STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loudoun Rehabilitation and Nursing Center	235 Old Waterford Road, Northwest Leesburg, VA 20176

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, resident interview, staff interview and clinical record review, it was determined that facility staff failed to promote resident's dignity for two of 31 current residents in the survey sample, Residents #1 (R1) and R7. The findings include: 1a. For R1, facility staff failed to wash R1's hands before eating and stood while providing feeding assistance. R1 was admitted to the facility with diagnoses that included but were not limited to hemiplegia (1). On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/25/2024, R1 scored 11 out of 15 on the BIMS (brief interview for mental status), indicating R1 was moderately impaired of cognition for making daily decisions. GG0130 Self-Care coded R1 as requiring Partial/moderate assistance - helper does ESS THAN HALF the effort. Helper lifts or holds trunk or limbs, but provides less than half the effort with eating and coded Dependent for Personal hygiene: The ability to maintain personal hygiene, including combing hair shaving, applying makeup, washing/drying face and hands. On 05/12/2025 at approximately 1:20 p.m. R1 was observed in her room sitting in her wheelchair with an over-the-bed table in front of her and placed R1's lunch on the over-the-bed table. Further observations failed to evidence CNA (certified nursing assistant) #8 washing R1's hands before R1 started eating. At approximately 1:25 p.m. another observation of R1 revealed CNA #8 standing next to R1 while providing feeding assistance to R1. On 05/14/2025 at approximately 5:00 p.m. an interview was conducted with R1. When asked she felt about the CNA standing next to her when he was providing her with feeding assistance, R1 stated that it made her uncomfortable and that the staff should sit when assisting her. When asked about not having her hands washed before eating R1 stated that the staff do not wash her hands before or after eating her meals. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05 19/2025 at approximately 3:06 p.m. an interview was conducted with CNA #8. When informed of the above observations and interview with R1, CNA #8 stated he recalled the situation. CNA #8 stated the unit (long term care) was short staffed that day and it took time to get back to R1 because he had all the lunch trays to deliver to residents that could eat independently and had residents to feed. He stated he did not have enough help. When asked about standing while he provided feeding assistance to R1, he stated it was not dignified. He further stated that he should have been sitting next to or in front of R1 when assisting with the meal. When asked about washing R1's hands before and after eating, CNA #8 stated it should be done, and it is not dignified for residents not to clean their hands before and after eating. The facility's policy Resident's Rights documented in part, 4. Respect and dignity. The resident has a right to be treated with respect and dignity. The facility's policy Activities of Daily Living documented in part, Policy Explanation and Compliance Guidelines: 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. On 05/20/2025 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency References: (1) Loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 1b. For R1, the facility staff failed to serve the meal at the same time the roommate received their meal in the same room. On 05/12/2025 at approximately 12:55 p.m. R1 was observed in her room sitting in her wheelchair with an over-the-bed table in front of her, dressed, neat and clean. Further observations revealed R1's lunch tray sitting on a counter next to the sink approximately six feet away from the resident. An observation of R1's roommate revealed she was sitting on the edge of her bed eating her lunch independently. At 1:20 p.m. CNA (certified nursing assistant) #8 entered R1's room and set up R1's lunch on the over-the-bed table in front of R1. On 05/14/2025 at approximately 5:00 p.m. an interview was conducted with R1. She was asked how she felt about waiting 25 minutes to receive her lunch on 05/12/2025 while her roommate ate their own meal while she waited. R1 stated that she should not have to wait that long, and the food could get cold. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05 19/2025 at approximately 3:06 p.m. an interview was conducted with CNA #8. When informed of the above observations and interview with R1 regarding CNA #8 stated he recalled the situation. When asked about R1 having to wait 25 minutes to receive her lunch while her roommate was eating and finished their meal before R1 received her meal, CNA #8 stated the facility was short staffed that day and it took time to get back to R1 because he had two other residents to feed. He further stated it was not dignified to have R1 wait for her meal while her roommate was eating. On 05/20/2025 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit. 2. For R7, facility staff stood while providing feeding assistance. R7 was admitted to the facility with diagnoses that included but were not limited to muscle weakness. On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/04/2024, R7 scored 5 (five) out of 15 on the BIMS (brief interview for mental status), indicating R1 was severely impaired of cognition for making daily decisions. GG0130 Self-Care coded R7 as requiring Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. On 05/12/2025 at approximately 1:30 p.m., an observation revealed R7 receiving assistance with feeding by CNA (certified nursing assistant) #8. Further observations revealed CNA #8 was standing next to R7's bed while providing assistance. On 05 19/2025 at approximately 3:06 p.m. an interview was conducted with CNA #8. When informed of the above observations and interview with R1, CNA #8 stated he recalled the situation. When asked about standing while he provided feeding assistance to R7, he stated it was not dignified. He further stated that he should have been sitting next to the bed when assisting with the meal. On 05/20/2025 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to notify the physician and responsible party as required for three of 31 current residents in the survey sample, Residents #1 (R1), R24 and R29. The findings include: 1. For R1, facility staff failed to notify the physician and responsible party (RP) when the Lidocaine (1) patch was not available. R1 was admitted to the facility with diagnoses that included but were not limited to hemiplegia (2). On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/25/2024, R1 scored 11 out of 15 on the BIMS (brief interview for mental status), indicating R1 was moderately impaired of cognition for making daily decisions. Section J0100 Pain Management coded R1 as having occasional pain. The physician's order for R1 documented, Lidocare Arm/Neck/Leg Patch 4 % (four percent) (Lidocaine). Apply to right upper back/neck topically (on the outside of the body) one time a day for myalgia (3) removed the patch at 1800 (6:00 p.m.) and remove per schedule. Order Dare: 8/9/2023. Start Date: 8/10/2023. The eMARs (electronic medication administration records) for R1 dated January 2025, February 2025, March 2025 and April 2025 documented in part, Lidocare Arm/Neck/Leg Patch 4 % (Lidocaine). Apply to right upper back/neck topically one time a day for myalgia removed the patch at 1800 (6:00 p.m.) and remove per schedule. Start Date: 8/10/2023 0800 (8:00 a.m.). The eMAR for R1 dated January 2025 for the administration of Lidocaine at 8:00 a.m. documented, 13 on 01/03/2025, 01/04/2025, 01/05/2025, 01/10/2025 and 9 (nine) on 01/20/2025 and on 01/27/2025. The eMAR Chart Codes documented, 13=Medication Not Available and 0=Other / See Progress Notes. The eMAR for R1 dated February 2025 for the administration of Lidocaine at 8:00 a.m. documented, 9 on 02/05/2025 and on 02/13/2025. The eMAR for R1 dated March 2025 for the administration of Lidocaine at 8:00 a.m. documented, 13 on 03/10/2025 and 9 on 03/04/2025, 03/05/2025, 03/15/2025 and on 03/17/2025. The eMAR for R1 dated April 2025 for the administration of Lidocaine at 8:00 a.m. documented, 13 on 04/05/2025 and 9 on 04/01/2025 and on 04/14/2025. Review of the facility's progress notes for R1 dated 01/01/2025 through 04/28/2025 failed to evidence documentation regarding the eMAR codes of 13 and 9 on the dates listed above. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's packing lists from (Name of Medical Supply Company) were reviewed. The packing lists with the following dates documented: 01/07/2025 documented 10 boxes of Lidocaine patches shipped on 01/07/2025, 01/14/2025 documented 7 (seven) boxes of Lidocaine patches shipped on 01/14/2025, 01/21/2025 documented 12 boxes of Lidocaine patches shipped on 01/21/2025, 01/28/2025 documented 12 boxes of Lidocaine patches shipped on 01/28/2025, 02/04/2025 documented 12 boxes of Lidocaine patches shipped on 02/04/2025, 02/11/2025 documented 12 boxes of Lidocaine patches shipped on 02/11/2025, 02/17/2025 documented 12 boxes of Lidocaine patches shipped on 02/17/2025, 02/25/2025 documented 8 (eight) boxes of Lidocaine patches shipped on 02/25/2025, 03/04/2025 documented 12 boxes of Lidocaine patches shipped on 03/04/2025, 03/11/2025 documented 16 boxes of Lidocaine patches shipped on 03/11/2025, 03/25/2025 documented 14 boxes of Lidocaine patches shipped on 03/25/2025, 04/01/2025 documented 14 boxes of Lidocaine patches shipped on 04/01/2025, 04/16/2025 documented 14 boxes of Lidocaine patches shipped on 04/16/2025 and 04/29/2025 documented 14 boxes of Lidocaine patches shipped on 04/29/2025. The facility's list of House Supply of Over-the-Counter Medicine documented in part Lidocaine, 4% Patches. On 05/15/2025 at approximately 11:20 a.m. an interview and observation of facility supplies was conducted with OSM (other staff member) #17, central supply coordinator. He was asked to describe the procedure for ordering and maintaining supplies in the facility for the residents and staff. OSM #17 stated he orders PPE (personal protective equipment), medical supplies, incontinence supplies, dry and wet wipes, supplements, resident hygiene and grooming supplies (e.g., toothbrush, toothpaste, combs, body soap, peri cleaner, etc), peri cleaner and over the counter medications (e.g., vitamins, acetaminophen, etc). He stated that there is a supply room on each floor in the facility and he checks them twice a day to determine what supplies need to be restocked and when he restocks the supply rooms the items are rotated to help eliminate expired items being used. OSM #17 stated that on Fridays he checks the supply rooms and restocks double the common supplies (e.g., incontinent supplies, wipes, gloves, PPE) to cover the weekend. He also stated that a nurse on each of the units has a key to access the central supply room to get any supplies they may run out of in the supply rooms. When asked about ordering supplies OSM #17 stated he submits the order through an electronic ordering system to the vendor. He stated that the purchasing manager for the facility reviews the order and makes the final decision as to what is ordered based on cost effectiveness and quantity needed. On 05/19/2025 at approximately 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked about coding on a resident's eMAR she stated when a resident is administered the medication there is a check mark, and if the resident refuses the medication, it is coded the number 9 (nine) and it is documented in the progress note. After reviewing the nursing progress notes dated January 6, 2025, the eMAR notes dated January 6, 2025, at 10:58 am., January 2025 eMAR for R1, LPN #2 was asked about the code 9 above her initials on 01/06/2025 for Lidocaine at 8:00 a.m. She stated the medication was not available. LPN #2 further stated that sometimes they had the Lidocaine and sometimes they did not. When asked about the procedure when a resident refused their medication or it was not available, she stated that the physician or NP (nurse practitioner) should be notified each time and documented in the progress notes. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/19/2025 at approximately 4:00 p.m. an interview was conducted with LPN #8, regarding the coding on a resident's eMAR. She stated that code 9 indicates that they do not have the medication or it's on the way from the pharmacy, code 13 indicated that the medication was not available and not in the facility, and a check mark (?) indicated the medication was administered. After reviewing the eMAR dated March 10 coding R1's Lidocaine was 13, not available at 8:00 a.m., and the eMAR notes for the same day, LPN #8 was asked about the absence of documentation to the pharmacy about the medication not being available. She did not have an explanation. When asked to describe the procedure when a resident's medication is not available, she stated that the pharmacy is notified, and it is documented in the resident's progress notes. When asked if the physician is notified that a resident did not receive a medication and/ or it was not available for administration she stated no. On 05/19/2025 at approximately 4:10 p.m. an interview was conducted with LPN #10 regarding the coding on a resident's eMAR. She stated that code 9 (number nine) indicated that they do not have the medication, code 13 indicated that the medication was not available and not in the facility, and a check mark (?) indicated the medication was administered. When asked to describe the procedure when a resident's medication is not available, LPN #10 stated the nurse practitioner or physician is notified and it is documented in the progress notes. On 05/20/2025 at 9:20 a.m., an interview was conducted ASM (administrative staff member) #2, director of nursing, regarding the coding on a resident's eMAR. She stated a check mark (?) indicated the medication was given, code 9 refers to a progress note that explains why a medication was not given and code 13 indicated that the medication was not in the facility. She further stated that if the medication is not on the medication cart, the nurse should be checking the supply rooms and the Pixis (an automated medication dispensing system) for over-the-counter medications. When asked to describe the procedure when a resident's medication is not available ASM #2 stated that the physician and the responsible party or the resident, if they are their own responsible party, should be notified and it should be documented in the progress notes. On 05/21/2025 at approximately 8:30 a.m. an interview was conducted with OSM #17 regarding over-the-counter medications. He stated the procedure for ordering over-the-counter medications is the same procedure he followed when ordering other supplies as described during the interview on 05/15/2025. He stated that he checks the supply room on the first floor, the inventory in the central supply room and checks the director of nursing and the nursing staff to see if they need any specific medications other than what is normally ordered. He stated the order for over-the-counter medications is sent in once a week on Mondays and usually arrives by Wednesday or Thursday of the same week. When asked about the quantity the Lidocaine patches are shipped in, he stated that each case contains 12 boxes, and each box contains five patches. On 05/20/2025 at 1:14 p.m., an interview was conducted ASM #2, director of nursing after reviewing R1's eMARS for the dates listed above, the progress notes dated 01/01/2025 through 04/28/2025. ASM #2 stated that R1's lidocaine patch was not available on the dates listed above that were coded thirteen and nine on the eMARs listed above. She further stated that there was no documentation that the physician or RP was notified when the medication was unavailable. The facility's policy Unavailable Medications documented in part, 4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	known that the medication is unavailable: b. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold. 5. If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reactions to omission of the medication. On 05/20/2025 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency References: (1) Used to stop pain. This information was obtained from the website:https://www.drugs.com/cdi/lidocaine-patch.html. (2) Loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html. (3) The medical term for muscle pain. This information was obtained from the website: https://myclevelandclinic.org/health/symptoms/myalgia-muscle-pains. 2. For Resident #24 (R24), the facility staff failed to notify the RR (resident representative) of a new medication order. On the annual MDS (minimum data set) with an ARD (assessment reference date) of 2/7/24, R24 was coded as being moderately cognitively impaired. A review of R24's clinical record revealed the following order dated 8/16/24: Valacyclovir (1) HCl Oral Tablet 1 GM (gram) (Valacyclovir HCl) Give 2 tablets by mouth every 12 hours for herpes labialis for 1 Day. A review of R24's August 2024 MAR (medication administration record) revealed he received the medication as ordered. Further review of R24's clinical record failed to reveal evidence that his RR (resident representative) was notified of this new medication order. On 5/19/25 at 2:31 p.m., LPN (licensed practical nurse) #2 was interviewed. She stated if a resident has a new diagnosis requiring a new medication, the RR should always be notified. She stated the nurse who processes the order is responsible for this notification. She added: [The RR] needs to be aware of what is going on with the resident. On 5/20/25 at 4:27 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided prior to exit. Reference (1) Valacyclovir is used to treat herpes zoster (shingles) and genital herpes. It does not cure herpes infections but decreases pain and itching, helps sores to heal, and prevents new ones from forming. This information is taken from the website https://medlineplus.gov/druginfo/meds/a695010.html. 3. For Resident #29 (R29), the facility staff failed to notify the responsible party and physician of multiple medication refusals between 4/1/24-6/30/24. On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 5/19/24, the resident scored one out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. The assessment documented no behaviors or rejection of care. The admission record for R29 documented the daughter as the financial and care power of attorney and emergency contact. Review of the eMAR (electronic medication administration record) for R29 dated 4/1/24-4/30/24 documented the following scheduled medications: - Amlodipine Besylate 5 mg tab. Give 1 tablet orally one time a day for HTN (hypertension). Scheduled daily at 9:00 a.m. - Benztropine Mes 1mg tablet. Give 1 tablet orally two times a day for EPS (extrapyramidal symptoms). Scheduled daily at 9:00 a.m. and 5:00 p.m. - Clonidine 0.1 mg/day patch. Apply 1 patch transdermally one time a day every Thu for HTN and remove per schedule. Scheduled to remove at 7:59 a.m. and apply at 8:00 a.m. weekly on Thursdays. - Famotidine 40 mg tablet. Give 1 tablet orally one time a day for GERD (gastroesophageal reflux disease). Scheduled daily at 8:00 a.m. - Furosemide 40 MG tablet. Give 1 tablet orally one time a day for Edema. Scheduled daily at 8:00 a.m. - Incruse Ellipta 62.5 MCG Inh 1 capsule inhale orally at bedtime for COPD (chronic obstructive pulmonary disease). Scheduled daily at 9:00 p.m. - Losartan Potassium 50 mg tab. Give 1 tablet orally one time a day for HTN. Scheduled daily at 8:00 a.m. - Potassium Cl ER 20 MEQ Tablet. Give 1 tablet orally one time a day for Supplement. Scheduled daily at 8:00 a.m. - Risperdal Consta 25 mg VIAL Inject 1 vial intramuscularly one time a day every 14 day(s) for Schizophrenia. Scheduled on 4/3/24 and 4/26/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Carbidopa-Levodopa 25-100 Tab. Give 1 tablet orally three times a day for Parkinsons. Scheduled daily at 9:00 a.m., 1:00 p.m., and 9:00 p.m. - Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium). Give 2 capsule by mouth three times a day for Mood DO (disorder). It can be sprinkled into food or drinks. Scheduled daily at 6:00 a.m., 2:00 p.m., and 10:00 p.m. - Hydralazine 50 mg Tablet. Give 1 tablet orally three times a day for HTN. Scheduled daily at 9:00 a.m., 1:00 p.m. and 9:00 p.m. All medications scheduled between 4/1/24-4/30/24 were documented as not administered with a 9 or 2 documented. The administration key documented in part, 2=Drug refused and 9=Other/See Progress Notes. Review of the eMAR for R29 dated 5/1/24-5/31/24 documented the medications as listed above from the April 2024 eMAR except for the Risperdal Consta 25 mg VIAL Inject 1 vial intramuscularly scheduled on 5/10/24 and 5/24/24 and the Depakote Sprinkles 125 MG decreased to twice a day scheduled at 9:00 a.m. and 5:00 p.m. starting on 5/17/24. All medications scheduled between 5/1/24-5/31/24 were documented as not administered with a 9 or 2 documented except for the Benztropine mes 1mg on 5/14/24 at 5:00 p.m., Carbidopa/Levodopa 25-100 tab on 5/6/24 and 5/18/24 at 9:00 p.m., Incruse Ellipta 62.5mcg on 5/18/24 at 9:00 p.m., and Hydralazine 50mg on 5/6/24 at 9:00 p.m. and 5/18/24 at 9:00 p.m. The administration key documented in part, 2=Drug refused and 9=Other/See Progress Notes. Review of the eMAR for R29 dated 6/1/24-6/30/24 documented the medications as listed above from the April 2024 eMAR except for the Risperdal Consta 25 mg VIAL Inject 1 vial intramuscularly scheduled on 6/7/24 and 6/21/24 and the Depakote Sprinkles 125 MG scheduled at 9:00 a.m. and 5:00 p.m. All medications scheduled between 5/1/24-5/31/24 were documented as not administered with a 9 or 2 documented except for the Famotidine 40mg, Furosemide 40mg, Losartan Potassium 50mg and Potassium CL ER 20meq on 6/18/24 at 8:00 a.m., and the Carbidopa/Levodopa 25-100 tab on 6/18/24 at 9:00 a.m. The administration key documented in part, 2=Drug refused and 9=Other/See Progress Notes. Review of the progress notes/eMAR administration notes documented R29 refusing medications. The notes failed to evidence notification of the physician/nurse practitioner or responsible party of the refusals of medication. Physician notes on 4/1/24 and 6/10/24 documented a history of refusal of medications. On 5/19/25 at 2:34 p.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that R29 occasionally would agree to take her medications but refused them most of the time. She stated that R29 had behaviors of yelling, throwing things and being aggressive to staff. She stated that when R29 refused the medication they attempted again after leaving for a little while and if she still refused they documented it. She stated that the responsible party and the nurse practitioner should be notified every time a resident refuses medication. She stated that she did not recall calling the responsible party and that she may have notified the nurse practitioner, but she should have documented it in the notes. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loudoun Rehabilitation and Nursing Center	235 Old Waterford Road, Northwest Leesburg, VA 20176

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/19/25 at 2:40 p.m., an interview was conducted with ASM (administrative staff member) #3, nurse practitioner. ASM #3 stated that she remembered that R29 was non-compliant with medications and care, and it was difficult to give her the medication. She stated that R29 was aggressive, and she had continued the medication orders because she needed them and there were times when she would take them so the strategy was to keep as much in her system that she would let them, and to try to stay on top of the behaviors. On 5/20/25 at 9:11 a.m., an interview was conducted with ASM #2, the director of nursing who stated that when a resident refused their medications they first attempted to find out why they were refusing them and try to educate the resident. She stated that if the resident was not alert and oriented they notified the power of attorney and the physician what was going on and they may be able to do an alternative treatment or medication. She stated that they should care plan the refusals and have more frequent rounds with the psychiatry provider. The facility policy Notification of Changes dated 9/24, documented in part, .The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification . On 5/20/25 at 4:18 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concern. No further information was obtained 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. Based on staff interview and clinical record review, it was determined that the facility staff failed to keep residents free from neglect for two of 31 residents in the survey sample, Residents #13 (R13) and R19. The findings include: 1. For R13, the facility staff failed to check and perform incontinence care in a timely manner. R13 was admitted to the facility with diagnoses that included but were not limited to dementia (1). On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/14/2025, R13 scored 2 (two) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. Section H0300 Urinary Continence coded R13 as being always incontinent. On 05/13/2025 at 12:42 p.m. until 5:00 p.m. continuous observations were conducted of R13. During the four hour and 17 minutes of observation, R13 was not checked by a nurse or a CNA (certified nursing assistant) for incontinence care. On 05/13/2025 at approximately 5:05 p.m. an interview was conducted with CNA #3. When asked if he was assigned to R13 for the 3:00 p.m. to 11:00 p.m. shift he stated yes. He asked to describe the procedure for residents who are dependent on staff for incontinence care. CNA #3 stated residents are checked for incontinence care at the beginning of each shift, checked every two hours throughout the shift and at the end of each shift. He also stated at the beginning of the shift he receives report from the previous shift CNA that includes the resident's condition, and which residents had received incontinence care. When asked about consequences a resident may encounter if they are left wet and/or soiled for extended periods of time he stated the resident could have skin breakdown. When asked if he received information regarding R13's incontinence care from the CNA on the previous shift (7:00 a.m. - 3:00 p.m.), CNA #3 stated he was not informed. When informed of the observation stated above, CNA #3 stated he would check R13 immediately. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 5:15 p.m., CNA (certified nursing assistant) #3 and CNA #4 were observed attempting to provide incontinence care to R13 in his room. R13 displayed stiffness and tremors in his arms, and stiffness in his legs as he sat in his wheelchair. CNA #3 repeatedly placed his hands on R13's arms attempting to pull the resident up from a sitting position in the wheelchair in order to transfer the resident to the bed for incontinence care. The resident repeatedly resisted; CNA #3 persisted in his efforts. CNA #4 told CNA #3 that R13 would not respond to this type of action, and that R13 would be able to transfer with minimal assistance if CNA #3 would not touch the resident. CNA #3 continued to attempt to take the resident's arm and assist him to move toward the bed. CNA #4 took over the effort, and assisted the resident to self-propel his wheelchair over to the sink area. CNA #4 stated: Put your hands on the counter and stand up. You are soaking wet. R13 refused to stand at the sink. CNA #4 assisted the resident to self-propel in the wheelchair back to the bed, and CNA #4 and CNA #3 physically lifted R13 from the wheelchair and moved him to a supine position on the bed. CNA #3 removed the resident's pants and incontinence brief. The brief was saturated with urine to the point that the brief contained hardened ridges where urine had pooled over time. The brief contained a large amount of feces, some of it soft, and some of it dried on the resident's buttocks. On 05/20/2025 at approximately 5:08 p.m. an interview was conducted with LPN (licensed practical nurse) #13. When asked what would constitute neglect of a resident she stated it would include not feeding a resident, not administering their medications and not providing ADL (activities of daily living) care. When asked to describe the process for ensuring a resident who is dependent on incontinence care is not left wet or soiled she stated that the resident should be checked every two hours. LPN #13 also stated that it would be neglect if a resident was not checked every two hours for incontinence care. On 05/20/2025 at approximately 5:12 p.m. an interview was conducted with CNA (certified nursing assistant) #17. When asked what would constitute neglect of a resident she stated it would include leaving a resident unattended or not giving care. When asked to describe the process for ensuring a resident who is dependent on incontinence care is not left wet or soiled she stated that the resident should be checked every two hours. LPN #13 also stated that it would be neglect if a resident was not checked every two hours for incontinence care. On 05/20/2025 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency Reference: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 2. For R19, the facility staff failed to check and perform incontinence care in a timely manner. R19 was admitted to the facility with diagnoses that included but were not limited to a stroke. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/29/2025, R19 scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. Section H0300 Urinary Continence coded R13 as being always incontinent. On 05/13/2025 at 12:42 p.m. until 5:00 p.m. continuous observations were conducted of R19. During the four hour and 17 minutes of observation, R19 was not checked by a nurse or a CNA (certified nursing assistant) for incontinence care. On 05/13/2025 at 5:00 p.m. an interview was conducted with CNA #6. When asked if she was assigned to R19 from the 3:00 p.m. to 11:00 p.m. shift she stated yes. When asked to describe the procedure for incontinence care for residents who are dependent on staff for incontinence care. CNA #6 stated residents are checked for incontinence care at the beginning of each shift, checked every two hours throughout the shift and at the end of each shift. She also stated at the beginning of the shift she receives report from the previous shift CNA that includes which residents have received incontinence care. When asked about consequences a resident may encounter if they are left wet and/or soiled for extended periods of time she stated the resident could have skin breakdown. When asked if she received information regarding R19's incontinence care from the CNA on the previous shift (7:00 a.m. - 3:00 p.m.), CNA #6 stated she was not informed. When informed of the observation stated above, CNA #6 stated she would check R19 immediately. On 5/13/25 at 5:02 p.m., CNA #6 entered R19's room carrying wipes and a clean incontinence brief. R19 saw the incontinence care supplies and started to shake her head. CNA #6 stated: I would like to change you. R19 continued to refuse. CNA #6 told the resident she would return again and ask about incontinence care just before dinner trays were distributed. CNA #6 stated R19 frequently refused incontinence care. CNA #6 stated even if a resident is known to refuse care, the care should still be offered every 2 hours. On 05/20/2025 at approximately 5:08 p.m. an interview was conducted with LPN (licensed practical nurse) #13. When asked what would constitute neglect of a resident she stated it would include not feeding a resident, not administering their medications and not providing ADL (activities of daily living) care. When asked to describe the process for ensuring a resident who is dependent for incontinence care is not left wet or soiled she stated that the resident should be checked every two hours. LPN #13 also stated that it would be neglect if a resident was not checked every two hours for incontinence care. On 05/20/2025 at approximately 5:12 p.m. an interview was conducted with CNA (certified nursing assistant) #17. When asked what would constitute neglect of a resident she stated it would include leaving a resident unattended or not giving care. When asked to describe the process for ensuring a resident who is dependent on incontinence care is not left wet or soiled she stated that the resident should be checked every two hours. LPN #13 also stated that it would be neglect if a resident was not checked every two hours for incontinence care. On 05/20/2025 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint deficiency

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on staff interview and facility document review, it was determined that the facility staff failed to obtain criminal background checks to screen for abuse of six of six contract employees. The findings include: On 05/13/2025 criminal background checks were requested from ASM (administrative staff member) #1, the administrator for six contracted construction workers who were observed working in the facility. On 05/14/2025 review of the documents provided by the facility failed to evidence criminal record background checks. The employees identified were: OSM (other staff member) #20, construction worker with a hire date of 06/24/2024. OSM #21, construction worker with a hire date of 06/24/2024. OSM #22, construction worker with a hire date of 06/24/2024. OSM #23, construction worker with a hire date of 04/07/2025. OSM #24, electrician with a hire date of 02/2025. OSM #25, electrician with a hire date of 06/24/2024. On 05/20/2025 at approximately 10:28 a.m., an interview was conducted with ASM #4, regional administrator, regarding background checks for construction workers in the facility. ASM #4 stated that the general contractor of the construction company stated the construction workers did not have social security numbers but could provide national background checks for the construction workers. ASM #4 stated she was provided background checks from Ecuador and accepted them. When asked if the background checks from Ecuador met the regulations ASM #4 stated she did not know if the background checks met the regulations. The facility policy Abuse, Neglect and Exploitation documented in part, I. Screening: A1. Background, reference, and credentials' check shall be conducted on potential employees, contracted temporary staff, student affiliated with academic institutions, volunteers and consultants. A2. Screenings may be conducted by the facility staff itself, third-party agency or academic institutions. A3. The facility will maintain documentation of proof that the screening occurred. On 05/20/2025 at approximately 4:30 p.m., ASM #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview and facility document review, it was determined that the facility staff failed to implement the abuse policy for of six of six contract employees and failed to investigate and report allegations of abuse and exploitation for one of 31 residents in the survey sample, Resident #18 (R18). The findings include: 1. On 05/13/2025 criminal background checks were requested from ASM (administrative staff member) #1, the administrator for six contracted construction workers who were observed working in the facility. On 05/14/2025 review of the documents provided by the facility failed to evidence criminal record background checks. The employees identified were: 1. OSM (other staff member) #20, construction worker with a hire date of 06/24/2024. 2. OSM #21, construction worker with a hire date of 06/24/2024. 3. OSM #22, construction worker with a hire date of 06/24/2024. 4. OSM #23, construction worker with a hire date of 04/07/2025. 5. OSM #24, electrician with a hire date of 02/2025. 6. OSM #25, electrician with a hire date of 06/24/2024. On 05/20/2025 at approximately 10:28 a.m., an interview was conducted with ASM #4, regional administrator, regarding background checks for construction workers in the facility. ASM #4 stated that the general contractor of the construction company stated the construction workers did not have social security numbers but could provide national background checks for the construction workers. ASM #4 stated she was provided background checks from Ecuador and accepted them. When asked if the background checks from Ecuador met the regulations ASM #4 stated she did not know if the background checks met the regulations. The facility policy Abuse, Neglect and Exploitation documented in part, I. Screening: A1. Background, reference, and credentials' check shall be conducted on potential employees, contracted temporary staff, student affiliated with academic institutions, volunteers and consultants. A2. Screenings may be conducted by the facility staff itself, third-party agency or academic institutions. A3. The facility will maintain documentation of proof that the screening occurred. On 05/20/2025 at approximately 4:30 p.m., ASM #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow a policy to prevent abuse, and to report and investigate an allegation of resident exploitation for one of 31 residents in the survey sample, Resident #28, and for six of six contract staff records reviewed. The findings include: 1. For Resident #28 (R28), the facility staff failed to follow its policy to report an allegation of resident exploitation to the state agency (SA) and to investigate this allegation. A review of the facility policy, Abuse, Neglect, and Exploitation, revealed, in part: 'Exploitation' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent Investigation .An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, and exploitation, occur .Written procedures for investigation include .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation .Providing complete and thorough documentation of the investigation .Reporting/Response .The facility will have written procedures that include .reporting of alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies .within specified timeframes. A review of R28's progress notes revealed the following: 10/11/2023 .Social / Psychosocial Note .Social Work Note: The Director of Nursing let this writer know that [R28]'s daughter expressed concerns that her father is being exploited of his funds by a friend of his whom she does not know. This writer met with [R28] who denied all allegations. [R28] in fact, is alert and oriented X4 and denied these allegations. [R28] did share his wishes .to no longer have his daughter manage his bank account. This writer reached out to the Ombudsman who recommended SS (social services) to contact APS (adult protective services) and file a report. This writer contacted [name of county] Adult Protective Services .today to file a report that [R28] wishes his daughter to be investigated. APS will be reaching out to SS Department when they have filed a claim. 1/4/2024 .Social / Psychosocial Note .This writer spoke with resident's APS worker regarding case for exploitation of funds. [APS worker] . stated she will be closing the case and has spoken to resident regarding issuing funds inappropriately and providing banking information to unknown individuals. Resident seems to be in denial and not receptive. APD (sic) requested facility become payee. SS will continue to provide support as needed. On 5/19/25 and 5/20/25, requests were made of facility management to provide evidence of a report to the SA regarding R28's allegation of exploitation and of an investigation of the allegation. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 8:32 a.m., ASM (administrative staff member) #1, the administrator, was interviewed. He stated any reports of possible resident exploitation should be reported from front line team members to the manager, then the manager should report the allegation to the administrator or the DON (director of nursing). He stated the report should be made immediately. Following the report, the administrator or DON should submit a report to the SA and to APS. After the allegation is reported, the facility should immediately begin an investigation, including interviews with the resident, staff, and any outside party who may have knowledge of the situation. The SA should receive a final report with the results of the investigation within five business days. ASM #1 stated he was still looking for evidence that the allegation of exploitation of R28 had been reported to the SA. On 5/20/25 at 4:27 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. ASM #1 stated no report to the SA or evidence of an investigation had been located as of yet. No additional information was provided prior to exit.

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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, facility document review, and clinical record review, the facility staff failed to report an allegation of resident exploitation to the State Agency (SA) for one of 31 residents in the survey sample, Resident #28. The findings include: For Resident #28 (R28), the facility staff failed to report an allegation of exploitation to the SA when staff members became aware on 10/11/23. A review of R28's progress notes revealed the following: 10/11/2023 .Social / Psychosocial Note .Social Work Note: The Director of Nursing let this writer know that [R28]'s daughter expressed concerns that her father is being exploited of his funds by a friend of his whom she does not know. This writer met with [R28] who denied all allegations. [R28] in fact, is alert and oriented X4 and denied these allegations. [R28] did share his wishes .to no longer have his daughter manage his bank account. This writer reached out to the Ombudsman who recommended SS (social services) to contact APS (adult protective services) and file a report. This writer contacted [name of county] Adult Protective Services .today to file a report that [R28] wishes his daughter to be investigated. APS will be reaching out to SS Department when they have filed a claim. 1/4/2024 .Social / Psychosocial Note .This writer spoke with resident's APS worker regarding case for exploitation of funds. [APS worker] . stated she will be closing the case and has spoken to resident regarding issuing funds inappropriately and providing banking information to unknown individuals. Resident seems to be in denial and not receptive. APD (sic) requested facility become payee. SS will continue to provide support as needed. On 5/19/25 and 5/20/25, requests were made of facility management to provide evidence of a report to the SA regarding R28's allegation of exploitation. On 5/20/25 at 8:32 a.m., ASM (administrative staff member) #1, the administrator, was interviewed. He stated any reports of possible resident exploitation should be reported from front line team members to the manager, then the manager should report the allegation to the administrator or the DON (director of nursing). He stated the report should be made immediately. Following the report, the administrator or DON should submit a report to the SA and to APS. After the allegation is reported, the facility should immediately begin an investigation, including interviews with the resident, staff, and any outside party who may have knowledge of the situation. The SA should receive a final report with the results of the investigation within five business days. ASM #1 stated he was still looking for evidence that the allegation of exploitation of R28 had been reported to the SA. On 5/20/25 at 4:27 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. ASM #1 stated no report to the SA had been located as of yet. (continued on next page)

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	495275	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loudoun Rehabilitation and Nursing Center	235 Old Waterford Road, Northwest Leesburg, VA 20176

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy, Abuse, Neglect, and Exploitation, revealed, in part: 'Exploitation' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent .Reporting/Response .The facility will have written procedures that include .reporting of alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies .within specified timeframes. No additional information was provided prior to exit.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on staff interview, facility document review, and clinical record review, the facility staff failed to investigate an allegation of resident exploitation for one of 31 residents in the survey sample, Resident #28. The findings include: For Resident #28 (R28), the facility staff failed to investigate an allegation of exploitation when staff members became aware on 10/11/23. A review of R28's progress notes revealed the following: 10/11/2023 .Social / Psychosocial Note .Social Work Note: The Director of Nursing let this writer know that [R28]'s daughter expressed concerns that her father is being exploited of his funds by a friend of his whom she does not know. This writer met with [R28] who denied all allegations. [R28] in fact, is alert and oriented X4 and denied these allegations. [R28] did share his wishes .to no longer have his daughter manage his bank account. This writer reached out to the Ombudsman who recommended SS (social services) to contact APS (adult protective services) and file a report. This writer contacted [name of county] Adult Protective Services .today to file a report that [R28] wishes his daughter to be investigated. APS will be reaching out to SS Department when they have filed a claim. 1/4/2024 .Social / Psychosocial Note .This writer spoke with resident's APS worker regarding case for exploitation of funds. [APS worker] . stated she will be closing the case and has spoken to resident regarding issuing funds inappropriately and providing banking information to unknown individuals. Resident seems to be in denial and not receptive. APD (sic) requested facility become payee. SS will continue to provide support as needed. On 5/19/25 and 5/20/25, requests were made of facility management to provide evidence of an investigation regarding R28's allegation of exploitation. On 5/20/25 at 8:32 a.m., ASM (administrative staff member) #1, the administrator, was interviewed. He stated any reports of possible resident exploitation should be reported from front line team members to the manager, then the manager should report the allegation to the administrator or the DON (director of nursing). He stated the report should be made immediately. Following the report, the administrator or DON should submit a report to the SA and to APS. After the allegation is reported, the facility should immediately begin an investigation, including interviews with the resident, staff, and any outside party who may have knowledge of the situation. The SA should receive a final report with the results of the investigation within five business days. ASM #1 stated he was still looking for evidence that the allegation of exploitation of R28 had been investigated. On 5/20/25 at 4:27 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. ASM #1 stated no investigation had been located as of yet. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy, Abuse, Neglect, and Exploitation, revealed, in part: 'Exploitation' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent .Investigation .An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, and exploitation, occur .Written procedures for investigation include .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation .Providing complete and thorough documentation of the investigation. No additional information was provided prior to exit.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide a safe discharge for one of 31 residents in the survey sample, Resident #28. The findings include: For Resident #28 (R28), the facility staff failed to discharge the resident to a safe environment with a comprehensive discharge plan. A review of R28's clinical record revealed he was admitted to the facility with diagnoses including Parkinson's disease and alcoholism. Further review of the clinical record revealed multiple progress notes documenting the resident's continued alcohol abuse, including the following progress notes: 2/3/2024 16:16 (4:16 p.m.) Health Status Note .At around 1330 (1:30 p.m.) patient came back from outing. When patient returned this writer went in to take his vitals. Pt (patient) was noted aggressive, screaming, appeared red, slurring words. Pt was redirected. Noted smells of alcohol. Supervisor/NP (nurse practitioner) aware. 2/3/2024 22:45 (10:45 p.m.) Health Status Note .Resident went out to buy beer, got drunk but was calm on this shift, although he complained a little bit about his dinner in his room. 2/21/2024 15:20 (3:20 p.m. Medical Visit .Diagnoses: ETOH abuse .CIWA Clinical Institute Withdrawal Assessment for Alcohol (1) inpatient .Parkinson's Disease .Psych: irritable mood, normal affect .HX (history) of ETOH (alcohol) abuse .patient noted to have gone on LOA (leave of absence) and returned intoxicated recently, counsel alcohol cessation, follow and support process for risk reduction rt (related to) ETOH use. 4/12/2024 16:48 (4:48 p.m.) Medical Visit .Pt. asked to be seen by staff for recert (recertification) .Asked by staff to eval (evaluate) pt (patient) for q (each) 30/60 day follow up .Reason for admission: Diagnoses: Debility, Alcohol dependence .Parkinson's disease .Assessment/Plan: Worsening weakness, unsteady gait, unintentional weight loss, multiple falls Suspected due to chronic alcoholism .Alcohol use/withdrawal .As per the patient last drink was 1 week ago however the daughter at bedside disagrees. We will place on CIWA protocol .Rehab potential: fair. Further review of the clinical record revealed the following notes regarding the resident's discharge from the facility: (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/29/2024 11:05 (a.m.) IDT (Interdisciplinary Team) Note .IDT Quarterly CARE PLAN MEETING .POC (plan of care) reviewed/discussed and continued. All questions presented by Mr. [NAME] were addressed by the IDT members .Recommendations for psych (psychiatric) referral made due to resident behaviors of irritation and aggression. The Social Services dept (department) will continue to monitor and address concerns as they arise. [R28] remains a long-term care placement and has been issued a 30 day notice due to nonpayment, Will continue plan of care with goals and approaches. SS (social services) will continue to provide support as needed. 4/29/2024 16:08 (4:08 p.m.) COMMUNICATION - with Resident .Writer met and spoke w/ (with) [R28] in regard to his move out plan, he informed that w/ his income he would not be able to afford a hotel, but he has a backup for a family member in which he would not disclose to pick him up Saturday. He stated If the Family Member does not come then he has no other options no money, I asked what county his ID listed and he Informed me [name of county], requested if tomorrow 4/30 we could look into shelters. 4/30/2024 14:22 (2:22 p.m.) COMMUNICATION - with Resident .Admin (administrator) and Writer met w/ resident to inform of discharge plan. Resident agreed and understood terms and options provided. Will discharge Saturday. 5/4 Resident states a Friend will be picking him up, but he seems unsure. informed facility will provide transportation and pay for hotel for a few nights. Writer Called several Shelters and found one that will accept in [name of adjacent state]. 5/4/2024 17:25 (5:25 p.m.) Health Status Note .RESIDENT discharged WITH ALL BELONGINGS AT 1625 (4:25 p.m.). NO DISTRESS NOTED. RESIDENT SIGNED DISCHARGE PAPER. A review of facility documents revealed a Notice of Transfer or discharge date d 2/8/24. This notice contained, in part, the following: To: [R28] The purpose of this letter is to inform you that after careful consideration, it is our plan to transfer or discharge you for the following reasons .[R28] failed, after reasonable and appropriate notice, to pay (or to have paid under Medicare or Medicaid) a stay at the nursing facility. Total amount due to the facility is $6251.60 and you and/or your representative were previously given notice of payment due on 1/22/2024. The notice contained information regarding immediate payment instructions, appeal resources, and ombudsman contact information. The notice did not indicate a proposed date of discharge or a discharge location. The notice was signed by the former facility administrator, ASM (administrative staff member) #6. R28's record review failed to reveal evidence of the date he received this notice. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/25 at 4:01 p.m., OSM (other staff member) #11, a social worker, was interviewed. She stated she began working at the facility in December 2023. She stated her role in a resident's planned discharge is to find out the discharge destination, and to determine the resident's medical needs at discharge. These could include durable medical equipment, wound care services, home health services, and outpatient therapy services. She stated she would set up psychiatric services if those are needed and would handle getting the resident's prescriptions to the resident's pharmacy of choice. She explained that in order to facilitate a safe discharge, the facility must know exactly where the resident will be living. After reviewing the discharge notification letter addressed to R28, OSM #11 confirmed there was no date of discharge, and no discharge destination contained in the letter. She stated ASM #6 instructed her to find placement for [R28] because he had to be discharged . According to her, ASM #6 told her the facility would pay for three nights in a hotel if that's what was needed, but [R28] had to leave regardless. OSM #11 told ASM #6 she was not comfortable discharging R28 to a hotel and attempted to find an alternative. She stated she located a homeless shelter in an adjacent state, contacted the shelter staff, and was assured there would be a bed for the resident. She stated at one time, she, ASM #6, and R28 agreed on a discharge date and time, but the plan changed several times after the agreement was made. OSM #11 stated ASM #6 was clear on me leaving out certain things about the discharge. He wanted me to leave out the final discharge location and the real reason we were discharging [R28]. OSM #11 stated she was not aware of R28's alcohol abuse and dependency as she had only been employed by the facility for a few months when R28 was discharged . She stated the resident's discharge plan should have included substance abuse counseling, and there was no plan to address the resident's substance abuse after discharge. She stated: This was not a safe discharge, adding the social services team was kept out of the loop until the very last days of discharge management for R28. On 5/19/25 at 4:21 p.m., OSM #19, the director of social services, was interviewed. After reviewing the facility's notification of discharge to R28, she stated there was no indication of the date the resident received the notification or the discharge destination. She stated she was not directly involved in R28's discharge but remembers advising OSM #11 because OSM #11 was new to the facility. She added: [ASM #6] was basically doing [this discharge] solo, without anyone's input. On 5/20/25 at 8:32 a.m., ASM #1, the administrator, was interviewed. He stated that a resident, the facility staff would need to make sure the resident would have everything medically needed after discharge. He stated it was difficult for him to speak to the specifics of R28's discharge because it was well before the beginning of his employment at the facility. On 5/20/25 at 10:08 a.m., OSM #19 stated she had searched R28's records and could not find any evidence that the resident had been discharged safely. She stated the progress notes were not clear about where the resident was going and about with whom the resident left the facility. She explained that if the social workers are aware that a resident with alcohol dependency is discharging, this should be addressed in the resident's discharge plan. She added: That is part of social services' responsibilities. On 5/20/25 at 4:27 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy, Transfer and Discharge, revealed, in part: If the information in the [discharge] notice changes prior to effecting the transfer or discharge, the Social Services Director or designee must update the recipients of the notice as soon as practicable once the updated information becomes available. For significant changes, such as a change in the transfer or discharge destination, a new notice will be given that clearly describes the change(s) and resets the transfer or discharge date in order to provide 30-day advance notification .Orientation for transfer or discharge will be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team .The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following .A post discharge plan of care that is developed with the participation of the resident and the resident's representative(s) which will assist the resident to adjust to his or her new living environment .Supporting documentation shall include evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge plan, and documented discussions with the resident and/or resident representative. No additional information was provided prior to exit. Reference (1) The CIWA-Ar assesses the severity of common symptoms of alcohol withdrawal syndrome, including but not limited to tremors, sensory disturbances, and agitation. Generally, mild alcohol withdrawal is defined as a CIWA-Ar score of 8 or less. CIWA-Ar scores between 8 and 15 indicate moderate withdrawal, and scores above 15 imply severe withdrawal. This information is taken from the website https://www.ncbi.nlm.nih.gov/books/NBK442882/.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide required documentation for discharge for one of 31 residents in the survey sample, Resident #28. The findings include: For Resident #28 (R28), the facility staff failed to include the date of the planned discharge or the location of discharge for R28's discharge from the facility. A review of R28's clinical record revealed he was discharged from the facility on 5/4/24. A review of facility documents for R28 revealed a Notice of Transfer or discharge date d 2/8/24. This notice contained, in part, the following: To: [R28] The purpose of this letter is to inform you that after careful consideration, it is our plan to transfer or discharge you for the following reasons .[R28] failed, after reasonable and appropriate notice, to pay (or to have paid under Medicare or Medicaid) a stay at the nursing facility. Total amount due to the facility is $6251.60 and you and/or your representative were previously given notice of payment due on 1/22/2024. The notice contained information regarding immediate payment instructions, appeal resources, and ombudsman contact information. The notice did not indicate a proposed date of discharge or a discharge location. The notice was signed by the former facility administrator, ASM (administrative staff member) #6. R28's record review failed to reveal evidence of the date he received this notice. On 5/19/25 at 4:01 p.m., OSM (other staff member) #11, a social worker, was interviewed. She stated she began working at the facility in December 2023. After reviewing the discharge notification letter addressed to R28, OSM #11 confirmed there was no date of discharge, and no discharge destination contained in the letter. She stated ASM (administrative staff member) #6, a former administrator, instructed her to find placement for [R28] because he had to be discharged . She stated at one time, she, ASM #6, and R28 agreed on a discharge date and time, but the plan changed several times after the agreement was made. OSM #11 stated ASM #6 was clear on me leaving out certain things about the discharge. He wanted me to leave out the final discharge location and the real reason we were discharging [R28]. On 5/19/25 at 4:21 p.m., OSM #19, the director of social services, was interviewed. After reviewing the facility's notification of discharge to R28, she stated there was no indication of the date the resident received the notification or the discharge destination. She stated she was not directly involved in R28's discharge but remembers advising OSM #11 because OSM #11 was new to the facility. She added: [ASM #6] was basically doing [this discharge] solo, without anyone's input. On 5/20/25 at 8:32 a.m., ASM #1, the administrator, was interviewed. He stated it was difficult for him to speak to the specifics of R28's discharge because it was well before the beginning of his employment at the facility. On 5/20/25 at 4:27 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy, Transfer and Discharge, revealed, in part: The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided .The effective date of transfer or discharge .The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged .For significant changes, such as a change in the transfer or discharge destination, a new notice will be given that clearly describes the change(s) and resets the transfer or discharge date in order to provide 30-day advance notification. No additional information was provided prior to exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to implement the comprehensive care plan for one of 31 residents in the survey sample, Resident #2. The findings include: For Resident #2 (R2), the facility staff failed to implement the comprehensive care plan to A) provide showers on dates in August, September and October of 2024, B) provide incontinence care on dates in January and February of 2025 and C) monitor vital signs as ordered. On the most recent MDS (minimum data set) a quarterly assessment with an ARD (assessment reference date) of 2/8/25, the resident scored 0 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. The assessment documented R2 dependent on staff for showering/bathing and always incontinent of bowel and bladder. An annual assessment with an ARD of 6/12/24 documented R2 dependent on staff for showering/bathing and always incontinent of bowel and bladder. A) The comprehensive care plan for R2 documented in part, Resident requires assistance with self care and mobility R/T (related to) dementia, schizophrenia. Date Initiated: 11/28/2023. Under Interventions it documented in part, Shower/Bathing; Dependent. Date Initiated: 01/31/2025. It further documented, [Name of R2] has an ADL self-care performance deficit r/t Dementia, depression, Schizophrenia and alcohol dependence. re-admitted to the center on 7/13/23 with new order. See MAR. Date Initiated: 07/14/2023. Under Interventions it documented in part, .Provide sponge bath when a full bath or shower cannot be tolerated. Date Initiated: 07/14/2023. The resident requires staff assistance with bathing/showering and as necessary. Date Initiated: 07/14/2023 . Review of the ADL documentation for R2 dated 8/1/24-8/31/24 documented Shower Schedule: Mon/Thur Eve Shift. On 8/26/24 it documented 1,NA,NA. The documentation key documented in part, Task Completed? 0-Yes, 1-No . NA- Not Applicable . Review of the ADL documentation for R2 dated 9/1/24-9/30/24 documented Shower Schedule: Mon/Thur Eve Shift. On 9/19/24 it documented 1,NA,NA. The documentation key documented in part, Task Completed? 0-Yes, 1-No . NA- Not Applicable . On 9/23/24 it documented 1,NA,5. The documentation key documented in part, Task Completed? 0-Yes, 1-No . NA- Not Applicable .Skin Observation .5-None of the above observed . Review of the ADL documentation for R2 dated 10/1/24-10/31/24 documented Shower Schedule: Mon/Thur Eve Shift. On 10/28/24 it documented 1,NA,5. The documentation key documented in part, Task Completed? 0-Yes, 1-No . NA- Not Applicable .Skin Observation .5-None of the above observed . The clinical record for R2 failed to evidence refusals for baths/showers on the dates above. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 8:59 a.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that the purpose of the care plan was to show how to provide care for the residents, show what they needed and what the expectations were. She stated that the care plan was implemented and should be implemented to provide the care for the resident. On 5/20/25 at 9:11 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. ASM #2 stated that the shower documentation on the ADLs looked like it said not applicable and she was not sure why it would be not applicable. She stated that the shower/bathing, dependent documentation listed underneath the shower schedule showed the amount of assistance required to have a shower and it did not show that a shower was provided. On 5/20/25 at 9:55 a.m., an interview was conducted with CNA (certified nursing assistant) #15 who stated that R2 required total care with all ADLs. She stated that R2 was dependent for bathing and was always incontinent and wore briefs. CNA #15 stated that showers were provided twice a week and his were Mondays and Thursdays on the evening shift. She stated that the care they provided was evidenced by documenting it in the electronic medical record and any refusals were documented there and reported to the nurse. On 5/20/25 at 2:00 p.m., ASM #2 stated that she had spoken with a staff member who had documented the NA on the ADL documentation and normally it was documented when it was not the residents scheduled shower dates. She stated that those were his dates so it may have been an accident. She stated that NA does not apply to showers. The facility provided policy Care Plan Revisions Upon Status Change dated 9/24, failed to evidence guidance regarding implementing the care plan. On 5/20/25 at 4:18 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit. B) The comprehensive care plan for R2 documented in part, The resident has bowel and bladder incontinence r/t impaired mobility. Date Initiated: 11/29/2023. Under Interventions it documented in part, Brief Use: The resident uses disposable briefs. Change as soiled and frequently with rounding. Date Initiated: 11/29/2023. Clean peri-area with each incontinence episode. Date Initiated: 11/29/2023 . It further documented, [Name of R2] has an ADL self-care performance deficit r/t Dementia, depression, Schizophrenia and alcohol dependence. re-admitted to the center on 7/13/23 with new order. See MAR. Date Initiated: 07/14/2023. Under Interventions it documented in part, . Skin Inspection: The resident requires SKIN inspection every shift and after each incontinence episode, Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse. Date Initiated: 05/11/2023. Revision on: 07/07/2023 . Review of the ADL documentation for R2 dated 1/1/25-1/31/25 failed to evidence incontinence care/toileting assistance provided on evening shift 1/7/25 and 1/17/25 and night shift on 1/4/25 and 1/31/25. The dates documented NA or were blank. The documentation key documented NA-not applicable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loudoun Rehabilitation and Nursing Center	235 Old Waterford Road, Northwest Leesburg, VA 20176

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the ADL documentation for R2 dated 2/1/25-2/28/25 failed to evidence incontinence care/toileting assistance provided on evening shift 2/9/25 and 2/11/25 and night shift on 2/1/25, 2/2/25, 2/8/25, 2/14/25, 2/21/25, 2/22/25 and 2/28/25. The dates documented NA or were blank. The documentation key documented NA-not applicable. The clinical record for R2 failed to evidence refusals for incontinence care on the dates above. On 5/14/25 at 8:59 a.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that the purpose of the care plan was to show how to provide care for the residents, show what they needed and what the expectations were. She stated that the care plan was implemented and should be implemented to provide the care for the resident. On 5/20/25 at 9:55 a.m., an interview was conducted with CNA (certified nursing assistant) #15 who stated that R2 required total care with all ADLs. She stated that R2 was always incontinent and wore briefs. She stated that the care they provided was evidenced by documenting it in the electronic medical record and any refusals were documented there and reported to the nurse. On 5/20/25 at 4:18 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit. C) The comprehensive care plan for R2 documented, The resident has S&S (signs and symptoms) of potential fluid deficit r/t (related to) Poor intake and hypernatremia. IV (intravenous) fluids per MD order. Date Initiated: 01/18/2025. Created on: 01/20/2025. Under Interventions it documented in part, .Monitor vital signs as ordered/per protocol and record. Notify MD of significant abnormalities. Date Initiated: 01/18/2025 . The physician's order summary for R2 documented in part, - Check Vital signs every 2 hours. every shift for Abnormal Vital signs (Elevated Temperature). Order Date: 03/15/2025. Start Date: 03/15/2025. The progress notes for R2 documented in part, - 03/15/2025 18:37 (6:37 p.m.) .Primary Chief Complaint: Fever. History Present Illness: The patient is alert and oriented to self. Current temperature readings are 101.9°F and Per Nurse dropped to 99.2°F earlier this am after first suppository insertion. A chest x-ray has been ordered. stat lab order, signs of infection were noted reviewed. prophylactic antibiotic orders and started. A single dose of Rocephin was administered, pending the chest x-ray. The next dose of Rocephin is scheduled for 1700 today . Plan: . Check vital signs every 2 hours . Review of the vital signs documented a temperature summary with temperatures documented twice on 3/15/25 and 3/16/25, once on 3/18/25, once on 3/20/25, 3/21/25, 3/22/25, 3/23/25, and 3/24/25, once on 3/27/25, twice on 3/28/25 and once on 3/30/25. The vital signs failed to evidence checks every two hours as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record failed to evidence documentation of vital signs checked every two hours. On 5/14/25 at 8:59 a.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that the purpose of the care plan was to show how to provide care for the residents, show what they needed and what the expectations were. She stated that the care plan was implemented and should be implemented to provide the care for the resident. On 5/19/25 at 3:48 p.m., an interview was conducted with LPN #8 who stated that vital signs were monitored as ordered or more often if indicated. She stated that they were documented in the vital signs portion of the electronic medical record. On 5/20/25 at 4:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern. No further information was provided prior to exit.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on staff interview and clinical record review, it was determined that the facility staff failed to revise the comprehensive care plan for one of 31 residents in the survey sample, Residents #1 (R1). For R1, facility staff failed to revise the comprehensive care plan for the discontinued use of a voice amplifier. R1 was admitted to the facility with diagnoses that included but were not limited to muscle weakness. On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/25/2024, R1 scored 11 out of 15 on the BIMS (brief interview for mental status), indicating R1 was moderately impaired of cognition for making daily decisions. The physician's order for R1 documented in part, SPECIAL EQUIPMENT: Voice amplifier and charger will be stored at bedside per resident request. Day Nurse will give to assigned CNA before breakfast, Eve Nurse will obtain from CNA HS. every day and evening shift Monitor every shift for appliance safety/ensure use. Evening shift to charge amplifier at night. Order Date 05/24/2024. Start Date: 05/24/2024. The comprehensive care plan for R1 with a revision date 01/25/2024 documented in part, Focus. Resident requires assistance with self care and mobility R/T (related to) right sided hemiplegia, parkinson's with ADL (activities of daily living) fluctuations according to disease process. Revision on: 01/25/2024. Under Interventions it documented in part, Special Equipment: Voice amplifier and charger will be stored at bedside per resident request. Day Nurse will give to assigned CNA (certified nursing assistant) before breakfast. Eve (evening) nurse will obtain from CNA HS (hours of sleep). Date Initiated: 08/07/2024. On 05/14/2025 at approximately 8;00 a.m., an interview was conducted with OSM (other staff member) #30, speech therapist. When asked about the voice amplifier for R1 she stated that it was something that the family wanted R1 to try. OSM # 30 stated R1 attempted it in therapy a few times but did not like using and did not want it. She further stated that R1 does not use the voice amplifier. On 05/20/2025 at approximately 2:15 p.m., an interview was conducted with RN (registered nurse) #4, MDS coordinator. When asked to describe the procedure for revising a resident's care plan she stated it is revised quarterly. She also stated that if there is a new medication, change in medication or treatments, the care plan is updated immediately. She also stated that when updating or revising the care plan she would check the physician's orders and check with the resident's nurse and CNAs. After reviewing R1 care plan for the use of a voice she stated the care plan for the voice amplifier should have been reviewed and revised. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy Care Plan Revisions Upon Status Change documented in part, Policy:The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. e. Staff involved in the care of the resident will report resident response to new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care. On 05/20/2025 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 2. For R1, the facility staff failed to provide a scheduled bath. R1 was admitted with diagnoses that included but were not limited to hemiplegia (1). On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/25/2024, R1 scored 11 out of 15 on the BIMS (brief interview for mental status), indicating R1 was moderately impaired of cognition for making daily decisions. Section GG 0130 Self Care coded R1 as being dependent for showers or bathing self. The facility's POC (point of care) sheet for R1 dated May 2025 documented, in part, Shower Schedule: Wed/Sat Eve (Wednesday/Saturday Evening) shift. Review of the POC revealed a a blank on 05/07/2025 for showers. The comprehensive care plan for R1 with a revision date 01/25/2024 documented in part, Focus. Resident requires assistance with self care and mobility R/T (related to) right sided hemiplegia, parkinson's with ADL (activities of daily living) fluctuations according to disease process. Revision on: 01/25/2024. Under Interventions it documented in part, Shower/Bathing: dependent. Date Initiated: 10/31/2023. On 05/20/2025 at approximately 2:00 p.m. an interview was conducted with CNA (certified nursing assistant) #15. When asked how and where it is evidenced that residents receive their scheduled showers, she stated that it is documented in PCC. On 05/20/2025 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency References: (1) The loss of muscle function in part of your body. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. Based on observation, staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide ADL (activities of daily living) care to a dependent resident for two of 31 residents in the survey sample, Resident #2 and Resident #1. The findings include: 1. For Resident #2 (R2), the facility staff failed to A) evidence showers provided on dates in August, September and October of 2024 and B) evidence incontinence care provided on dates in January and February of 2025. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the most recent MDS (minimum data set) a quarterly assessment with an ARD (assessment reference date) of 2/8/25, the resident scored 0 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. The assessment documented R2 dependent on staff for showering/bathing and always incontinent of bowel and bladder. An annual assessment with an ARD of 6/12/24 documented R2 dependent on staff for showering/bathing and always incontinent of bowel and bladder. A) Review of the ADL documentation for R2 dated 8/1/24-8/31/24 documented Shower Schedule: Mon/Thur Eve Shift. On 8/26/24 it documented 1,NA,NA. The documentation key documented in part, Task Completed? 0-Yes, 1-No . NA- Not Applicable . Review of the ADL documentation for R2 dated 9/1/24-9/30/24 documented Shower Schedule: Mon/Thur Eve Shift. On 9/19/24 it documented 1,NA,NA. The documentation key documented in part, Task Completed? 0-Yes, 1-No . NA- Not Applicable . On 9/23/24 it documented 1,NA,5. The documentation key documented in part, Task Completed? 0-Yes, 1-No . NA- Not Applicable .Skin Observation .5-None of the above observed . Review of the ADL documentation for R2 dated 10/1/24-10/31/24 documented Shower Schedule: Mon/Thur Eve Shift. On 10/28/24 it documented 1,NA,5. The documentation key documented in part, Task Completed? 0-Yes, 1-No . NA- Not Applicable .Skin Observation .5-None of the above observed . The clinical record for R2 failed to evidence refusals for baths/showers on the dates above. The comprehensive care plan for R2 documented in part, Resident requires assistance with self care and mobility R/T (related to) dementia, schizophrenia. Date Initiated: 11/28/2023. Under Interventions it documented in part, Shower/Bathing; Dependent. Date Initiated: 01/31/2025. It further documented, [name of R2] has an ADL self-care performance deficit r/t Dementia, depression, Schizophrenia and alcohol dependence. re-admitted to the center on 7/13/23 with new order. See MAR. Date Initiated: 07/14/2023. Under Interventions it documented in part, .Provide sponge bath when a full bath or shower cannot be tolerated. Date Initiated: 07/14/2023. The resident requires staff assistance with bathing/showering and as necessary. Date Initiated: 07/14/2023 . On 5/13/25 at 9:57 a.m., an interview was conducted with OSM (other staff member) #14, anonymous staff member. OSM #14 stated that R2 was not showered for weeks when they were at the facility. OSM #14 stated that APS (adult protective services) came in to investigate a concern and they had started showering him but after the investigation they stopped showering him again. On 5/13/25 at 10:08 a.m., an interview was conducted with OSM #12, anonymous staff member. OSM #12 stated that R2 was rarely showered when they were at the facility, and they worried about the lack of care they received. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 5:49 p.m., an interview was conducted with OSM #16, the former director of nursing. OSM #16 stated that APS had come in to investigate concerns about care of R2 when they were at the facility. She stated that they had investigated the concern as well and were not able to substantiate any of the care concerns. OSM #16 stated that R2 did look disarrayed at times, and he had some staff that worked with him better than others. She stated that some were able to shower him and get him to do things. On 5/20/25 at 9:11 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. ASM #2 stated that the shower documentation on the ADLs looked like it said not applicable and she was not sure why it would be not applicable. She stated that the shower/bathing, dependent documentation listed underneath the shower schedule showed the amount of assistance required to have a shower and it did not show that a shower was provided. On 5/20/25 at 9:55 a.m., an interview was conducted with CNA (certified nursing assistant) #15 who stated that R2 required total care with all ADLs. She stated that R2 was dependent for bathing and was always incontinent and wore briefs. CNA #15 stated that showers were provided twice a week and his were Mondays and Thursdays on the evening shift. She stated that the care they provided was evidenced by documenting it in the electronic medical record and any refusals were documented there and reported to the nurse. On 5/20/25 at 2:00 p.m., ASM #2 stated that she had spoken with a staff member who had documented the NA on the ADL documentation and normally it was documented when it was not the residents scheduled shower dates. She stated that those were his dates so it may have been an accident. She stated that NA does not apply to showers. The facility policy, Activities of Daily Living (ADLs) dated 9/24, documented in part, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation; 3. Toileting; 4. Eating to include meals and snacks; and 5. Using speech, language or other functional communication systems . A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene . On 5/20/25 at 4:18 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit. B) Review of the ADL documentation for R2 dated 1/1/25-1/31/25 failed to evidence incontinence care/toileting assistance provided on evening shift 1/7/25 and 1/17/25 and night shift on 1/4/25 and 1/31/25. The dates documented NA or were blank. The documentation key documented NA-not applicable. Review of the ADL documentation for R2 dated 2/1/25-2/28/25 failed to evidence incontinence care/toileting assistance provided on evening shift 2/9/25 and 2/11/25 and night shift on 2/1/25, 2/2/25, 2/8/25, 2/14/25, 2/21/25, 2/22/25 and 2/28/25. The dates documented NA or were blank. The documentation key documented NA-not applicable. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record for R2 failed to evidence refusals for incontinence care on the dates above. The comprehensive care plan for R2 documented in part, The resident has bowel and bladder incontinence r/t impaired mobility. Date Initiated: 11/29/2023. Under Interventions it documented in part, Brief Use: The resident uses disposable briefs. Change as soiled and frequently with rounding. Date Initiated: 11/29/2023. Clean peri-area with each incontinence episode. Date Initiated: 11/29/2023 . It further documented, [Name of R2] has an ADL self-care performance deficit r/t Dementia, depression, Schizophrenia and alcohol dependence. re-admitted to the center on 7/13/23 with new order. See MAR. Date Initiated: 07/14/2023. Under Interventions it documented in part, . Skin Inspection: The resident requires SKIN inspection every shift and after each incontinence episode, Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse. Date Initiated: 05/11/2023. Revision on: 07/07/2023 . On 5/13/25 at 9:57 a.m., an interview was conducted with OSM (other staff member) #14, anonymous staff member. OSM #14 stated that R2 often smelled like urine and wore clothing that was wet with urine. On 5/13/25 at 10:08 a.m., an interview was conducted with OSM #12, anonymous staff member. OSM #12 stated that R2 often smelled like urine and the room smelled like urine frequently. On 5/13/25 at 10:25 a.m., an interview was conducted with OSM #11, anonymous staff member. OSM #11 stated that R2 was incontinent, and the room smelled strongly of urine. OSM #11 stated that R2's clothing was rarely changed and when it was reported to the former administration they became defensive anytime anyone brought it up but nothing ever changed. OSM #11 stated that staff kept R2's door closed most of the time. On 5/14/25 at 5:49 p.m., an interview was conducted with OSM #16, the former director of nursing. OSM #16 stated that APS had come in to investigate concerns about care of R2 when they were at the facility. She stated that they had investigated the concern as well and were not able to substantiate any of the care concerns. OSM #16 stated that R2 did look disarrayed at times, and he had some staff that worked with him better than others. She stated that some were able to shower him and get him to do things. On 5/20/25 at 9:55 a.m., an interview was conducted with CNA (certified nursing assistant) #15 who stated that R2 required total care with all ADLs. She stated that R2 was always incontinent and wore briefs. She stated that the care they provided was evidenced by documenting it in the electronic medical record and any refusals were documented there and reported to the nurse. On 5/20/25 at 4:18 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to follow the physician's order for two of 31 current residents in the survey sample, Residents #1 (R1) and R2. The findings include: 1. For R1, facility staff failed to administer a Lidocaine patch (1) according to the physician's orders. R1 was admitted to the facility with diagnoses that included but were not limited to hemiplegia (2). On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of [DATE], R1 scored 11 out of 15 on the BIMS (brief interview for mental status), indicating R1 was moderately impaired of cognition for making daily decisions. Section J0100 Pain Management coded R1 as having occasional pain. The physician's order for R1 documented, Lidocare Arm/Neck/Leg Patch 4 % (four percent) (Lidocaine). Apply to right upper back/neck topically (on the outside of the body) one time a day for myalgia (3) removed the patch at 1800 (6:00 p.m.) and remove per schedule. Order Dare: [DATE]. Start Date: [DATE]. The eMARs (electronic medication administration records) for R1 dated [DATE], February 2025, [DATE] and [DATE] documented in part, Lidocare Arm/Neck/Leg Patch 4 % (Lidocaine). Apply to right upper back/neck topically one time a day for myalgia removed the patch at 1800 (6:00 p.m.) and remove per schedule. Start Date: [DATE] 0800 (8:00 a.m.). The eMAR for R1 dated [DATE] for the administration of Lidocaine at 8:00 a.m. documented, 13 on [DATE], [DATE], [DATE], [DATE] and 9 (nine) on [DATE] and on [DATE]. The eMAR Chart Codes documented, 13=Medication Not Available and 0=Other / See Progress Notes. The eMAR for R1 dated February 2025 for the administration of Lidocaine at 8:00 a.m. documented, 9 on [DATE] and on [DATE]. The eMAR for R1 dated [DATE] for the administration of Lidocaine at 8:00 a.m. documented, 13 on [DATE] and 9 on [DATE], [DATE], [DATE] and on [DATE]. The eMAR for R1 dated [DATE] for the administration of Lidocaine at 8:00 a.m. documented, 13 on [DATE] and 9 on [DATE] and on [DATE]. Review of the facility's progress notes for R1 dated [DATE] through [DATE] failed to evidence documentation regarding the eMAR codes of 13 and 9 on the dates listed above. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loudoun Rehabilitation and Nursing Center	235 Old Waterford Road, Northwest Leesburg, VA 20176

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's packing lists from (Name of Medical Supply Company) were reviewed. The packing lists with the following dates documented: [DATE] documented 10 boxes of Lidocaine patches shipped on [DATE], [DATE] documented 7 (seven) boxes of Lidocaine patches shipped on [DATE], [DATE] documented 12 boxes of Lidocaine patches shipped on [DATE], [DATE] documented 12 boxes of Lidocaine patches shipped on [DATE], [DATE] documented 12 boxes of Lidocaine patches shipped on [DATE], [DATE] documented 12 boxes of Lidocaine patches shipped on [DATE], [DATE] documented 12 boxes of Lidocaine patches shipped on [DATE], [DATE] documented 8 (eight) boxes of Lidocaine patches shipped on [DATE], [DATE] documented 12 boxes of Lidocaine patches shipped on [DATE], [DATE] documented 16 boxes of Lidocaine patches shipped on [DATE], [DATE] documented 14 boxes of Lidocaine patches shipped on [DATE], [DATE] documented 14 boxes of Lidocaine patches shipped on [DATE], [DATE] documented 14 boxes of Lidocaine patches shipped on [DATE] and [DATE] documented 14 boxes of Lidocaine patches shipped on [DATE]. The facility's list of House Supply of Over-the-Counter Medicine documented in part Lidocaine, 4% Patches. On [DATE] at approximately 11:20 a.m. an interview and observation of facility supplies was conducted with OSM (other staff member) #17, central supply coordinator. He was asked to describe the procedure for ordering and maintaining supplies in the facility for the residents and staff. OSM #17 stated he orders PPE (personal protective equipment), medical supplies, incontinence supplies, dry and wet wipes, supplements, resident hygiene and grooming supplies (e.g., toothbrush, toothpaste, combs, body soap, peri cleaner, etc), peri cleaner and over the counter medications (e.g., vitamins, acetaminophen, etc). He stated that there is a supply room on each floor in the facility and he checks them twice a day to determine what supplies need to be restocked and when he restocks the supply rooms the items are rotated to help eliminate expired items being used. OSM #17 stated that on Fridays he checks the supply rooms and restocks double the common supplies (e.g., incontinent supplies, wipes, gloves, PPE) to cover the weekend. He also stated that a nurse on each of the units has a key to access the central supply room to get any supplies they may run out of in the supply rooms. When asked about ordering supplies OSM #17 stated he submits the order through an electronic ordering system to the vendor. He stated that the purchasing manager for the facility reviews the order and makes the final decision as to what is ordered based on cost effectiveness and quantity needed. On [DATE] at approximately 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked about coding on a resident's eMAR she stated when a resident is administered the medication there is a check mark, and if the resident refuses the medication, it is coded the number 9 (nine) and it is documented in the progress note. After reviewing the nursing progress notes dated [DATE], the eMAR notes dated [DATE], at 10:58 am., [DATE] eMAR for R1, LPN #2 was asked about the code 9 above her initials on [DATE] for Lidocaine at 8:00 a.m. She stated the medication was not available. LPN #2 further stated that sometimes they had the Lidocaine and sometimes they did not. On [DATE] at approximately 4:00 p.m. an interview was conducted with LPN #8, regarding the coding on a resident's eMAR. She stated that code 9 indicates that they do not have the medication or it's on the way from the pharmacy, code 13 indicated that the medication was not available and not in the facility, and a check mark (?) indicated the medication was administered. After reviewing the eMAR dated [DATE] coding R1's Lidocaine was 13, not available at 8:00 a.m., and the eMAR notes for the same day, LPN #8 was asked about the absence of documentation to the pharmacy about the medication not being available. She did not have an explanation. When asked to describe the procedure when a resident's medication is not available, she stated that the pharmacy is notified, and it is documented in the resident's progress notes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at approximately 4:10 p.m. an interview was conducted with LPN #10 regarding the coding on a resident's eMAR. She stated that code 9 (number nine) indicated that they do not have the medication, code 13 indicated that the medication was not available and not in the facility, and a check mark (?) indicated the medication was administered. On [DATE] at 9:20 a.m., an interview was conducted ASM (administrative staff member) #2, director of nursing, regarding the coding on a resident's eMAR. She stated a check mark (?) indicated the medication was given, code 9 refers to a progress note that explains why a medication was not given and code 13 indicated that the medication was not in the facility. She further stated that if the medication is not on the medication cart, the nurse should be checking the supply rooms and the Pixis (an automated medication dispensing system) for over-the-counter medications. On [DATE] at approximately 8:30 a.m. an interview was conducted with OSM #17 regarding over-the-counter medications. He stated the procedure for ordering over-the-counter medications is the same procedure he followed when ordering other supplies as described during the interview on [DATE]. He stated that he checks the supply room on the first floor, the inventory in the central supply room and checks the director of nursing and the nursing staff to see if they need any specific medications other than what is normally ordered. He stated the order for over-the-counter medications is sent in once a week on Mondays and usually arrives by Wednesday or Thursday of the same week. When asked about the quantity the Lidocaine patches are shipped in, he stated that each case contains 12 boxes, and each box contains five patches. On [DATE] at 1:14 p.m., an interview was conducted ASM #2, director of nursing after reviewing R1's eMARS for the dates listed above, the progress notes dated [DATE] through [DATE]. ASM #2 stated that R1's lidocaine patch was not available on the dates listed above that were coded thirteen and nine on the eMARs listed above. The facility's policy Unavailable Medications documented in part, 3. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications. 4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. On [DATE] at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency References: (1) Used to stop pain. This information was obtained from the website:https://www.drugs.com/cdi/lidocaine-patch.html. (2) Loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(3) The medical term for muscle pain. This information was obtained from the website: https://myclevelandclinic.org/health/symptoms/myalgia-muscle-pains. 2. For Resident #2 (R2), the facility staff failed to follow physician orders to monitor vital signs every two hours. The physician's order summary for R2 documented in part, - Check Vital signs every 2 hours. every shift for Abnormal Vital signs (Elevated Temperature). Order Date: [DATE]. Start Date: [DATE]. The progress notes for R2 documented in part, - [DATE] 18:37 (6:37 p.m.) .Primary Chief Complaint: Fever. History Present Illness: The patient is alert and oriented to self. Current temperature readings are 101.9°F and Per Nurse dropped to 99.2°F earlier this am after first suppository insertion. A chest x-ray has been ordered. stat lab order, signs of infection were noted reviewed. prophylactic antibiotic orders and started. A single dose of Rocephin was administered, pending the chest x-ray. The next dose of Rocephin is scheduled for 1700 today . Plan: . Check vital signs every 2 hours . The comprehensive care plan for R2 documented, The resident has S&S (signs and symptoms) of potential fluid deficit r/t (related to) Poor intake and hypernatremia. IV (intravenous) fluids per MD order. Date Initiated: [DATE]. Created on: [DATE]. Under Interventions it documented in part, .Monitor vital signs as ordered/per protocol and record. Notify MD of significant abnormalities. Date Initiated: [DATE] . Review of the vital signs documented a temperature summary with temperatures documented twice on [DATE] and [DATE], once on [DATE], once on [DATE], [DATE], [DATE], [DATE], and [DATE], once on [DATE], twice on [DATE] and once on [DATE]. The vital signs failed to evidence checks every two hours as ordered. A review of the clinical record failed to evidence documentation of vital signs checked every two hours. On [DATE] at 3:48 p.m., an interview was conducted with LPN (licensed practical nurse) #8 who stated that vital signs were monitored as ordered or more often if indicated. She stated that they were documented in the vital signs portion of the electronic medical record. On [DATE] at 9:55 a.m., an interview was conducted with CNA (certified nursing assistant) #15 who stated that currently they did vital signs on long term care residents daily. She stated that day shift did odd numbered rooms and evening shift did odd number rooms. She stated that she did not recall how often they checked R2's vital signs when they resided at the facility. On [DATE] at 4:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern. No further information was provided prior to exit.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2.a. For Resident #15 (R15), the facility staff failed to assess the resident to determine if the resident could safely spend time unsupervised on the courtyard patio and failed to provide supervision and a safe environment on the courtyard patio. R15 was unsupervised and fell on the courtyard patio. The resident sustained a head injury that required hospitalization, two staples for a laceration, and a C2 (second cervical) vertebral fracture. R15's diagnoses included but were not limited to congestive heart failure, muscle wasting and atrophy, paranoid personality disorder, auditory hallucinations, and dementia. R15's comprehensive care plan dated 7/19/23 failed to document information regarding the resident spending time outside on the courtyard patio. A review of R15's clinical record revealed the resident sustained falls on 1/9/25, 2/25/25, 3/23/25, and 3/27/25. R15's Morse fall scale assessments dated 1/9/25, 2/25/25, 3/23/25, and 3/27/25 documented the resident was at a high risk for falling. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/21/25, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately cognitively impaired for making daily decisions. An activities note dated 1/31/25 documented, Resident at 11:30 today, the housekeeping director noticed that resident was trying to access the outside looking for a 'cat'. The director went outside for him to check and confirmed there was no cat. He then explains that every nursing home has a cat. Residents' cognitive health seems to be altered. Continues to try to leave to the patio in inappropriate clothing for the weather. A physical therapy progress note dated 4/27/25 documented, Remaining Impairments: strength impairments, decreased dynamic balance, balance deficits and decreased functional capacity. A nurse's note dated 4/30/25 documented, Resident Observed laying on ground outside in Paddio [sic]/Back yard. Upon skin assessment noted blood on head 0.5cm (centimeter) x 0.01cm to scalp. assisted resident off the ground with 3 persons to assist. and back to the room. Assessed resident no other injury noted. Physician notified with new order to send resident to ED (Emergency Department) for evaluation secondary to resident currently on Eliquis (a blood thinning medication). Scanty blood noted to scalp. Family POA (Power of Attorney) notified (name). Hospital documentation dated 4/30/25 revealed R15 sustained a fractured second cervical vertebra and a head laceration to the scalp that required two staples. R15 was re-admitted to the facility on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Further review of R15's clinical record (including physical therapy documentation, nursing assessments, physician/nurse practitioner notes, and nurses' notes for 1/31/25 through 5/11/25) failed to reveal the facility staff assessed R15 to determine if the resident could safely spend time unsupervised on the courtyard patio and failed to reveal the facility staff implemented interventions to ensure the resident was supervised while going outside. On 5/13/25 at 4:17 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated the physical therapy staff complete assessments to determine if residents can safely go out to the patio unsupervised and there was no nursing assessment. LPN #2 stated R15 resides on the second floor and has a wander guard device so if the resident attempted to get on the elevator and go to the first floor, an alarm would sound when he attempted to get on the elevator. On 5/13/25 at 5:15 p.m., an observation of R15 was conducted. No wander guard was observed on the resident's body or wheelchair. Also, a review of R15's clinical record failed to reveal documentation regarding a wander guard. On 5/13/25 at 5:02 p.m., an interview was conducted with OSM (other staff member) #4 (a physical therapist who treated R15). OSM #4 stated R15's cognition and safety awareness was poor. OSM #4 stated she educated R15 that he needed to wait for someone to help him with transfers and obtaining items from the ground and he would not wait. OSM #4 stated R15 does not listen to staff education and is going to do what he wants to do. OSM #4 stated R15 has got to lift his bottom up when transferring or will fall, the resident has a history of falling, and the resident scoots out of the wheelchair. OSM #4 stated residents are not routinely assessed by therapy staff to determine if they can safely spend time on the courtyard patio unsupervised unless a resident says he or she wants to go outside or going outside aligns with their rehab goals. OSM #4 stated she did not think R15 was assessed to determine if he was safe while outside and unsupervised. On 5/14/25 at 7:53 a.m., an observation of R15 was conducted. No wander guard was observed on the resident's body or wheelchair. On 5/14/25 at 8:15 a.m., an observation of the courtyard patio was conducted. The patio was located on the first floor approximately 12 feet from the elevator. The patio door was unalarmed and accessible by opening the door. The following was observed on the patio: -pebbled pavers -multiple tables, chairs, benches, and wooden garden beds -a covered swing -a rectangular metal propane grill with two 20-pound propane tanks -a triangular corner waterfall rock pond (approximately 16 feet [base] by seven feet [corner] by seven feet [corner]); a rail was observed spanning across the base edge of the pond but there was open space (approximately three feet) between the rail and the ground. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 5/14/25 at 8:20 a.m., ASM (administrative staff member) #1 (the administrator) provided a list that documented R15 (and another resident) independently used the courtyard. ASM #1 stated this list was generated based on talking with staff. On 5/14/25 at 8:31 a.m., an interview was conducted with OSM (other staff member) #12 (an anonymous staff member). OSM #12 stated R15 used to go outside to the courtyard patio almost daily and stated the resident said he was leaving food for cats and dogs. OSM #12 stated that at times, the resident was supervised during activities but at other times, the resident was unsupervised. On 5/14/25 at 8:47 a.m., another interview was conducted with OSM #4. OSM #4 stated R15 was non-compliant with rehab recommendations and education. OSM #4 stated she was not aware R15 had been going outside on the courtyard patio and had not been evaluated. On 5/14/25 at 9:07 a.m., an interview was conducted with LPN #4. LPN #4 stated R15 is, always all over the place and always sneaks around. LPN #4 stated sometimes R15 went outside on the patio and sometimes R15 went outside the front entrance but the last time she was aware of the resident going outside was when the resident fell on the patio. LPN #4 stated R15 was currently physically capable of wheeling himself outside to the patio. On 5/14/25 at 11:25 a.m., another interview was conducted with LPN #2. LPN #2 stated she mistakenly spoke when she said R15 had a wander guard, and the resident did not have a wander guard. LPN #2 stated she was the nurse caring for R15 on 4/30/25. LPN #2 stated that on that date, another nurse brought R15 upstairs and said the resident had fallen on the courtyard patio and hit his head on the grill. LPN #2 stated she assessed R15, and the resident was alert and moving all extremities but there was blood coming from his head. LPN #2 stated the nurse practitioner ordered for R15 to be transferred to the hospital because the resident was prescribed a blood thinning medication. On 5/14/25 at 12:37 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were notified of IJ (Immediate Jeopardy). The facility presented the following IJ removal plan which was accepted on 5/14/25 at 9:31 p.m. 1. Director of Nursing will instruct resident that he is unable to access the courtyard alone as of 5/14/25. Resident #15 is currently on therapy caseload for improving strength, functional mobility, transfers, gait, endurance, utilizing a reacher & self care. He is currently independent in his wheelchair. Morse Fall Scale and BIMs was completed 5/14/25. Nursing staff that work that unit have been educated to not allow resident to use courtyard without supervision on 5/14/25. A staff member will be posted at the door of the patio 24 hours a day until a locking system can be installed on the courtyard door. 2. Other residents using the courtyard independently could be affected by this practice. List of residents using courtyard independently has been generated as of 5/14/25. 3. The Director of Nursing or designee will educate all staff that resident is unable to access the courtyard alone as of 5/14/25. All staff are being re-educated on ensuring residents requesting to use courtyard without supervision have been assessed by therapy for independence outdoors and will not be allowed to work until re-educated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	If therapy is unable to assess a resident who desires to go into the courtyard, the resident will not be able to enter the courtyard alone until the assessment is complete. This assessment will be completed within 3 business days. Should the therapy assessment deem a resident unsafe in the courtyard, the resident will not be allowed to be in the courtyard unsupervised and this will be reflected on their plan of care and in a progress note. Facility staff or family/visitor for that resident will provide supervision. 4. Therapy will screen all new admissions for their ability to go outside independently for the next 6 weeks. Current residents will be screened quarterly for their ability to go outside independently. A list of residents who require supervision to be in the courtyard will be placed on each unit and the receptionist desk. Any resident attempting to enter the courtyard without supervision will be redirected. 5. AOC: 5/14/25 Time: 11:59pm On 5/14/25 at 7:45 p.m., an interview was conducted with OSM #3 (a physical therapist who treated R15). OSM #3 stated residents who present with a fall risk and decreased safety awareness are not safe when unsupervised outside because there is more of a chance for falls and risk of hospitalization. OSM #3 stated R15 had not been assessed for being outside in the courtyard patio unsupervised because staff knows the resident is not safe out there. OSM #3 stated there is a downhill slope at the entrance to the patio and now construction is being completed. OSM #3 stated R15 is safe as long as he doesn't transfer himself without assistance, but the resident does. On 5/15/25 at 9:52 a.m., an interview was conducted with OSM #2 (an occupational therapist). OSM #2 stated there are many components to determine if a resident can safely go out into the courtyard such as managing the door, inclines, declines, coordinating around the area, and cognition. On 5/15/25 the survey team, through observations, interviews, and documentation review, verified the removal plan had been fully implemented by the facility. On 5/15/25 at 12:39 p.m., ASM #1 was informed that the abatement plan was verified. On 5/16/25 at 8:55 a.m., ASM #1 was informed the IJ had been abated. On 5/20/25 at 9:43 a.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse who observed R15 on the ground in the courtyard patio on 4/30/25). LPN #3 stated that on 4/30/25, he was inside the building on the first floor and a family member came to him and asked him to go to the courtyard patio. LPN #3 stated he went out to the patio and found R15 laying in front of his wheelchair with his right elbow and legs on the ground, and his head facing the grill. LPN #3 stated that by looking at R15's position and the injury on the resident's head, it looked like R15 hit his head on the grill. LPN #3 stated R15 had two bananas and a shovel, and the resident stated he wanted to plant the bananas in the ground. On 5/20/25 at 11:25 a.m., an interview was conducted with ASM #1. ASM #1 stated a comprehensive assessment including residents' functional and cognitive abilities should be completed to determine if a resident can safely go out on the courtyard patio unsupervised. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 5/20/25 at 1:58 p.m., ASM #1 presented a form titled, Outdoor Safety Screening Tool that was developed after Immediate Jeopardy. The form documented, Trigger Questions: BIMs score (BIMs to be completed same day as screen). If BIMs score is 12 or below, resident is supervised outdoors and remainder of tool does not need to be completed. The facility policy titled, Accidents and Supervision documented, The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary .1. Identification of Hazards and Risks- the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. a. All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. b. The facility should make a reasonable effort to identify the hazards and risk factors for each resident. c. Various sources may include, but are not limited to: i. Quality assessment and assurance (QAA) activities. ii. Environmental rounds. iii. MDS/CAA (minimum data set/care area assessment) data. iv. Medical history. v. Physical exam. iv. Facility assessment. vii. Individual observation. e. This information is to be documented and communicated across all disciplines. 2. Evaluation and Analysis- the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process. a. Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location, etc. b. Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk. c. Evaluations also look at trends such as time of day, location, etc. 3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: a. Communicating the interventions to all relevant staff. b. Assigning responsibility. c. Providing training as needed. d. Documenting interventions (e.g., plans of action developed through the QAA Committee or care plans for the individual resident). e. Ensuring that the interventions are put into action. f. Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with relevant standards, including evidence-based practice. g. Development of interim safety measures may be necessary if interventions cannot immediately be implemented fully. h. Facility-based interventions may include, but are not limited to: i. Educating staff. ii. Repairing the device/equipment. iii. Developing or revising policies and procedures. i. Resident-directed approaches may include: i. Implementing specific interventions as part of the plan of care. ii. Supervising staff and residents, etc. iii. Facility records document the implementation of these interventions. 4. Monitoring and Modification- Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include: a. Ensuring that interventions are implemented correctly and consistently. b. Evaluating the effectiveness of interventions. c. Modifying or replacing interventions as needed. d. Evaluating the effectiveness of new interventions. 5. Supervision- Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. Defined by type and frequency. b. Based on the individual resident's assessed needs and identified hazards in the resident environment. (continued on next page)

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	495275	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loudoun Rehabilitation and Nursing Center	235 Old Waterford Road, Northwest Leesburg, VA 20176

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. The facility staff failed to A) provide a safe environment for a census of 97 residents on 12/21/24 and B) notify the fire department of a fire that occurred in the enclosed patio area at the facility on 12/21/24. On 12/21/24, Resident #23 (R23), a resident with known history of unsupervised smoking, threw a lit cigarette into the trash can in the enclosed patio area resulting in a fire which cracked the glass on the patio entrance door. A) On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/17/25, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. On the quarterly MDS assessment with an ARD of 11/17/24, the resident scored 13 out of 15 on the BIMS assessment, indicating the resident was cognitively intact for making daily decisions. On 5/14/25 at 9:52 a.m., an interview was conducted with R23 in their room. When asked about smoking, R23 stated that they were a current smoker and smoked 1-2 times a day outside of the facility and had last smoked on 5/13/25. R23 stated that the facility did not allow smoking on the property, but he was allowed to go off the property and smoke and described taking the elevator downstairs to the basement, going out the loading dock doors and outside to a cigarette disposal receptacle located off the property. R23 stated that they kept their cigarettes and lighter in the closet where their clothes were, but an unknown nurse had taken them away on 5/13/25 and did not tell him why. When asked about the fire on 12/21/24, R23 stated that he remembered the incident. R23 stated that someone did not put out a cigarette and had put it in the trash can which caught fire on the patio. When asked about the wander guard monitor, R23 stated that staff had placed a monitor on him a while ago but he had taken it off and thrown it away. No wander guard monitor was observed on R23's person or on R23's wheelchair. The progress notes for R23 documented in part, - Effective Date: 10/08/2024 19:54 (7:54 p.m.) Type: Medical Visit . History: 40 pack history of tobacco use; currently smokes 1/4 ppd (pack per day). H/o (history of) of ETOH (alcohol) abuse in the past . Current Tobacco Use. -40 pack year history, - Cont (continue) Nicoderm, -Counsel on cessation . - 11/24/2024 03:22 (3:22 a.m.) Note Text: Nicoderm CQ Transdermal Patch 24 Hour (Nicotine) Apply 1 patch transdermally one time a day for tobacco abuse and remove per schedule. Pharmacy. Active: 10/8/2024 08:00. Resident who wears a transdermal nicotine patch has been going downstairs to the first floor and outdoors smoking. The supervisor told the resident several times that smoking isn't allowed on the premises and that he shouldn't be smoking. Writer re-enforced the information regarding smoking to the resident. - 12/21/2024 21:54 Note Text: Resident went to the patio to smoke even though he knows that the facility is a smoke free area. Resident put the lighter [sic] cigarette in the trash can and the trash can caught on fire. Fire extenguisher [sic] used to put the fire out. The glass door at the enterance [sic] of the patio is craked [sic] due to the heat from the fire. The resident admitted to putting the lighted cigarette in the trash can. Resident talked to about the dangers of smoking. 1 pack of cigarette [sic] and 2 lighters were taken from the resident for safe keeping. Will monitor closely. A sigh [sic] was placed on the door to prevent people from using the door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The nursing admission assessment for R23 dated 10/7/24 documented the resident being a current smoker, smoking 1-2 cigarettes per day. The assessment documented R23 requiring supervision when smoking and documented, Resident is smoker last time was before his admission to the hospital on [DATE] . The assessment further documented R23 was not an elopement risk. A smoking assessment for R23 dated 12/21/24 documented the resident being a current smoker, smoking 5-10 cigarettes per day. The assessment documented, .The resident is not safe to smoke. This is a smoke-free facility; [Name of R23] has disregarded our non-smoking policy. He put his cigarette in the patio trash can while it was still lit. The trash can caught fire. Luckily, staff was able to extinguish the fire swiftly. Resident is not able to smoke unsupervised. Our facility remains smoke free . The physician orders documented in part, Order Date: 4/3/2025. Special equipment: wander guard on at all times. Check placement and function every shift for monitoring right ankle. An elopement risk assessment dated [DATE] documented R23 being at risk to wander with a previous history of wandering and history of elopement. The comprehensive care plan for R23 documented in part, MD order for wander guard. Date Initiated: 04/03/2025 . The care plan failed to evidence documentation regarding R23's smoking status or smoking non-compliance. The clinical record failed to evidence documentation regarding rationale for the wander guard placement on 4/3/25, or checks of the wander guard from 4/3/25 to the present. The clinical record failed to evidence interventions put into place to prevent hazards from unsupervised smoking for the resident after they were first aware of the resident smoking at the facility. On 5/14/25 at 10:11 a.m., an observation was made of the facility loading dock area and parking lot area. Double doors opened to the loading dock area with a ramp area that opened to the parking lot. Approximately 100 yards across the paved parking lot a standing smoking receptacle was observed at the edge of the adjoining hospital property parking lot. On 5/14/25 at 9:58 a.m., an interview was conducted with CNA (certified nursing assistant) #8 who stated that staff had taken R23's smoking materials last year and they were kept at the nurse's station. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 5/14/25 at 10:05 a.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked where R23's smoking materials were kept, LPN #2 stated that they were kept in a cabinet behind the desk at the nurse's station. When asked to see the location that they were stored, LPN #2 went to a cabinet located inside of the nurse's station and stated that they were not there. She stated that someone must have removed them because that was where they were. When asked about the smoking process at the facility, LPN #2 stated that they did not allow smoking and R23 was not allowed to smoke. She stated that last year was the last time she knew he was smoking as far as she knew. On 5/14/25 at 11:13 a.m., a follow up interview was conducted with LPN #2 who stated that last year R23's family had brought him cigarettes and a lighter and he had been caught smoking on the patio. She stated that time, the manager had called the family and told them that smoking was not allowed and not to give him any smoking materials. LPN #2 stated that R23 had been receiving a nicotine patch daily since coming to the facility to help him not smoke and he was not supposed to leave their floor but there were times when he tried to leave, and they redirected him. LPN #2 stated that R23 could leave the unit if they did not watch him, and they did not allow him to leave the unit because the last time he went outside he almost burned the place, and they did not know who brought the things to him. She stated that R23 was reliable, and she thought he knew if something happened but may have some short-term memory loss. When asked what staff did to keep R23 from going off the unit to smoke, LPN #2 stated that they provided snacks and drinks and explained to R23 about why he should not leave the unit. She stated that she explained to him about the Nicoderm patch and encouraged him and then he was fine. LPN #2 stated that she did not remove any smoking materials from R23 yesterday and it may have been another nurse. She stated that R23's wander guard was placed when they caught him smoking outside and the monitor would beep when he got near the elevator. She stated that R23 had tried to take the wander guard off the wheelchair in the past or left the wheelchair and tried to walk down without any assistance. She stated that when she worked with him she saw patterns and knew what he was trying to do so she would intervene. LPN #2 stated that R23 would say he was going to use the bathroom by the elevator because his was locked and they would have to stop him because he wanted to smoke. She stated that she did not have eyes on him for the entire shift, but the other staff watched him also and they relied on the wander guard to alert them if R23 was attempting to leave the unit. On 5/14/25 at 1:15 p.m., an interview was conducted with OSM #14, anonymous staff member, who stated that staff observed R23 outside smoking in the patio area about a week before the fire on 12/21/24 and it was reported to the former director of nursing in the stand-up meeting. OSM #14 stated that staff were watching R23 more closely now, but it was possible for him to go out because there were not always staff in the basement area to monitor who was coming down there, the doors were normally not locked, and the cameras down there had not worked for a long time. On 5/14/25 at 1:21 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that she was in front of the elevator on the first floor when she saw a bright light and turned and saw the fire in a trash can in the interior patio area. She stated that she ran out and moved R23 inside and got another staff member to get the fire extinguisher. She stated that the staff member put the fire out and she assessed R23, took the cigarettes and lighter and locked them in the medication cart. RN #1 stated that R23 told her that he did not know that the cigarette was still lit when he threw it in the trash can in the courtyard. She stated that she told R23 that it was a non-smoking facility, and the fire was out but could have been something else. RN #1 stated that she had seen R23 about 10 minutes prior to the incident when he told her that he was going to the bathroom downstairs. She stated that she had reported the fire to the former director of nursing who stated that she did not need to call the fire department because they had extinguished the fire. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 5/14/25 at 1:40 p.m., an interview was conducted with OSM #11, social worker. OSM #11 stated that when R23 was caught smoking and had caused the fire she was asked to speak with him about smoking. She stated that she talked to him and his family who felt that he should be able to smoke. OSM #11 stated that she had started looking for another facility that allowed smoking, but they had not been able to find any placement as of now but were still actively looking. She stated that R23's family had mentioned their dad had seen employees smoking and she had explained that they could not control hospital employees off their property and their dad should not be out far enough to see them. She stated that staff were aware that at one point he was going outside to the hospital property to smoke prior to the incident and it was probably in November 2024. She stated that since 12/24 she was not aware of him going out and she thought that he may have had stuff hidden in his room but was not aware of anyone removing anything yesterday. OSM #11 stated that she believed the daughters were bringing him the smoking materials but was not sure, as one daughter had admitted it in the past but not currently. She stated that R23 did not leave the unit that she knew of because her office was by the elevator. OSM #11 stated that when she was in her office she saw him go to the bathroom in the sunroom and he had a wander guard on and the elevator alarm would have sounded if he had gone on the elevator. She stated that she has never smelled smoke in the bathroom. OSM #11 stated that she recalled nursing reporting R23 had been caught out in the back of the facility smoking in morning stand up meeting, but nothing had happened. She stated that they always knew R23 was smoking, and the report was probably mid November 2024. OSM #11 stated that this was based on her emails with the family that discuss his care plan. She stated that she remembered that one of the night nurses had caught him outside smoking, and she thought that it was the former unit manager who had reported it in the meeting. On 5/14/25 at 5:49 p.m., an interview was conducted with OSM #16, former director of nursing. OSM #16 stated that R23 started sneaking out of the building soon after admission to smoke and they had spoken with him and his family about it being a non-smoking facility. She stated that they had attempted to find R23 a smoking facility and he had agreed not to smoke until he moved but they had reports that his family still took him out to smoke. On 5/16/25 at 9:30 a.m., an interview was conducted with OSM #11, anonymous staff member. OSM #11 stated that they had never witn[TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on staff interview and clinical record review, it was determined that the facility staff failed to provide incontinence care for two of 31 residents in the survey sample, Residents #13 (R13) and R19. The findings include: 1. For R13, the facility staff failed to perform incontinence care. R13 was admitted to the facility with diagnoses that included but were not limited to dementia (1). On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/14/2025, R13 scored 2 (two) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. Section H0300 Urinary Continence coded R13 as being always incontinent. On 05/13/2025 at 12:42 p.m. until 5:00 p.m. continuous observations were conducted of R13. During the four hour and 17 minutes of observation, R13 was not checked by a nurse or a CNA (certified nursing assistant) for incontinence care. On 05/13/2025 at approximately 5:05 p.m. an interview was conducted with CNA #3. When asked if he was assigned to R13 for the 3:00 p.m. to 11:00 p.m. shift he stated yes. He asked to describe the procedure for residents who are dependent on staff for incontinence care. CNA #3 stated residents are checked for incontinence care at the beginning of each shift, checked every two hours throughout the shift and at the end of each shift. He also stated at the beginning of the shift he receives report from the previous shift CNA that includes the resident's condition, and which residents had received incontinence care. When asked about consequences a resident may encounter if they are left wet and/or soiled for extended periods of time he stated the resident could have skin breakdown. When asked if he received information regarding R13's incontinence care from the CNA on the previous shift (7:00 a.m. - 3:00 p.m.), CNA #3 stated he was not informed. When informed of the observation stated above, CNA #3 stated he would check R13 immediately. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 5:15 p.m., CNA (certified nursing assistant) #3 and CNA #4 were observed attempting to provide incontinence care to R13 in his room. R13 displayed stiffness and tremors in his arms, and stiffness in his legs as he sat in his wheelchair. CNA #3 repeatedly placed his hands on R13's arms attempting to pull the resident up from a sitting position in the wheelchair in order to transfer the resident to the bed for incontinence care. The resident repeatedly resisted; CNA #3 persisted in his efforts. CNA #4 told CNA #3 that R13 would not respond to this type of action, and that R13 would be able to transfer with minimal assistance if CNA #3 would not touch the resident. CNA #3 continued to attempt to take the resident's arm and assist him to move toward the bed. CNA #4 took over the effort, and assisted the resident to self-propel his wheelchair over to the sink area. CNA #4 stated: Put your hands on the counter and stand up. You are soaking wet. R13 refused to stand at the sink. CNA #4 assisted the resident to self-propel in the wheelchair back to the bed, and CNA #4 and CNA #3 physically lifted R13 from the wheelchair and moved him to a supine position on the bed. CNA #3 removed the resident's pants and incontinence brief. The brief was saturated with urine to the point that the brief contained hardened ridges where urine had pooled over time. The brief contained a large amount of feces, some of it soft, and some of it dried on the resident's buttocks. On 05/20/2025 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency Reference: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 2. For R19, the facility staff failed to perform incontinence care. R19 was admitted to the facility with diagnoses that included but were not limited to a stroke. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/29/2025, R19 scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. Section H0300 Urinary Continence coded R13 as being always incontinent. On 05/13/2025 at 12:42 p.m. until 5:00 p.m. continuous observations were conducted of R19. During the four hour and 17 minutes of observation, R19 was not checked by a nurse or a CNA (certified nursing assistant) for incontinence care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/2025 at 5:00 p.m. an interview was conducted with CNA #6. When asked if she was assigned to R19 from the 3:00 p.m. to 11:00 p.m. shift she stated yes. When asked to describe the procedure for incontinence care for residents who are dependent on staff for incontinence care. CNA #6 stated residents are checked for incontinence care at the beginning of each shift, checked every two hours throughout the shift and at the end of each shift. She also stated at the beginning of the shift she receives report from the previous shift CNA that includes which residents have received incontinence care. When asked about consequences a resident may encounter if they are left wet and/or soiled for extended periods of time she stated the resident could have skin breakdown. When asked if she received information regarding R19's incontinence care from the CNA on the previous shift (7:00 a.m. - 3:00 p.m.), CNA #6 stated she was not informed. When informed of the observation stated above, CNA #6 stated she would check R19 immediately. On 5/13/25 at 5:02 p.m., CNA #6 entered R19's room carrying wipes and a clean incontinence brief. R19 saw the incontinence care supplies and started to shake her head. CNA #6 stated: I would like to change you. R19 continued to refuse. CNA #6 told the resident she would return again and ask about incontinence care just before dinner trays were distributed. CNA #6 stated R19 frequently refused incontinence care. CNA #6 stated even if a resident is known to refuse care, the care should still be offered every 2 hours. On 05/20/2025 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 2. For R1, the facility staff failed to store a nebulizer (1) mask in a sanitary manner. R1 was admitted to the facility with diagnoses that included but were not limited to pneumonia. On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/25/2024, R1 scored 11 out of 15 on the BIMS (brief interview for mental status), indicating R1 was moderately impaired of cognition for making daily decisions. On 05/14/2024 at approximately 2:00 p.m. an observation of R1's nebulizer mask revealed it was sitting on top of R1's bedside table uncovered. On 05/14/2024 at approximately 5:00 p.m. an observation of R1's nebulizer mask revealed it was sitting on top of R1's bedside table uncovered. On 05/15/2024 at approximately 9:40 a.m. an observation of R1's nebulizer mask revealed it was sitting on top of R1's bedside table uncovered. The physician's order for R1 documented, Ipratropium-Albuterol Solution (2) 0.5-2.5 MG (milligrams)/3ML (milliliters). 1 (one) vial (small container) inhale orally two times a day for Shortness of breath. Order Date: 8/21/2024. On 05/20/2025 at approximately 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) #8. When asked how a resident's nebulizer mask should be stored when not in use She stated that it should be placed in a plastic bag with the date, time and resident name. On 05/20/2025 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit. References: (1) A small machine that turns liquid medicine into a mist. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000006.htm. (2) The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html. Based on observation, clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice for two of 31 residents, Resident #2 and Resident #1. The findings include: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loudoun Rehabilitation and Nursing Center	235 Old Waterford Road, Northwest Leesburg, VA 20176

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. For Resident #2 (R2), the facility staff failed to implement pulmonology consult recommendations made to titrate oxygen to maintain SpO2 (oxygen saturation) >92% and encourage IS/Flutter (incentive spirometry/flutter valve) for pulmonary toileting. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/8/25, the resident scored 0 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section O documented no oxygen use. The progress notes for R2 documented in part, - 03/17/2025 15:47 (3:47 p.m.) Medical Visit. Reason for visit : Pulmonary Consult. Abnormal Chest X-ray . Assessment/Plan : Abnormal Chest X-ray . Encourage IS/Flutter for pulmonary toileting . - 03/19/2025 15:01 (3:01 p.m.) Type: Medical Visit. Reason for visit: Reason for visit-ID (infectious disease) consult- [Name of physician]consult- IV (intravenous) antibx - Pneumonia . Assessment/plan: Abnormal chest x-ray concern for pneumonia . incentive spirometry. continue supportive oxygen and wean as tolerated. Continue pulmonary toileting . - 03/21/2025 14:08 (2:08 p.m.) Type: Medical Visit. Reason for visit : Pulmonary Consult. Abnormal Chest X-ray . Assessment/Plan: Abnormal Chest X-ray. -Maintain SpO2 >92%. -Titrate Oxygen per facility policy to maintain SpO2 goal. -Encourage IS/Flutter for pulmonary toileting . - 03/26/2025 17:32 (5:32 p.m.) Type: Medical Visit. Reason for visit: ID progress note- ID consult- [Name of physician] consult- Previous IV antibx - Pneumonia . Assessment/plan: . incentive spirometry. continue supportive oxygen and wean as tolerated. Continue pulmonary toileting . - 03/28/2025 13:45 (1:45 p.m.) Medical Visit. Reason for visit: Pulmonary Consult . Assessment/Plan: Abnormal Chest X-ray. -Maintain SpO2 >92%, -Titrate Oxygen per facility policy to maintain SpO2 goal, -Encourage IS/Flutter for pulmonary toileting . - 03/28/2025 23:04 (11:04 p.m.) Note Text: Resident is Alert. Vitals taken; BP 95/60, P 64, Temp 97.8, Oxygen 90% at room temperature . - 03/29/2025 15:43 (3:43 p.m.) Note Text: Resident is observed having shortness of breath and physically unable to swallow medications. Difficulty swallowing noted Vital signs were 89/66 (blood pressure), p (pulse) 116, 02 (oxygen) 94, R (respirations) 28, and T (temperature) 98.0. Shift supervisor and Incoming nursing made aware to monitor the resident. - 03/30/2025 03:23 (3:23 a.m.) (Virtual physician visit note) Date of Service: 03/30/2025 12:52 AM CT Details: [Name of nurse] Patient Name: [name of R2] Primary Chief Complaint: General: Hospice Patient Declining. History Present Illness: Pt is not hospice but on comfort medications, is DNR (do not resuscitate) DNH (do not hospitalize) and nurse now notifies that pt is having significant decline: increased shortness of breath with RR (respiratory rate) 52, shallow, spO2 78% and HR 127. Pt is unresponsive, frail and cachectic on video evaluation. Nurse reports consult is planned for Hospice on Monday. Unfortunately the pt is presenting as actively dying at this time . Plan: . supplemental oxygen 2-4liters per NC PRN to keep spO2 >90%. Disposition: Stay at Facility. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician orders for R2 documented an order for supplemental O2 2-4L per nasal cannula as needed to keep spO2 >90% as needed dated 3/30/25. Physician orders failed to evidence an order for incentive spirometry or recommendations made on 3/28/25 for titrating oxygen to maintain the SpO2 >92%. The eTAR (electronic treatment administration record) for R2 dated 3/1/25-3/31/25 documented oxygen use from 3/15/25-3/24/25 with discontinuation of the order on 3/25/25. The eTAR failed to evidence oxygen use or monitoring of oxygen saturations after 3/24/25 or incentive spirometry use. The eMAR (electronic medication administration record) for R2 dated 3/1/25-3/31/25 failed to evidence oxygen use or monitoring of oxygen saturations after 3/24/25 or incentive spirometry use. The vital sign summary for R2 documented oxygen saturations as follows between 3/24/25-3/30/25. - 3/24/25 16:03 (4:03 p.m.) 96% (room air). - 3/26/25 17:36 (5:36 p.m.) 96% (room air). - 3/27/25 22:45 (11:45 p.m.) 97% (room air). - 3/28/25 15:53 (3:53 p.m.) 94% (room air). - 3/30/25 02:30 (2:30 a.m.) 89% (oxygen via nasal cannula). Low of 90.0 exceeded. The comprehensive care plan for R2 documented in part, The resident has altered respiratory status/difficulty breathing r/t lung sarcoidosis. Date Initiated: 11/29/2023. The clinical record failed to evidence implementation of the pulmonology consult recommendations made for IS/Flutter for pulmonary toileting. The record failed to evidence staff response to the oxygen saturation of 90% documented in the progress notes on 3/28/25 or titrating oxygen to maintain the SpO2 >92%. On 5/19/25 at 3:48 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that when the residents had pulmonary consults, they came back with the recommendations. She stated that the nurses put in the orders and clarified anything needed with the house nurse practitioner. She stated that when a resident needed an incentive spirometer they would put in an order telling staff how often to assist the resident to use it and document it on the eMAR or eTAR. She stated that when there were recommendations regarding maintaining oxygen saturation they would monitor it every shift and follow the orders when not in the parameters. LPN #8 stated that she was not sure what pulmonary toileting was but if an incentive spirometer was ordered they had them available in the supply closet. LPN #8 stated that she had called the NP who saw R2 virtually on 3/30/25 during the night shift. She stated that R2 had a rapid decline, and she had placed oxygen on him prior to calling the NP and she had increased it during the call. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 9:11 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that pulmonology consult recommendations were communicated with the staff who put the orders in. She stated that the consulting pulmonologist wrote notes with their recommendations in them. When asked about the recommendations on the pulmonology consult for R2, ASM #2 stated that the expectation was for the staff to check the oxygen saturations every shift or more often if the resident was in distress. She stated that an order should be put in for the incentive spirometer. ASM #2 stated that for R2 they should have been doing oxygen saturations more often, but she was not sure if he was strong enough to use the incentive spirometer at that time. She stated that he was still walking around at that time but was very weak and someone had to be with him at that point. The facility policy, Oxygen Administration dated 9/24, documented in part, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences . The facility failed to offer guidance on incentive spirometer use. On 5/20/25 at 4:18 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain sufficient nursing staff to care for a resident's needs for one of 31 residents in the survey sample, Resident #1 (R1). The findings include: 1a. For R1, the facility staff failed to wash R1's hands before eating, stood while providing feeding assistance and serve the meal at the same time the roommate received their meal in the same room due to insufficient CNA (certified nursing assistant) staffing. R1 was admitted with diagnoses that included but were not limited to hemiplegia (1). On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/25/2024, R1 scored 11 out of 15 on the BIMS (brief interview for mental status), indicating R1 was moderately impaired of cognition for making daily decisions. Section GG 0130 Self Care coded R1 as being dependent for showers or bathing, Partial/moderate assistance with eating and Dependent for Personal hygiene: The ability to maintain personal hygiene, including combing hair shaving, applying makeup, washing/drying face and hands. On 05/12/2025 at approximately 12:55 p.m. R1 was observed in her room sitting in her wheelchair with an over-the-bed table in front of her, dressed, neat and clean. Further observations revealed R1's lunch tray sitting on a counter next to the sink approximately six feet away from the resident. An observation of R1's roommate revealed she was sitting on the edge of her bed eating her lunch independently. At 1:20 p.m. CNA #8 entered R1's room and set up R1's lunch on the over-the-bed table in front of R1. Further observations failed to evidence CNA #8 washing R1's hands before R1 started eating. At approximately 1:25 p.m. another observation of R1 revealed CNA #8 standing next to R1 while providing feeding assistance to R1. The facility's As Worked schedule dated 05/12/2025 documented five CNAs scheduled on the long-term care unit/floor during 7:00 a.m. to 3:00 p.m. shift. Further review revealed that a CNA's name for the 7:00 a.m. to 3:00 p.m. shift on the long-term care unit/floor was struck out and CNA #18's written in for that shift on the long-term care unit. On 05/14/2025 at approximately 5:00 p.m. an interview was conducted with R1. When asked she felt about the CNA standing next to her when he was providing her with feeding assistance, R1 stated that it made her uncomfortable and that the staff should sit when assisting her. When asked about not having her hands washed before eating R1 stated that the staff do not wash her hands before or after eating her meals. On 05/19/2025 at approximately 3:06 p.m. an interview was conducted with CNA #8. When informed of the above observations and interview with R1, CNA #8 stated he recalled the situation. CNA #8 stated the unit (long term care) was short staffed that day and it took time to get back to R1 because he had all the lunch trays to deliver to residents that could eat independently and had residents to feed. He stated he did not have enough help and had to hurry to get everything done. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/2025 at approximately 10:55 a.m. an interview was conducted with OSM (other staff member) #18, staffing coordinator. When asked to describe CNA staffing requirements she stated that the day and evening shifts have five CNAs on the skilled (first floor) and long-term care (second floor) units, three CNAs on the skilled unit and two CNAs on the long-term care unit for the overnight (11:00 p.m. to 7:00 a.m.) shift. When asked about the procedure for staff call outs, OSM #18 stated she will try to get staff from other shifts to come in early, call PRN (as needed) staff and try to pull CNAs from another floor to help out. She also stated that sometimes a nurse will volunteer to fill in as a CNA. When asked about the effects of units being short staffed, OSM #18 stated that it can affect resident care. When asked about the staff call out on 05/12/2025 on the long-term care unit during the 7:00 a.m. to 3:00 p.m. shift OSM #18 stated that she pulled CNA #18 from the first floor (skilled unit) to the long-term care unit so the unit was fully staffed for the shift. On 05/20/2025 at approximately 3:20 p.m. an interview was conducted with CNA #18. After reviewing the As Worked schedule dated 05/12/2025 for the 7:00 a.m. to 3:00 p.m. shift on the long-term care unit, CNA #18 stated she was reassigned to the long-term care floor from the skilled floor for the 7:00 a.m. to 3:00 p.m. shift. She also stated that she had provided care for one resident and was about to provide care to another resident when she was instructed by another CNA to go back to the first floor (skilled unit) because they were short staffed on that unit. When asked if that left the long-term care unit short staffed, she stated yes. The Facility's Assessment with a revision date of 5/1/25 documented in part, Facility Assessment and Staffing Needs: This facility assessment will be used to: Inform staffing decisions to ensure that there are a sufficient number of staff, with the appropriate competencies and skill sets necessary to care for its resident's needs as identified through resident assessment and plans of care; Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population; Consider specific staffing needs for each shift, such as day, evening, night and adjust as necessary based on any changes to its resident population. On 05/20/2025 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit. Reference: (1) The loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 1b. For R1, the facility staff failed to provide a scheduled bath due to insufficient CNA (certified nursing assistant) staffing. The facility's POC (point of care) sheet for R1 dated May 2025 documented, in part, Shower Schedule: Wed/Sat Eve (Wednesday/Saturday Evening) shift. Review of the POC revealed a a blank on 05/07/2025 for showers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan for R1 with a revision date 01/25/2024 documented in part, Focus. Resident requires assistance with self care and mobility R/T (related to) right sided hemiplegia, parkinson's with ADL (activities of daily living) fluctuations according to disease process. Revision on: 01/25/2024. Under Interventions it documented in part, Shower/Bathing: dependent. Date Initiated: 10/31/2023. The facility's As Worked schedule dated 05/07/2025 documented four CNAs on the facility's long term care unit (second floor) during the evening shift (3:00 p.m. to 11:00 p.m). On 05/20/2025 at approximately 10:55 a.m. an interview was conducted with OSM (other staff member) #18, staffing coordinator. When asked to describe CNA staffing requirements she stated that the day and evening shifts have five CNAs on the skilled (first floor) and long-term care (second floor) units, three CNAs on the skilled unit and two CNAs on the long-term care unit for the overnight (11:00 p.m. to 7:00 a.m.) shift. When asked about the procedure for staff call outs, OSM #18 stated she will try to get staff from other shifts to come in early, call PRN (as needed) staff and try to pull CNAs from another floor to help out. She also stated that sometimes a nurse will volunteer to fill in as a CNA. When asked about the effects of units being short staffed, OSM #18 stated that it can affect resident care. On 05/20/2025 at approximately 2:00 p.m. an interview was conducted with CNA (certified nursing assistant) #15. When asked how and where it is evidenced that residents receive their scheduled showers, she stated that it is documented in PCC. After reviewing the facility As Worked schedule dated 05/07/2025 for the evening shift, she stated that the shift was short staffed because there was four CNAs scheduled and there should have been five for the evening shift. CNA #15 further stated that it was hard to give proper care to residents when they are short staffed. On 05/20/2025 at approximately 4:30 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, and ASM #4, regional administrator, were made aware of the above findings. No further information was provided prior to exit.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on staff interview and facility document review, the facility staff failed to complete an annual performance review for three of five CNA (certified nursing assistant) reviews. The findings include: For CNA #10, CNA #11, and CNA #12, the facility staff failed to complete an annual performance review. CNA #10 was hired on 11/1/23. CNA #11 was hired on 10/10/23. CNA #12 was hired on 10/23/23. The facility staff could not provide an annual performance review for the three CNAs. On 5/20/25 at 11:06 a.m., an interview was conducted with OSM (other staff member) #18 (the human resources assistant). OSM #18 stated she pulls a monthly report to see who is due for an annual performance review, based on their hire date, then she prints out blank performance reviews and provides them to the unit managers who are supposed to complete them. On 5/20/25 at 1:24 p.m., another interview was conducted with OSM #18. OSM #18 stated that annual performance reviews are important to make sure staff are compliant with facility needs, staff know the rules and protocols of the facility, and staff understand quality of care for the residents. On 5/20/25 at 4:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Training Requirements failed to document information regarding performance reviews. No further information was presented prior to exit.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide medically related social services for one of 31 residents in the survey sample, Resident #28. The findings include: For Resident #28 (R28), the facility social services staff failed to develop a safe discharge plan. A review of R28's clinical record revealed he was admitted to the facility with diagnoses including Parkinson's disease and alcoholism. Further review of the clinical record revealed multiple progress notes documenting the resident's continued alcohol abuse, including the following progress notes: 2/3/2024 16:16 (4:16 p.m.) Health Status Note .At around 1330 (1:30 p.m.) patient came back from outing. When patient returned this writer went in to take his vitals. Pt (patient) was noted aggressive, screaming, appeared red, slurring words. Pt was redirected. Noted smells of alcohol. Supervisor/NP (nurse practitioner) aware. 2/3/2024 22:45 (10:45 p.m.) Health Status Note .Resident went out to buy beer, got drunk but was calm on this shift, although he complained a little bit about his dinner in his room. 2/21/2024 15:20 (3:20 p.m. Medical Visit .Diagnoses: ETOH abuse .CIWA Clinical Institute Withdrawal Assessment for Alcohol (1) inpatient .Parkinson's Disease .Psych: irritable mood, normal affect .HX (history) of ETOH (alcohol) abuse .patient noted to have gone on LOA (leave of absence) and returned intoxicated recently, counsel alcohol cessation, follow and support process for risk reduction rt (related to) ETOH use. 4/12/2024 16:48 (4:48 p.m.) Medical Visit .Pt. asked to be seen by staff for recert (recertification) .Asked by staff to eval (evaluate) pt (patient) for q (each) 30/60 day follow up .Reason for admission: Diagnoses: Debility, Alcohol dependence .Parkinson's disease .Assessment/Plan: Worsening weakness, unsteady gait, unintentional weight loss, multiple falls Suspected due to chronic alcoholism .Alcohol use/withdrawal .As per the patient last drink was 1 week ago however the daughter at bedside disagrees. We will place on CIWA protocol .Rehab potential: fair. Further review of the clinical record revealed the following notes regarding the resident's discharge from the facility: 2/29/2024 11:05 (a.m.) IDT (Interdisciplinary Team) Note .IDT Quarterly CARE PLAN MEETING .POC (plan of care) reviewed/discussed and continued. All questions presented by Mr. [NAME] were addressed by the IDT members .Recommendations for psych (psychiatric) referral made due to resident behaviors of irritation and aggression. The Social Services dept (department) will continue to monitor and address concerns as they arise. [R28] remains a long-term care placement and has been issued a 30 day notice due to nonpayment, Will continue plan of care with goals and approaches. SS (social services) will continue to provide support as needed. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/29/2024 16:08 (4:08 p.m.) COMMUNICATION - with Resident .Writer met and spoke w/ (with) [R28] in regard to his move out plan, he informed that w/ his income he would not be able to afford a hotel, but he has a backup for a family member in which he would not disclose to pick him up Saturday. He stated If the Family Member does not come then he has no other options no money, I asked what county his ID listed and he Informed me [name of county], requested if tomorrow 4/30 we could look into shelters. 4/30/2024 14:22 (2:22 p.m.) COMMUNICATION - with Resident .Admin (administrator) and Writer met w/ resident to inform of discharge plan. Resident agreed and understood terms and options provided. Will discharge Saturday. 5/4 Resident states a Friend will be picking him up, but he seems unsure. informed facility will provide transportation and pay for hotel for a few nights. Writer Called several Shelters and found one that will accept in [name of adjacent state]. 5/4/2024 17:25 (5:25 p.m.) Health Status Note .RESIDENT discharged WITH ALL BELONGINGS AT 1625 (4:25 p.m.). NO DISTRESS NOTED. RESIDENT SIGNED DISCHARGE PAPER. A review of facility documents revealed a Notice of Transfer or discharge date d 2/8/24. This notice contained, in part, the following: To: [R28] The purpose of this letter is to inform you that after careful consideration, it is our plan to transfer or discharge you for the following reasons .[R28] failed, after reasonable and appropriate notice, to pay (or to have paid under Medicare or Medicaid) a stay at the nursing facility. Total amount due to the facility is $6251.60 and you and/or your representative were previously given notice of payment due on 1/22/2024. The notice contained information regarding immediate payment instructions, appeal resources, and ombudsman contact information. The notice did not indicate a proposed date of discharge or a discharge location. The notice was signed by the former facility administrator, ASM (administrative staff member) #6. R28's record review failed to reveal evidence of the date he received this notice. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loudoun Rehabilitation and Nursing Center	235 Old Waterford Road, Northwest Leesburg, VA 20176

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/25 at 4:01 p.m., OSM (other staff member) #11, a social worker, was interviewed. She stated she began working at the facility in December 2023. She stated her role in a resident's planned discharge is to find out the discharge destination, and to determine the resident's medical needs at discharge. These could include durable medical equipment, wound care services, home health services, and outpatient therapy services. She stated she would set up psychiatric services if those are needed and would handle getting the resident's prescriptions to the resident's pharmacy of choice. She explained that in order to facilitate a safe discharge, the facility must know exactly where the resident will be living. After reviewing the discharge notification letter addressed to R28, OSM #11 confirmed there was no date of discharge, and no discharge destination contained in the letter. She stated ASM #6 instructed her to find placement for [R28] because he had to be discharged . According to her, ASM #6 told her the facility would pay for three nights in a hotel if that's what was needed, but [R28] had to leave regardless. OSM #11 told ASM #6 she was not comfortable discharging R28 to a hotel and attempted to find an alternative. She stated she located a homeless shelter in an adjacent state, contacted the shelter staff, and was assured there would be a bed for the resident. She stated at one time, she, ASM #6, and R28 agreed on a discharge date and time, but the plan changed several times after the agreement was made. OSM #11 stated ASM #6 was clear on me leaving out certain things about the discharge. He wanted me to leave out the final discharge location and the real reason we were discharging [R28]. OSM #11 stated she was not aware of R28's alcohol abuse and dependency as she had only been employed by the facility for a few months when R28 was discharged . She stated the resident's discharge plan should have included substance abuse counseling, and there was no plan to address the resident's substance abuse after discharge. She stated: This was not a safe discharge, adding the social services team was kept out of the loop until the very last days of discharge management for R28. On 5/19/25 at 4:21 p.m., OSM #19, the director of social services, was interviewed. After reviewing the facility's notification of discharge to R28, she stated there was no indication of the date the resident received the notification or the discharge destination. She stated she was not directly involved in R28's discharge but remembers advising OSM #11 because OSM #11 was new to the facility. She added: [ASM #6] was basically doing [this discharge] solo, without anyone's input. On 5/20/25 at 8:32 a.m., ASM #1, the administrator, was interviewed. He stated that a resident, the facility staff would need to make sure the resident would have everything medically needed after discharge. He stated it was difficult for him to speak to the specifics of R28's discharge because it was well before the beginning of his employment at the facility. On 5/20/25 at 10:08 a.m., OSM #19 stated she had searched R28's records and could not find any evidence that the resident had been discharged safely. She stated the progress notes were not clear about where the resident was going and about with whom the resident left the facility. She explained that if the social workers are aware that a resident with alcohol dependency is discharging, this should be addressed in the resident's discharge plan. She added: That is part of social services' responsibilities. On 5/20/25 at 4:27 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's job description for Social Services (non-licensed), revealed, in part: Works with the resident, family, and other members of the health care team to formulate a discharge plan that provides the resident services in the appropriate post-acute setting. Gathers and assesses information regarding the resident's physical needs, mental status, family support system, financial resources, and available community and governmental resources. Employs assessment to develop a comprehensive case management plan that will address the needs identified .Implements discharge plan through service referral and coordination activities. As part of the discharge plan development process, collaborates with other healthcare professionals in multi-disciplinary meetings and resident rounds .In accordance with established clinical guidelines, standards, and pathways, establishes a comprehensive discharge plan for those residents with post-acute care needs. The Social Worker will organize, secure, integrate, and modify the resources necessary to meet the goals stated in the discharge plan. The Social Worker will monitor resident care across the continuum through the follow-up with residents, families, and community services. A review of the facility's job description for Director of Social Services revealed, in part: Serves as Discharge Planning Coordinator, determining social and emotional needs relating to discharge and utilizing community resources to meet such needs. No additional information was provided prior to exit. Reference (1) The CIWA-Ar assesses the severity of common symptoms of alcohol withdrawal syndrome, including but not limited to tremors, sensory disturbances, and agitation. Generally, mild alcohol withdrawal is defined as a CIWA-Ar score of 8 or less. CIWA-Ar scores between 8 and 15 indicate moderate withdrawal, and scores above 15 imply severe withdrawal. This information is taken from the website https://www.ncbi.nlm.nih.gov/books/NBK442882/.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, family interview, staff interview and facility document review, it was determined the facility staff failed to discard biologicals past their expiration date in one of two nursing unit storage closets and one of one central supply storage areas. The findings include: The facility failed to discard expired biologicals in the storage closet on the second-floor nursing unit and in the central supply storage area. On [DATE] at approximately 10:27 a.m., during an interview with a current resident family member, the family member voiced concerns regarding expired supplies since the new ownership had changed the medical supplier. On [DATE] at approximately 11:25 a.m., an observation was made of the Unit 2 storage closet. Observation revealed medical supplies located on shelving units against the walls on the left side of the room available for use. Ten IV (intravenous) start kits were observed on a shelf in a bin with an expiration date of [DATE]. Forty-eight 3x3 oil emulsion dressings were observed with an expiration date of [DATE]. A sixteen-ounce bottle of isopropyl rubbing alcohol 70% was observed with an expiration date of [DATE]. Three 16-ounce bottles of hydrogen peroxide 3% were observed with one bottles expiration date [DATE] and two bottles expiration date [DATE]. On [DATE] at approximately 11:20 a.m., an observation was made of the facility's central supply room revealed Foley catheters with several others loosely stacked and in boxes on a shelf available for use. Observation of the catheters revealed three with expiration dates of [DATE], [DATE] and [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at approximately 11:20 a.m. an interview was conducted with OSM (other staff member) #17, central supply coordinator. He was asked to describe the procedure for ordering and maintaining supplies in the facility for the residents and staff. OSM #17 stated he ordered PPE (personal protective equipment), medical supplies, incontinence supplies, dry and wet wipes, supplements, resident hygiene and grooming supplies (e.g., toothbrush, toothpaste, combs, body soap, peri cleaner, etc.) and over the counter medications (e.g., vitamins, acetaminophen, etc). He stated that there was a supply room on each floor in the facility and he checked them twice a day to determine what supplies need to be restocked and when he restocked the supply rooms the items were rotated to help eliminate expired items being used. On Fridays, OSM #17 stated he checks the supply rooms and restocks double the common supplies (e.g., incontinent supplies, wipes, gloves, PPE) to cover the weekend. He also stated that a nurse on each of the units has a key to access the central supply room to get any supplies they may run out of in the supply rooms. When asked about ordering supplies OSM #17 stated he submits the order through an electronic ordering system to the vendor. He stated that the purchasing manager for the facility reviews the order and makes the final decision as to what is ordered based on cost effectiveness and quantity needed. When asked how he ensures that expired supplies are not available for use, he stated that the stock is rotated, expired items are removed from the supply rooms when being restocked on Fridays. He further stated that nursing also checks for expired items in the supply rooms. On [DATE] at 11:52 a.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that the central supply staff member came to the unit each day and stocked supplies on the unit. She stated that he was responsible for rotating stock and checking for expired supplies. LPN #2 stated that everything in the supply closet was available for resident use and they normally just pulled out what they needed because they were busy. She stated that she checked the dates on any medicines, like the enemas in the supply closet but the other items in the closet were not checked because that was his job. LPN #2 observed the supplies documented above from the Unit 2 storage closet and stated that they were expired and should not be available for use. The facility policy, Clinical Supplies in Case of Emergency dated 9/2024, documented in part, .Par levels of various supplies will be set, based on use, and procedures for reordering will be followed accordingly to ensure availability of supplies on an ongoing basis . The policy failed to evidence guidance on disposal of expired supplies. On [DATE] at 4:18 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, staff interview, and facility document review, it was determined the facility staff failed to serve pureed food in a form to meet the needs of residents in one of one kitchen. The findings include: On 5/12/25 during dinner service test trays were conducted. The test trays left the kitchen on 5/12/25 at 5:20 p.m. with the final food cart. The last resident tray was served at 5:32 p.m. The test tray was then tested for temperature by OSM (other staff member) #8, dietary manager. There were no concerns regarding the temperature of the food. Observation of the pureed test tray revealed snow peas served which had pod fibers present in the serving with the consistency not being smooth and appearing chopped. At that time, the test tray was tasted by OSM #29, the district manager for dietary services and two surveyors. Pod fibers were present in the food and not palatable. When asked about the pureed snow peas, OSM #29 stated that he saw what the problem was and OSM #8 stated that he did not think that snow peas could be pureed, and they should have substituted regular peas. On 5/16/25 at 10:12 a.m., an interview was conducted with OSM #8, dietary manager. OSM #8 stated that pureed food was prepared using the Robot Coupe blender and should be a pudding-like consistency. He stated that on 5/12/25 there was a lot going on and the pureed snow peas got past him. He stated that he had educated his staff and had started sending pictures of the pureed foods to his corporate manager to have extra eyes on them now. The facility policy, Food: Quality and Palatability revised 2/2023, documented in part, . Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs . The attached Diet Consistencies & Therapeutic Diets dated March 2025, documented in part, . Pureed- Food is blended to a smooth consistency. No lumps. Not sticky. Liquid must not separate from solid. Cannot be drunk from a cup because it does not flow easily. Cannot be sucked through a straw . On 5/20/25 at 4:18 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to report a fire that occurred at the facility on 12/21/2024 to the state agency as required in 12VAC5-371-190. The findings include: The facility staff failed to report a fire on the interior patio of the facility on 12/21/24 which was caused by Resident #23 (R23) throwing a lit cigarette into the trash can. The fire caused damage to the glass on the patio door. The progress notes for R23 documented in part, - 12/21/2024 21:54 Note Text: Resident went to the patio to smoke even though he knows that the facility is a smoke free area. Resident put the lighter [sic] cigarette in the trash can and the trash can caught on fire. Fire extenguisher [sic] used to put the fire out. The glass door at the enterance [sic] of the patio is craked [sic] due to the heat from the fire. The resident admitted to putting the lighted cigarette in the trash can. Resident talked to about the dangers of smoking. 1 pack of cigarette [sic] and 2 lighters were taken from the resident for safe keeping. Will monitor closely. A sigh [sic] was placed on the door to prevent people from using the door. On 5/14/25 at 1:21 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that she was in front of the elevator on the first floor when she saw a bright light and turned and saw the fire in a trashcan in the interior patio area. She stated that she ran out and moved R23 inside and got another staff member to get the fire extinguisher. She stated that the staff member put the fire out and she assessed R23, took the cigarettes and lighter and locked them in the medication cart. RN #1 stated that R23 told her that he did not know that the cigarette was still lit when he threw it in the trash can in the courtyard. She stated that she told R23 that it was a non-smoking facility, and the fire was out but could have been something else. RN #1 stated that she had seen R23 about 10 minutes prior to the incident when he told her that he was going to the bathroom downstairs. She stated that she had reported the fire to the former director of nursing who stated that she did not need to call the fire department because they had extinguished the fire. On 5/20/25 at 8:32 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that when a fire was discovered the staff were to ensure that the residents were safe, they were to announce the fire and follow the RACE protocol (rescue, alarm, contain, extinguish/evacuate). He stated that after the fire there was an investigation conducted, the fire department should respond to follow up on their end to assist with anything that may be needed, and the fire should be reported to the state agency. ASM #1 stated that the fire department did not respond to the fire on 12/21/24 because the fire was able to be extinguished, and the call was made to not call them. He stated that he had received guidance from the regional administrator that the fire did not require reporting to the state agency, but it should have been reported. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to The Code of Virginia, Regulations for the Licensure of Nursing Facilities, 12VAC5-371-190. Safety and emergency procedures, documented in part, . E. In the event of a disaster, fire, emergency or any other condition that may jeopardize the health, safety and well-being of residents, the nursing facility shall notify the OLC of the conditions and status of the residents and the physical plant as soon as possible . The facility policy Fire and Disaster Safety Plan dated 9/24, documented in part, .This facility shall provide a course of action to follow should a fire or other disaster occur within our facility and a means of orderly transaction of emergency procedures should the need arise . On 5/20/25 at 4:18 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interview, facility document review, and clinical record review, the facility staff failed to maintain an accurate clinical record for one of 31 residents in the survey sample, Resident #28. The findings include: For Resident #28 (R28), the facility physician derroneously documented recommendation of an assessment which the facility staff are not trained to perform. A review of R28's clinical record revealed the following progress note: 4/12/2024 16:48 (4:48 p.m.) Medical Visit .Pt. asked to be seen by staff for recert (recertification) .Asked by staff to eval (evaluate) pt (patient) for q (each) 30/60 day follow up .Reason for admission: Diagnoses: Debility, Alcohol dependence .Parkinson's disease .Assessment/Plan: Worsening weakness, unsteady gait, unintentional weight loss, multiple falls Suspected due to chronic alcoholism .Alcohol use/withdrawal .As per the patient last drink was 1 week ago however the daughter at bedside disagrees. We will place on CIWA (Clinical Institute Withdrawal Assessment for Alcohol) (1) protocol .Rehab potential: fair. This note was written by ASM (administrative staff member) #7, an attending physician. Further review of R28's clinical record failed to reveal evidence of CIWA assessment's following ASM #7's documentation on 4/12/24. On 5/20/25 at 9:11 a.m., ASM #2, the director of nursing, was interviewed. She stated the facility staff does not perform CIWA assessments on residents. On 5/20/25 at 11:05 a.m., ASM #7 was interviewed. He stated his recommendation for the facility to perform CIWA assessments on R28 must have just been a mistake. He stated he knows a long term care facility does not ordinarily perform CIWA assessments. He stated this was an error on his part, and the clinical record was not accurate in this regard. On 5/20/25 at 4:27 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy, Documentation in Medical Record, revealed, in part: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident .Documentation shall be accurate, relevant and complete. No additional information was provided prior to exit. Reference (1) The CIWA-Ar assesses the severity of common symptoms of alcohol withdrawal syndrome, including but not limited to tremors, sensory disturbances, and agitation. Generally, mild alcohol withdrawal is defined as a CIWA-Ar score of 8 or less. CIWA-Ar scores between 8 and 15 indicate moderate withdrawal, and scores above 15 imply severe withdrawal. This information is taken from the website https://www.ncbi.nlm.nih.gov/books/NBK442882/.

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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 observation, staff interview and facility document review, it was determined the facility staff failed to transport resident personal laundry in a sanitary manner on one of two floors, second floor. The findings include: On 7/21/25 at 2:07 p.m. an observation revealed a rolling rack of clean resident clothes being pushed down the Teal Wing on the second floor. Observation of the clothing rack failed to evidence that the clothes were covered while being transported. A second observation was made on 7/21/25 at 2:48 p.m. on the [NAME] Wing on the second floor of a clothing rack with resident personal clothing, not covered while being transported. An interview was conducted with OSM (other staff member) #1, laundry aide, on 7/22/25 at 11:00 a.m. When asked about the process for putting the residents' clean laundry in their rooms, OSM #1 stated he puts the clean laundry on the cart that is labeled with the resident room numbers. He stated he brings the cart to the floor and goes room by room putting things away. The above observations were shared with OSM #1. OSM #1 stated the cart should be covered when he is transporting the clean laundry to the resident rooms and it was not covered yesterday, he didn't cover it yesterday. The facility policy, Handling Clean Linen, documented in part, 5. Guidelines for the storage of clean linen include, but are not limited to the following: a. Clean linen shall be delivered to resident care units on covered linen carts with covers down. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 7/22/25 at 3:41 p.m. No further information was provided prior to exit.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on staff interview, and facility document review, the facility staff failed to ensure effective communication training was completed for five of five direct care staff employee reviews. The findings include: For CNA (certified nursing assistant) #10, CNA #11, RN (registered nurse) #2, LPN (licensed practical nurse) #11, and OSM (other staff member) #7 (the director of rehab), the facility staff failed to ensure effective communication training was completed. CNA #10 was hired on 11/1/23. CNA #11 was hired on 10/10/23. RN #2 was hired on 4/1/23. LPN #11 was hired on 4/1/23. OSM #7 was hired on 4/1/23. The facility staff failed to provide evidence that these five employees had completed effective communication training. On 5/20/25 at 10:52 a.m., an interview was conducted with RN #3 (the education coordinator). RN #3 stated she assigns trainings for staff in a computerized training system and completes face-to-face in-services. RN #3 stated approximately three weeks ago, she and the director of nursing identified the need for effective communication training and plans to hold a session regarding this with staff next week. On 5/20/25 at 11:26 a.m., another interview was conducted with RN #3. RN #3 stated effective communication training is important because she wants to make sure staff communicate with residents and the interdisciplinary team accordingly and timely. On 5/20/25 at 4:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Training Requirements documented, Training content includes, at a minimum, with compliance to twelve (12) hours annual training: a. Effective communication for direct care staff. No further information was presented 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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on staff interview, and facility document review, the facility staff failed to ensure training regarding the facility QAPI (quality assurance and performance improvement) program was completed for two of five employee reviews. The findings include: For OSM (other staff member) #26 (a dietary aide), and OSM #27 (a housekeeper), the facility staff failed to ensure training regarding the facility QAPI program was completed. OSM #26 was hired on 4/3/23 and OSM #27 was hired on 4/6/23. The facility staff failed to provide evidence these two employees had completed training regarding the facility QAPI program. On 5/20/25 at 10:52 a.m., an interview was conducted RN #3 (the education coordinator). RN #3 stated QAPI education should be provided during orientation, but OSM #26 and OSM #27 are contracted employees and do not attend the facility orientation. On 5/20/25 at 11:26 a.m., another interview was conducted with RN #3. RN #3 stated the importance of QAPI training is so staff are aware the facility is constantly working on solving issues, but the issues need to be identified so areas of concern can be improved. On 5/20/25 at 4:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Training Requirements documented, Training content includes, at a minimum, with compliance to twelve (12) hours annual training: c. Elements and goals of the facility's QAPI program. No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loudoun Rehabilitation and Nursing Center	235 Old Waterford Road, Northwest Leesburg, VA 20176

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on staff interview, and facility document review, the facility staff failed to ensure CNAs (certified nursing assistants) completed required annual in-service trainings for two of five CNA reviews. The findings include: For CNA #10 and CNA #12, the facility staff failed to ensure the CNAs completed 12 hours of annual training. CNA #10 was hired on 11/1/23 and CNA #12 was hired on 10/23/23. A review of CNA #10 and CNA #12's record failed to reveal evidence that the two CNAs had completed 12 hours of annual training. On 5/20/25 at 10:52 a.m., an interview was conducted with RN (registered nurse) #3 (the education coordinator). RN #3 stated she assigns trainings in the computerized training software, tracks staff completion each quarter and submits a report of completion to the administrator and director of nursing. On 5/20/25 at 11:26 a.m., another interview was conducted with RN #3. RN #3 stated CNA #10 and CNA #12 did not complete 12 hours of annual training. RN #3 stated it is important for CNAs to complete 12 hours of annual training to keep up with their skills. RN #3 stated it is always good for staff to make sure they are practicing according to policy and the current standards of practice because things change all the time. On 5/20/25 at 4:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Training Requirements documented, Training content includes, at a minimum, with compliance to twelve (12) hours annual training. No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. Building B. Wing	05/21/2025

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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on staff interview, and facility document review, the facility staff failed to ensure behavioral health training was completed for four of five employee reviews. The findings include: For CNA (certified nursing assistant) #10, RN (registered nurse) #2, OSM (other staff member) #7 (the director of rehab), and OSM #26, (a dietary aide) the facility staff failed to ensure behavioral health training was completed. CNA #10 was hired on 11/1/23. RN #2 was hired on 4/1/23. OSM #7 was hired on 4/1/24 and OSM #26 was hired on 4/3/23. The facility staff failed to provide evidence that these four employees had completed behavioral health training. On 5/20/25 at 10:52 a.m., an interview was conducted with RN #3 (the education coordinator). RN #3 stated she assigns trainings for staff in a computerized training system and completes face-to-face in-services. RN #3 stated approximately three weeks ago, she and the director of nursing identified the need for behavioral health training and plans to hold a session regarding this with staff next week. On 5/20/25 at 11:26 a.m., another interview was conducted with RN #3. RN #3 stated behavioral health training is important because the facility staff have been seeing a lot more patients with behavioral issues and it's important for staff to identify and monitor their behaviors and follow up with psychiatry. On 5/20/25 at 4:45 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Training Requirements documented, Training content includes, at a minimum, with compliance to twelve (12) hours annual training: f. Behavioral health. No further information was presented prior to exit.