12:13 PM, an observation was made of R84 using the telephone at the nurses station. Two staff members were seated behind the nurses station, and one staff member was at the medication cart which was parked beside the nurses station at the time R84 was using the telephone. R84 was observed in a wheelchair at the outside of the nurses station with the telephone sitting on top of the ledge of the nurses station approximately two feet above their head. Further observation revealed R84 attempting to hang up the receiver from the wheelchair and dropping it down onto the nurses station due to the height of the ledge from the wheelchair.On 2/5/2026 at 1:22 PM, an interview was conducted with licensed practical nurse (LPN) #3 who stated that residents who did not have cell phones of their own could use the nurses station phone when they needed to call someone. She stated that the phone was available to them any time day or night and they sat it up on the ledge of the nurses station for the resident to sit outside of the station because they were not allowed inside. When asked about privacy, LPN #3 stated that the phones could not reach that far, but they pushed them out as much as they could and that was all they had to offer them at the nurses station. On 2/9/2026 at 9:42 AM, an interview was conducted with registered nurse (RN) #2 who stated that residents were allowed to use the telephone at the nurses station. She stated that the staff placed the phone up on the edge of the counter and the resident sat outside of the nurses station to talk and could use it anytime of day or night. On 2/9/2026 at 2:21 PM, an interview was conducted with certified nursing assistant (CNA) #6 who stated that residents normally went to the nurses station to use the telephone. She stated that residents could not go inside the nurses station but could sit outside and use the telephone.On 2/9/2026 at 3:02 PM, an interview was conducted with the director of nursing (DON) who stated that there were telephone lines throughout the building that were available for the residents to use but she did not think that there was a designated spot for the residents if they were looking to have a private phone call, but anyone would allow them to come into their office to use the telephone.The facility policy Resident Rights revised 11/14/2025 documented in part, The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility . The resident has the right to have reasonable access to the use of a telephone, including TTY (Teletypewriter) and TDD (Telecommunications Device for the Deaf) services, and a place in the facility where calls can be made without being overhead. This includes the right to retain and use a cellular phone at the resident's own expense On 2/9/2026 at approximately 4:37 PM, the administrator and the director of nursing were made aware of the concern.No further information was provided prior to exit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, and staff interview, the facility's staff failed to ensure the resident was allowed privacy while talking on the facility telephone located at the nurses' station for one (1) of 80 residents (Resident #82), in the survey sample.The finding include: Resident #82 was originally admitted to the facility on [DATE] and readmitted on [DATE] after an acute care hospital stay. The current diagnoses included: aphasia following cerebral infarction and contracture of the muscles of the right hand.The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 12/15/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 8 out of a possible 15. This indicated that Resident #82's cognitive abilities for daily decision making were moderately impaired.The care plan dated 12/30/25 read resident is independent in meeting emotional, intellectual, physical, and social needs r/t ambulation. The Goal is that the resident will maintain involvement in cognitive stimulation and social activities as desired. The interventions are: Encourage ongoing family involvement. Invite residents' family to attend special events, activities, meals, and preferred activities are: visiting with mother and family, socializing with peers in the smoke area, and watching television. On 02/09/2026 at approximately 1:22 pm, Resident #82 was overheard on the phone at the nurse's station talking to his mother. At one point, the Licensed Practical Nurse (LPN) #4 was heard saying to the resident, You're not falling asleep, are you? The resident shook his head, indicating no, and continued talking on the phone. A brief interview was conducted with LPN #4 concerning Resident #82. LPN #4 said that the resident used to have his own cell phone, but now uses the phone at the nurse's station to call his mother. LPN #4 was asked if they ever had a cordless phone at the nurses' station for privacy. She said, Yes, but I don't know what happened to it. On 02/09/2026 at approximately 4:40 p.m., the above findings were shared with the Administrator, Director of Nursing, and Regional Director.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on staff interview, clinical record review, facility document review, the facility staff failed to resolve grievances for one of 80 residents in the survey sample, Resident #125 (R125). The findings include:For Resident #125 (R125), facility staff failed to provide resolutions to grievances filed on 06/09/2025, 07/17/2025, 07/30/2025, and 07/31/2025. On 2/5/2026 at 10:28 AM, an interview was conducted with R125, who stated that they had filed multiple grievances with the facility, and they never received any follow-up regarding the outcomes. On the most recent minimum data set (MDS), a significant change assessment with an assessment reference date of 1/29/2026, Resident #125 (R125) scored 15 out of 15 on the brief interview for mental status (BIMS) assessment, indicating they were cognitively intact for making daily decisions. The facility's grievances filed by R125 dated 06/09/2025, 07/17/2025, 07/30/2025, and 07/31/2025 failed to document resolutions. On 02/10/2026 at approximately 10:30 a.m. an interview was conducted with the Social Worker regarding the process of completing the facility's grievance forms. She stated that anyone could file (fill out) a grievance form and it came to social services for review. She stated that depending on the area of concerns the grievance addresses, she gave it to the corresponding department for them to address and complete the grievance form. She further stated that all portions of the grievance form should be completed and the resolution for the grievance should be documented on the form. After reviewing the facility's grievance forms from R125 as dated above the Social Worker stated that there were no resolutions completed. When asked why it was important to have a resolution for a grievance, she stated that the resident could lose trust in the facility staff and feel as though the facility did not take their concerns seriously. The facility's policy Resident and Family Grievances documented in part, Policy Explanation and Compliance Guidelines: 2. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations. 10. Procedure: g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum: i. The date the grievance was received. Ii. The steps taken to investigate the grievance. iii. A summary of the pertinent findings or conclusions regarding the resident's concern(s). iv. A statement as to whether the grievance was confirmed or not confirmed. v. Any corrective action taken or to be taken by the facility as a result of the grievance. vi. The date the written decision was issued. On 02/10/2026 at approximately 4:36 p.m., the Administrator, Director of Nursing, and the Regional Director were made aware of the above findings. No further information was provided prior to exit.

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ghent Health and Rehabilitation	3900 Llewellyn Ave Norfolk, VA 23504

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 severe (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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(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 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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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and clinical record review, the facility's staff failed to ensure appropriate care and services were provided to prevent/reduce trauma to the urethra and bladder, and other complications while utilizing an indwelling catheter for 1 of 80 residents (Resident #106), in the survey sample.The findings included:Resident #106 was originally admitted to the facility 5/12/25 after an acute care hospital stay and re-admitted on [DATE].ˆThe current diagnoses included; Urinary Tract Infection.ˆ ˆThe 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.ˆˆˆ The personal centered care plan dated 11/19/25 read the resident has an indwelling catheter (20Fr 10cc) r/t Urinary Retention. The Goal for the resident is he will be/remain free from catheter-related trauma through review date. The Intervention: Check tubing for kinks each shift and the resident has (20 FR.) (Foley Catheter). Position catheter bag and tubing below the level of the bladder and away from 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 10:02 am, a bed bath observation was conducted with Certified Nursing Assistant (CNA) #8. The resident's indwelling urinary catheter (Foley-brand name) was observed unanchored. A brief interview was conducted with CNA #8 afterwards concerning the resident's Foley catheter not being anchored. CNA stated she normally works upstairs and is unsure if the resident usually has something to keep his Foley catheter anchored.On 2/06/26 at 3:56 pm, an interview was conducted with Registered Nurse (RN) #3 concerning the resident's Foley catheter. RN #8 said that having a Foley catheter anchored will keep it from pulling or causing pressure on the bladder, so it doesn't cause injury to the bladder. RN #8 also said that she was going to place a Stat Lock on the resident's leg.StatLock is a stabilizing device for urinary Foley catheters (https://mnhospitals.org/wp-content/uploads/Portals/Documents/patientsafety/PU_Med_dev/stat_lock_foley_poster.pdf)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. No comments were made.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide care and services for a urostomy consistent with professional standards of practice for one of 80 residents in the survey sample, Resident #125.The findings include:For Resident #125 (R125), the facility staff failed to maintain a urinary collection bag in a sanitary manner. R125 was admitted to the facility with diagnoses that included but were not limited to urostomy (1) and malignant neoplasm of bladder (2).On the most recent minimum data set (MDS), a significant change assessment with an assessment reference date of 1/29/2026, the resident scored 15 out of 15 on the brief interview for mental status (BIMS) assessment, indicating they were cognitively intact for making daily decisions. On 2/5/2026 at 10:28 AM, an interview was conducted with R125 in their room. R125 stated that they had a history of kidney stones and cancer and had surgery in the past with a urostomy placed. R125 stated that the urostomy drained into a collection bag and pointed to a urinary collection bag hanging onto the call bell cord. R125 stated that the facility had recently changed the bags and the new bags did not have a clip that was large enough to attach to the bed frame, so they had to hang the bag on the call bell cord. Observation of the collection bag revealed the bag clips hanging on the call bell cord and the bag observed touching the floor surface. Additional observation of R125's urine collection bag touching the floor surface was conducted on 2/5/2026 at 11:58 AM.The physician orders for R125 documented in part, Assess skin around urostomy site during care. Order Date: 9/29/2025.The comprehensive care plan for R125 documented in part, [R125] has urostomy and requires extensive assistance by staff to manage r/t (related to) generalized weakness recent admission to LTC (long term care) following hospital stay for ABD (abdominal) hernia, dx (diagnoses) Bladder CA (cancer) with obstructive and reflux uropathy, DVT (deep vein thrombosis), anticoagulation medication. Date Initiated: 01/30/2023. Revision on: 09/30/2025. On 2/5/2026 at 1:22 PM, an interview was conducted with licensed practical nurse (LPN) #3 who stated that urinary collection bags should be positioned below the bladder, so the urine did not back up into the bladder and cause a urinary tract infection. She stated that the bag should hang on the bed rail utilizing the hooks on the collection bag and should not touch the floor. LPN #3 stated that this was to prevent organisms from entering the body and for infection control purposes. On 2/5/2026 at 1:28 PM, LPN #3 observed R125's urinary collection bag hanging on the call bell cord in the room and the bag resting on the floor. She stated that the bag should not be touching the floor and should not be hanging on the call bell cord. The facility policy Catheter Care revised 11/7/2025 failed to evidence guidance for keeping the collection bag off the floor.On 2/6/2026 at 11:54 AM, the administrator and director of nursing were made aware of the concern.No further information was provided prior to exit.Reference:(1) urostomy- Instead of going to your bladder, urine will go outside of your abdomen. The part that is visible outside your abdomen is called the stoma. After a urostomy, your urine will go through your stoma into a special bag called a urostomy pouch . This information was obtained from the website: Urostomy - stoma and skin care: MedlinePlus Medical Encyclopedia(2) malignant neoplasm of bladder- Bladder cancer is a common type of cancer that begins in the cells of the bladder. The bladder is a hollow muscular organ in your lower abdomen that stores urine. Bladder cancer most often begins in the cells (urothelial cells) that line the inside of your bladder. Urothelial cells are also found in your kidneys and the tubes (ureters) that connect the kidneys to the bladder. Urothelial cancer can happen in the kidneys and ureters, too, but it's much more common in the bladder. Most bladder cancers are diagnosed at an early stage, when the cancer is highly treatable. But even early-stage bladder cancers can come back after successful treatment. For this reason, people with bladder cancer typically need follow-up tests for years after treatment to look for bladder cancer that recurs . This information was obtained from the website: Symptoms and causes - Mayo Clinic

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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 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 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on staff interview, clinical record review, facility document review, the facility staff failed to obtain an assessment and consent for the use of bed rails for one of 80 residents in the survey sample, Resident #125 (R125). The findings include:For Resident #125 (R125), facility staff failed to complete an assessment and obtain consent for the use of bed rails. R125 was admitted to the facility with a diagnosis that included but not limited to muscle weakness. On the most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/29/2026, R125 scored 2 15 out of 15 on the BIMS (brief interview for mental status), indicating R125 was cognitively intact for making daily decisions. On 02/03/2026 at approximately 3:33 p.m. an observation revealed R125 was in bed with bilateral (right and left) upper rails were raised. R125 stated he uses to move in bed. On 02/03/2026 at approximately 4:50 p.m. an observation revealed R125 was in bed with bilateral upper rails were raised. On 2/5/2026 at approximately 10:28 a.m. an observation revealed R125 was in bed with bilateral (right and left) upper rails were raised. On 2/5/2026 at approximately 11:58 a.m. an observation revealed R125 was in bed with bilateral (right and left) upper rails were raised Review of R125's clinical record failed to evidence documentation of an assessment and consent for the use of bed rails. On 02/09/2026 at approximately 3:30 p.m. the director of nursing in formed the surveyor stated that there was no consent and assessment for R125's use of bed rails. On 02/11/2026 at approximately 10:35 a.m. an interview was conducted with LPN (licensed practical nurse) #6 regarding the consent and assessment for a resident's use of bed rails. LPN #6 stated that the provider obtains the resident's consent for the use of bed rails and nursing assess the resident to determine if the resident needs bed rails. On 02/11/2026 at approximately 11:10 a.m. an interview was conducted with the Director of Nursing (DON) regarding the consent and assessment for a resident's use of bed rails. She stated that consent by the resident or responsible party and a bed rails assessment needs to be obtained for a resident using bed rails. The DON stated that any clinical staff (nursing) can obtain the consent. She also stated that nursing conducts a bed rail assessment to determine if the resident would be safe in using the bed rails appropriately for turning and positioning in bed. The facility's policy, Proper Use of Bed Rails documented in part, Policy Explanation and Compliance Guidelines: Resident Assessment. 2. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. 3. The resident assessment must also assess the resident's risk from using bed rails. Examples of the potential risks with the use of bed rails include: a. Accident hazards (e.g., falls, entrapment, and other injuries sustained from attempts to climb over, around, between, or through the rails, or over the footboard). b. Barrier to residents from safely getting out of bed. c. Physical restraint (e.g., hinders residents from independently getting out of bed or performing routine activities). d. Decline in resident function, such as muscle functioning/balance. e. Skin integrity issues. f. Decline in other areas of activities of daily living such as using the bathroom, continence, eating, hydration, walking and mobility. g. Other potential negative psychosocial outcomes such as an undignified self-image, altered self-esteem, feelings of isolation, or agitation/anxiety. 4. The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself. 5. The facility will assess to determine if the bed rail meets the definition of a restraint. A bed rail is considered to be a restraint if the bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently. If it is determined to be a restraint, the facility will follow their procedures related to physical restraints. Informed Consent. 6. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to (continued on next page)

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	installation and use of bed rails. This information should be presented in an understandable manner, and consent given voluntarily, free from coercion. On 02/09/2026 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.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation and a review of facility menus, the facility staff failed to serve portions of food planned on the facility's menu for 1 of 80 residents (Resident #109) in the survey sample. The findings include: Resident #109 was originally admitted to the facility 05/23/25 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Need for assistance with personal care and unspecified urinary incontinence.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. 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 5/27/25 has a nutritional problem or potential nutritional problem, aeb dx CVD, HTN, hypothyroidism; advanced age; underweight per BMI; mechanically altered diet texture. The Goal is that the resident will The resident will maintain adequate nutritional status asevidenced by no significant weight changes, no s/sx of malnutrition, and consuming >/=50% of most meals daily. The interventions are: Provide and serve the diet as ordered. Monitor intake and record q meal and RD to evaluate and make diet change recommendations PRN. On 2/5/26 at approximately 9:00 am, a meal observation was conducted of Certified Nursing Assistant/Restorative Aide #14 as Resident #109 was being fed. A review of Resident #109's lunch meal ticket dated 2/05/26 read: Beef Taco Filling for Flour Tortilla 3/8 cup shredded lettuce topping, pinto beans, cream style corn, and ground Pineapple tidbits. The Resident received on her tray all of the above, plus Mashed Potatoes, whole kernel corn instead of cream corn, and no lettuce. Throughout the meal, the resident would mention to CNA #14, Where's my taco sauce, where's my tomatoes, where's my lettuce, no more mashed potatoes, I don't like it.On 2/05/26 at approximately 9:30 am, a brief interview was conducted with CNA #14 concerning the resident's meal today. CNA #14 mentioned that the resident wasn't happy because she didn't receive Tacos for lunch and that she dislikes mashed potatoes.2/10/26 11:45 AM, a meal observation of CNA #9 was conducted. CNA #9 and the resident were heard speaking in Spanish, but the resident would occasionally speak in English: I don't like the mashed potatoes. CNA #9 reassured her that she would not give them to her again. A review of the resident's meal ticket listed: ground smothered chicken, creamed corn, sliced peaches, cornbread, and 8 oz tea. The resident's meal tray revealed ground-smothered chicken, mashed potatoes, whole-kernel corn, sliced peaches, and tea. On 2/10/26 at approximately 12:15 pm., a brief interview was conducted with CNA #9. CNA #9 said that she will inform the dietary department that the resident dislikes mashed potatoes.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 the Regional Director. No further comments were made.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident/staff interview, and facility document review, it was determined that the facility staff failed to provide snacks to residents who want to eat at non-traditional times for three of 80 residents, Resident #12 (R12), Resident #14 (R14) and Resident #137 (R137).The findings include: 1. During the survey period of 2/3/26-2/6/26 and 2/9/26-2/11/26 snacks were observed to be delivered at 10:00 AM, approximately 2:00 PM and 6:00 PM. Initial observation of snacks delivered and available on the four units included saltine crackers, graham crackers and on two of the units, some captain's crackers with peanut butter. Pitchers of juice were not observed in refrigerator on 2B till 2/5/26. A few puddings were available. 2/5/26 observed cart bringing boxes of oatmeal cookies, crackers and two pitchers of juice to unit 2B.R12 was admitted to the facility on [DATE] with diagnosis that included but were not limited to epilepsy, DM (diabetes mellitus) and CVA cerebrovascular accident.R12'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 R12's comprehensive care plan dated 5/24/22 revealed, FOCUS: The resident has a potential risk for nutrition/hydration imbalance related to current/past medical history as evidenced by generalized muscle weakness, schizophrenia, polyneuropathy, depression and epilepsy. INTERVENTIONS: Provide diet as ordered & per resident's preference.A review of R12's bedtime (hs) snacks offered per the ADL (activities of daily living) form revealed hs snacks not offered on 11/1, 11/2, 11/4, 11/5, 11/6, 11/7, 11/9, 11/14, 11/20, 11/23, 11/27, 11/28, 12/2, 12/5, 1/19, 1/24 and 1/25. Snacks not offered on following shifts and dates: D 2/2, 2/7, 2/8; E 2/1, 2/7, 2/8 and N 2/1, 2/2, 2/3, 2/4, 2/6, 2/9. During interview on 2/3/26 at 2:00 PM with R12, he described they do not offer snacks, we have to ask for them and it is usually saltine or graham crackers. If there is anything else, we do not get it.An interview regarding snacks was conducted on 2/4/26 at 11:40 AM with the dietary manager who described the snack delivery process as occurring at 10:00 AM, 2:00 PM and 6:00 PM; 6:00 PM is when we deliver the bedtime snacks.On 2/5/26 at 2:00 PM with CNA (certified nursing assistant) #3 showed nutrition area with bin of saltines, graham crackers, and half peanut butter sandwich. Dietary cart arrived with oatmeal cookies, crackers and juice. On 2/10/26 at 5:00 PM, the administrator and the director of nursing were made aware of the findings.No policy provided by facility.No further information was provided prior to exit. 2. During the survey period of 2/3/26-2/6/26 and 2/9/26-2/11/26 snacks were observed to be delivered on at 10:00 AM, approximately 2:00 PM and 6:00 PM. Initial observation of snacks delivered and available on the four units included saltine crackers, graham crackers and on two of the units, some captain's crackers with peanut butter. Pitchers of juice were not observed in refrigerator on 2B till 2/5/26. A few puddings were available. 2/5/26 observed cart bringing boxes of oatmeal cookies, crackers and two pitchers of juice to unit 2B.R14 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: polyneuropathy, HIV (Human Immunodeficiency Virus) and COPD (chronic obstructive pulmonary disease).R14's most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/26/26, coded the resident as scoring a 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 independent for bed mobility, transfer, hygiene.A review of R14's comprehensive care plan dated 6/3/25 revealed, FOCUS: The resident is at risk for nutritional problem or potential nutritional problem related to Disease process / diagnosis of HIV. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTERVENTIONS: Redirect and provide more food as indicated if resident is asking for food.A review of R14's bedtime (hs) snacks offered per the ADL (activities of daily living) form revealed hs snacks not offered on 12/2, 12/7, 12/20, 12/21, 12/22 and January 4th. Snacks not offered on following shifts and dates: D 2/1, 2/2, 2/3, 2/4, 2/7, 2/8; E 2/1, 2/2, 2/3, 2/7, 2/8 and N 2/1, 2/2, 2/3, 2/4, 2/6, 2/9. During interview on 2/3/26 at 2:00 PM with R14, he described snacks are not offered unless we ask for them.An interview regarding snacks was conducted on 2/4/26 at 11:40 AM with the dietary manager who described the snack delivery process as occurring at 10:00 AM, 2:00 PM and 6:00 PM; 6:00 PM is when we deliver the bedtime snacks.On 2/5/26 at 2:00 PM with CNA (certified nursing assistant) #3 showed nutrition area with bin of saltines, graham crackers, and half peanut butter sandwich. Dietary cart arrived with oatmeal cookies, crackers and juice. On 2/10/26 at 5:00 PM, the administrator and the director of nursing were made aware of the findings.No policy provided by facility.No further information was provided prior to exit. 3. During the survey period of 2/3/26-2/6/26 and 2/9/26-2/11/26 snacks were observed to be delivered on at 10:00 AM, approximately 2:00 PM and 6:00 PM. Initial observation of snacks delivered and available on the four units included saltine crackers, graham crackers and on two of the units, some captain's crackers with peanut butter. Pitchers of juice were not observed in refrigerator on 2B till 2/5/26. A few puddings were available. 2/5/26 observed cart bringing boxes of oatmeal cookies, crackers and two pitchers of juice to unit 2B.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 a nutritional problem or potential nutritional problem related to CVA diabetes and anemia. INTERVENTIONS: Provide, serve diet as ordered.A review of R137's bedtime (hs) snacks offered per the ADL (activities of daily living) form revealed hs snacks were offered in January and February. Snacks not offered on following shifts and dates: D 2/1, 2/2, 2/3, 2/5, 2/6, 2/7, 2/8, 2/9; E 2/1, 2/2, 2/3, 2/5, 2/7 and N 2/1, 2/5, 2/7.During interview on 2/3/26 at approximately 2:00 PM with R137, he described snacks are not provided.An interview regarding snacks was conducted on 2/4/26 at 11:40 AM with the dietary manager who described the snack delivery process as occurring at 10:00 AM, 2:00 PM and 6:00 PM; 6:00 PM is when we deliver the bedtime snacks.On 2/5/26 at 2:00 PM with CNA (certified nursing assistant) #3 showed nutrition area with bin of saltines, graham crackers, and half peanut butter sandwich. Dietary cart arrived with oatmeal cookies, crackers and juice. On 2/10/26 at 5:00 PM, the administrator and the director of nursing were made aware of the findings.No policy provided by facility.No further information was provided prior to exit.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and a review of the clinical record, the facility staff failed to have a hospice-coordinated plan of care for 1 of 80 residents (Resident #155) in the survey sample. The findings included: Resident #155 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included dementia. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 11/14/25, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 2 out of a possible 15. This indicated that Resident #155's cognitive abilities for daily decision-making were severely impaired. In section GG (Functional Abilities and Goals), the resident was coded as requiring setup or clean-up assistance with eating, supervision or touching assistance with oral care, and dependent with toileting, showers/bathe, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. On 2/4/26 at 10:45 AM, Resident #155 was observed in bed with the tip of an indwelling catheter in his hands, as he twisted the catheter back and forth. A lady was observed entering the resident's room and saying the resident's catheter is out. A review of the resident's Physician's Order Summary (POS) revealed an order dated 1/20/26 for hospice evaluation and treatment. A nurse's note dated 1/29/26 at 3:30 PM stated that the resident had been admitted to hospice, and the primary diagnosis was Senile Degeneration of the brain. An interview was conducted with the Assistant Director of Nursing (ADON) on 2/6/26 at approximately 11:40 AM. The ADON stated at 2:40 PM that no information was available regarding the services the hospice agency would provide or a schedule for staff to refer to; therefore, they would contact the agency. At the end of the day meeting on 2/6/26 with the Administrator (ADM), Director of Nursing (DON), and the Regional [NAME] President (RVP), the RVP stated that the facility uses a hospice binder for each resident receiving hospice services. The RVP stated that all hospice services should be documented in the binder, including admission documents; the services the hospice agency would provide; when and how those services would be provided; the communication process; and when or why the nursing facility staff should notify the hospice agency. On 2/11/26 at 9:25 AM and interview was conducted with Licensed Practical Nurse (LPN) #7. LPN #7 stated that she had contacted the hospice agency for the information needed to coordinate the residents' hospice care, but she had not received anything beyond verbal details regarding the Certified Nursing Assistant schedule. On 2/11/26 at approximately 11:00 AM, the ADON presented a hospice binder with forms that had been faxed to the facility on 2/10/26. 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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on staff interview, clinical record review, facility document review, the facility staff failed to conduct bed and bed rails inspections for one of 80 residents in the survey sample, Resident #125 (R125). The findings include:For Resident #125 (R125), facility staff failed to conduct a bed and bed rail safety inspection. R125 was admitted to the facility with a diagnosis that included but not limited to muscle weakness. On the most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/29/2026, R125 scored 2 15 out of 15 on the BIMS (brief interview for mental status), indicating R125 was cognitively intact for making daily decisions. On 02/03/2026 at approximately 3:33 p.m. an observation revealed R125 was in bed with bilateral (right and left) upper rails were raised. R125 stated he uses to move in bed. On 02/03/2026 at approximately 4:50 p.m. an observation revealed R125 was in bed with bilateral upper rails were raised. On 2/5/2026 at approximately 10:28 a.m. an observation revealed R125 was in bed with bilateral (right and left) upper rails were raised. On 2/5/2026 at approximately 11:58 a.m. an observation revealed R125 was in bed with bilateral (right and left) upper rails were raised Review of R125's clinical record failed to evidence documentation of an assessment and consent for the use of bed rails. On 02/09/2026 at approximately 3:30 p.m. the Director of Nursing (DON) in formed the surveyor that there were no bed rail or bed inspection for R125. On 02/11/2026 at approximately 8:27 a.m. an interview was conducted with the Maintenance Director regarding bed and bed rail inspections. He stated that the beds are inspected to make sure they are operating properly, raising and lowering the bed and the head-of-bed, making sure the mattress fits the bed frame to prevent entrapment. He also stated the bed rails are inspected to make sure they are operating properly and to prevent entrapment. The director of maintenance further stated that he has not started the bed and bed rail inspection and facility has recently hired an assistant for maintenance. The facility's policy, Proper Use of Bed Rails documented in part, Ongoing Monitoring and Supervision. 16. Responsibilities of ongoing monitoring and supervision are specified as follows: d. The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails. On 02/09/2026 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.