STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosedale Health & Rehabilitation	1719 Bellevue Avenue Richmond, VA 23227

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, and facility document review, the facility staff failed to provide dignity and respect for two of 17 residents in the survey sample, Residents #4 and #9. The findings include: 1. For Resident #4 (R4), the facility staff failed to speak to the resident in a respectful and dignified manner. A grievance form regarding R4, dated 12/12/24 documented, Per sister, (name of RN [registered nurse] #4 [agency nurse]) was rude and abrasive (with) resident and sister after waiting for hours for someone. Per (name of sister), (name of RN #4) stated things like, 'I am busy too.' Per sister, not customer service appropriate. Initial Action: Date: 12/11/2024: Spoke (with) (name of RN #4). Per (name of RN #4) felt verbally abused by sister. However was abrasive with this unit manager as well. Follow Up Action: Date: 12/12/2024: RN to be DNR (do not return) from facility. Resident council meeting minutes dated 12/18/24, 1/22/25, 2/19/25, and 3/19/25 documented, Nursing: Customer service issues/staff attitudes. On 4/2/25 at 6:26 a.m., an interview was conducted with CNA (certified nursing assistant) #6. CNA #6 stated the facility employs agency staff and there have been quite a few rude CNAs. CNA #6 stated that sometimes when a resident requests something, a staff member will state, Not now and walk off. CNA #6 stated she has also heard a resident request water and a staff member state, Didn't I just give you water. CNA #6 further stated she has heard a resident request their food be warmed up and a staff member state, No. I'm not warming it up. On 4/2/25 at 12:02 p.m., an interview was conducted with LPN (licensed practical nurse) #8 (the nurse who documented the above grievance form). LPN #8 stated she did not personally hear RN #4 speak to R4 or the resident's sister, but she spoke to RN #4 on the phone regarding the above grievance. LPN #8 stated she did not know if RN #4 was stressed out from demands by R4's family but RN #4 was short, curt, and was not very customer friendly. On 4/2/25 at 4:09 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Dignity documented, 1. Residents will be treated with dignity and respect at all times. No further information was presented prior to exit. 2. The facility failed to treat R9 in a respectful dignified manner. Resident #9 (R9) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: DM (diabetes mellitus), CHF (congestive heart failure), seizures and chronic respiratory failure with hypoxia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/14/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 1/18/25 revealed, FOCUS: The resident is at risk for weight loss, malnutrition or poor hydration status related to DM2, asthma, morbid obesity, HTN, heart failure, need for therapeutic diet. INTERVENTIONS: Identify and honor food preferences. A review of the facility event synopsis dated 1/8/25 revealed, R9 alleged that aide used profanity when speaking with her. Review of staff interview revealed, R9 stated that she does not want aide in her room because she is rude. Review of interview with R9 on 1/8/25 revealed, The CNA (certified nursing assistant) was very rude. I asked her why she was being rude, and she became verbally aggressive. An interview was conducted on 3/31/25 at 9:30 AM with R9. When asked if she had been treated with dignity and respect, R9 stated, no, there is an aide that does not work with me anymore as she was rude and disrespectful. When asked if she had been treated in a dignified manner, R9 stated, no, I was not. An interview was conducted on 3/31/25 at 12:00 PM with LPN (licensed practical nurse) #1. When asked if she had heard any staff being disrespectful to a resident. LPN #1 stated, yes, occasionally some of the agency staff will be short with the resident or use a hard tone of voice. When asked would this be considered verbal abuse, LPN #1 stated, no, no verbal abuse, just tone of voice mainly. An interview was conducted on 4/1/25 at 5:40 AM with CNA #7. When CNA #7 was asked if she had heard any staff talking with residents disrespectfully, CNA #7 stated, yes, some staff do not speak in a nice tone. When asked if the residents are being treated with dignity, CNA #7 stated, no, they are not being treated with dignity. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Dignity policy revealed, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Staff always speak respectfully to residents, including addressing the resident by his or her name of choice and not 'labeling' or referring to the resident by his or her room number, diagnosis, or care needs. No further information was provided prior to exit.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to meet room change requirements prior to a room change for one of 17 residents in the survey sample, Resident #3. The findings include: For Resident #3 (R3), the facility staff failed to provide a written notice of a room change and ensure the resident consented to the roommate assignment prior to the room change on 11/21/24. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/22/24, the resident scored 15 out of 15 on the (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. The assessment further documented no behaviors observed during the assessment period and active discharge planning occurring for the resident to return to the community. The admission record for R3 documented the resident as their own responsible party. The census list for R3 documented a room change on 11/21/24 from Unit one private room to Unit two semi-private room. The progress notes for R3 documented in part, - 11/20/2024 16:04 (4:04 p.m.) Nursing note. Note Text: Met with resident in his room with DON (director of nursing), SW (social worker), Administrator, and Admissions Coordinator to discuss plans for rooms change. Resident was given teaching that he does not have a clinical need to remain in a private room and that Medicaid has not paid for him to remain in a private room. Based on these factors he will be moved to another room that is more appropriate for his clinical needs. Resident resistant to moving. He notified ombudsman to mediate. Ombudsman spoke with DON, SW, and Administrator via conference call. Room change deferred pending ombudsman review. - 11/21/2024 13:38 (1:38 p.m.) Social services. Note Text: SW, DOA (director of admissions) and resident CNA (certified nursing assistant) went to resident room to assist in room change. Resident began yelling at DOA, telling her to get out and not to touch any of his things. He continued to yell at staff while they were helping pack his things in his room. As DOSS (director of social services) was trying to assist staff in packing, resident closed the DOSS hand in his dresser drawer while cussing and yelling get out, I don't want you in here. DOSS exited resident room along with DOA. CNA staff continued to pack resident and move him to his new room. The clinical record failed to evidence documentation of written notice of a room change was provided to R3 or that R3 consented to the roommate assignment prior to the room change on 11/21/24. On 4/2/25 at approximately 9:00 a.m., ASM (administrative staff member) #1, the administrator, stated that the director of nursing who wrote the nursing note on 11/20/24 at 4:04 p.m. no longer worked at the facility and could not be interviewed. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 8:11 a.m., an interview was conducted with OSM (other staff member) #5, the director of social services, who stated that they worked with R3 at the facility. She stated that when a resident's room was going to be changed, she went in to speak to the resident to make sure the resident was going to be okay with the roommate, discuss the room change with both residents in the shared room, discuss it with the family, complete the room change assessment and make sure the residents agree to the room change. She stated that R3 was in a private room and was not paying private room prices. She stated that R3 had converted to LTC and was to be moved to a shared space, but he had refused to move for some time. OSM #5 stated that R3 had yelled at the staff, screamed at them and disrespected the staff. She stated that they had gone to R3 as a team to discuss why they had to make the room change and he continued to refuse to move from the private room, saying that he did not have to move. She stated that they discussed discharge home and R3 did not want to leave the facility. OSM #5 stated that on 11/21/24 they had gone into R3's room and talked to him again while the nursing staff were packing his things. She stated that R3 had yelled at her to get out of the room, and she had left the room to leave the nursing staff to complete the move. She stated that she remembered that R3 had viewed the new room prior to the move but she could not say that he had met the new roommate prior to the move. OSM #5 stated that residents could make the choice about room changes and she was certain that the business office manager had offered R3 the ability to keep the private room and given the pricing but he had refused. She stated that the business office manager no longer worked at the facility. The facility policy, Room Change/Roommate Assignment dated 10/01/2021 documented in part, .Unless medically necessary or for the safety and well-being of the resident(s), a resident will be provided with an advance notice of the room change. Such notice will include the reason(s) why the move is recommended . On 4/2/25 at 4:08 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical operations were made aware of the above concern. No further information was presented prior to exit.

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F 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect a residents' right to refuse some types of non-requested transfers within the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to honor a resident's right to refuse a room change for one of 17 residents in the survey sample, Resident #3. The findings include: For Resident #3 (R3), the facility staff failed to honor a resident's right to refuse a room change on 11/21/24. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/22/24, the resident scored 15 out of 15 on the (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. The assessment further documented no behaviors observed during the assessment period and active discharge planning occurring for the resident to return to the community. The admission record for R3 documented the resident as their own responsible party. The census list for R3 documented an admission to Unit one to a private room with a room change on 11/21/24 to Unit two to a semi-private room. The progress notes for R3 documented in part, - 11/20/2024 16:04 (4:04 p.m.) Nursing note. Note Text: Met with resident in his room with DON (director of nursing), SW (social worker), Administrator, and Admissions Coordinator to discuss plans for rooms change. Resident was given teaching that he does not have a clinical need to remain in a private room and that Medicaid has not paid for him to remain in a private room. Based on these factors he will be moved to another room that is more appropriate for his clinical needs. Resident resistant to moving. He notified ombudsman to mediate. Ombudsman spoke with DON, SW, and Administrator via conference call. Room change deferred pending ombudsman review. - 11/21/2024 13:38 (1:38 p.m.) Social services. Note Text: SW, DOA (director of admissions) and resident CNA (certified nursing assistant) went to resident room to assist in room change. Resident began yelling at DOA, telling her to get out and not to touch any of his things. He continued to yell at staff while they were helping pack his things in his room. As DOSS (director of social services) was trying to assist staff in packing, resident closed the DOSS hand in his dresser drawer while cussing and yelling get out, I don't want you in here. DOSS exited resident room along with DOA. CNA staff continued to pack resident and move him to his new room. On 4/2/25 at approximately 9:00 a.m., ASM (administrative staff member) #1, the administrator, stated that the director of nursing who wrote the nursing note on 11/20/24 at 4:04 p.m. no longer worked at the facility and could not be interviewed. (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 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 8:11 a.m., an interview was conducted with OSM (other staff member) #5, the director of social services, who stated that they worked with R3 at the facility. She stated that when a resident's room was going to be changed, she went in to speak to the resident to make sure the resident was going to be okay with the roommate, discuss the room change with both residents in the shared room, discuss it with the family, complete the room change assessment and make sure the residents agree to the room change. She stated that R3 was in a private room and was not paying private room prices. She stated that R3 had converted to LTC (long term care) and was to be moved to a shared space, but he had refused to move for some time. OSM #5 stated that R3 had yelled at the staff, screamed at them and disrespected the staff. She stated that they had gone to R3 as a team to discuss why they had to make the room change and he continued to refuse to move from the private room, saying that he did not have to move. She stated that they discussed discharge home and R3 did not want to leave the facility. OSM #5 stated that on 11/21/24 they had gone into R3's room and talked to him again while the nursing staff were packing his things. She stated that R3 had yelled at her to get out of the room, and she had left the room to leave the nursing staff to complete the move. She stated that she remembered that R3 had viewed the new room prior to the move but she could not say that he had met the new roommate prior to the move. OSM #5 stated that residents could make the choice about room changes and she was certain that the business office manager had offered R3 the ability to keep the private room and given the pricing but he had refused. She stated that the business office manager no longer worked at the facility. On 4/2/25 at 10:30 a.m., an interview was conducted with OSM #8, the director of admissions who stated that R3 was moved on 11/21/24 due to the room being needed for isolation for a new admission. She stated that they had given R3 the option to pay for the private room and he had refused so they had completed the room change later that day. She stated that she did not have any documentation regarding this, but the social worker and former director of nursing had documented this. At that time a request was made to ASM #1, the administrator for evidence of the census on 11/21/24 with available rooms, and evidence of a private isolation room needed for the new resident. On 4/2/25 at 11:52 a.m., an interview was conducted with LPN (licensed practical nurse) #8 who stated that they remembered R3 was not happy with moving from a private to a semiprivate room. She stated that after the first night he was moved he stayed out of the facility and did not notify them and then not long after that he was discharged . She stated that she thought that the room change had to do with a payer change. On 4/2/25 at approximately 1:30 p.m., ASM #1 and OSM #8 provided documents for Resident #17 who was admitted to the facility on [DATE] which failed to evidence an isolation need. Review of R17's clinical record failed to evidence isolation while a resident at the facility. The empty locations list for 11/21/2024 documented two empty semi-private rooms and failed to evidence private rooms. (continued on next page)

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F 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 2:15 p.m., an interview was conducted with ASM #1 who stated that R17 was not on isolation and that the private room need may have been for behaviors. She stated that one of the empty semi-private rooms on Unit one was undergoing renovations on 11/21/24 and was still closed. She stated that the other empty semi-private room could have been an option for R3, but they would have had to look at the size of the room for R3's bed and there were no other private rooms open on 11/21/24. She stated that R3 was not forced out the room because they had explained to him that they needed the room for another resident who could be coming. ASM #1 stated that they had discussed with R3 that if he wanted a private room, he had to pay the private room rate and he basically said no. She stated that he decided to transition to LTC, and she was there the day of the move when there was a lot of cursing and telling them to get out. In a follow up interview at 3:56 p.m., ASM #1 was asked what it meant to transition to LTC. ASM #1 stated that R3 had originally admitted for short term for a stay about 30 days but had decided that he wanted to stay long term. She stated that even though they were dually certified, they tried to keep the LTC residents on Unit 2. She stated that they tried to keep Unit 1 as the post-acute unit. ASM #1 stated that they had 128 beds total, and all beds were dually certified. When asked what the clinical need was for R3 to have the private room on admission, she stated that she was not aware of what it was. The facility policy, Room Change/Roommate Assignment dated 10/01/2021 documented in part, .Residents have the right to refuse to move to another room in the facility if the purpose of the move is: a. To relocate the resident from a skilled nursing unit within the facility to one that is not a skilled nursing unit; b. To relocate the resident from a nursing unit with the facility to one that is a skilled nursing unit; or c. Solely for the convenience of the staff . On 4/2/25 at 4:08 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical operations were made aware of the above concern. No further information was presented prior to exit.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 2.a. For Resident #1 (R1), the facility staff failed to notify the physician or nurse practitioner in a timely manner when the antibiotic medication Ertapenem was not available for administration. A review of R1's clinical record revealed a urine culture report dated 11/11/24 that documented the resident presented with a urinary tract infection. Further review of R1's clinical record revealed a physician's order dated 11/11/24 for Ertapenem Sodium Solution- one gram intravenously every 24 hours for infection for seven days. Pharmacy alerts dated 11/11/24 documented a possible drug allergy and a possible drug interaction for Ertapenem. Administration notes dated 11/12/24 and 11/13/24 documented the nurses were waiting for the pharmacy to send Ertapenem. An administration note dated 11/14/24 documented, Pharmacy originally would not fill (Ertapenem) because of an allergy alert. Per NP (nurse practitioner) (name) it is ok for resident to take this drug, as she has been given it before. Per pharmacy medication will be delivered today. A review of R1's November 2024 medication administration record and a nurse's note dated 11/15/24 revealed R1 was not administered the first dose of Ertapenem until 11/15/24 (four days after the medication was ordered). On 4/2/25 at 10:10 a.m., an interview was conducted with ASM (administrative staff member) #6 (the nurse practitioner). ASM #6 stated the importance of immediately starting an antibiotic is to prevent the resident from going septic. ASM #6 stated she enters medication orders into the computer system then the nurses have to activate the orders. ASM #6 stated that when the nurses activate the orders, the system tells them if there are possible allergies or drug interactions. ASM #6 stated the nurses should call her as soon as they receive the alerts. ASM #6 stated that once she enters an order, she assumes the pharmacy will send the medication and if the medication does not come, it is the nurses' responsibility to notify her. On 4/2/25 at 11:19 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that when a nurse activates orders in the computer system and there are possible allergy or drug interactions, the system alerts the nurse before she saves the orders. LPN #7 stated right then and there, the nurse should contact the pharmacy and immediately call the physician or nurse practitioner. On 4/2/25 at 4:09 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 presented prior to exit. 2.b. For Resident #1 (R1), the facility staff failed to notify the resident representative when the resident's blood sugar read, High and the nurse practitioner ordered additional insulin. A review of R1's clinical record revealed a nurse's note dated 12/13/24 that documented, Resident blood glucose recording HI, Rechecked several times. Insulin lispro 15 mls (milliliters) administered subcutaneously, and 18 units of glargine insulin administered. Glucose continued to read high 30 min later. Message sent to NP (nurse practitioner), order to administer an additional 12 units of lispro insulin and recheck the glucose 2 hours later received. Further review of R1's clinical record failed to reveal R1's representative was notified regarding the high blood sugar and the order for additional insulin. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 11:19 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated a resident's representative should be called if the resident's blood sugar reads, High and the nurse practitioner orders additional insulin. On 4/2/25 at 2:23 p.m., an interview was conducted with RN (registered nurse) #3 (the nurse who documented the above nurse's note). RN #3 stated she did not remember calling R1's representative when the resident's blood sugar read, High and the nurse practitioner ordered additional insulin. On 4/2/25 at 4:09 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 presented prior to exit. Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to notify the physician/nurse practitioner and/or the responsible party of resident changes for two of 17 residents in the survey sample, Residents #6 and #1. The findings include: 1. For Resident #6 (R6), the facility staff failed to notify the responsible party and physician of refusal of care and a change in behavior on 7/26/24. On the most recent MDS (minimum data set) assessment, an admission assessment with an ARD (assessment reference date) of 7/28/24, the resident scored three out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section E documented physical and verbal behaviors directed towards others one to three days during the assessment period. The progress notes for R6 documented in part, - 7/24/2024 21:56 (9:56 p.m.) Note Text: resident arrived via stretcher from home, resident here for respite care. resident alert with some confusion. resident is a high fall risk. skin tear to left forearm. resident takes meds whole. regular diet. hydration at bedside call bell in reach, will cont. to monitor for needs and safety. - 7/25/2024 02:14 (2:14 a.m.) .Cognitive status assessed. Resident is cognitively intact. Oriented to person. Oriented to place. Oriented to time. Behavior/mood evaluated, and the resident is noted to be uncooperative . - 7/26/2024 05:41 (5:41 a.m.) Note Text: Accucheck. one time a day Notify physician for BG <70 or >400 Patient refused, kicking, using derogatory language and spitting at staff. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosedale Health & Rehabilitation	1719 Bellevue Avenue Richmond, VA 23227

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 7/26/2024 06:42 (6:42 a.m.) Note Text: The resident's behavior became combative, including the use of derogatory language, spitting, kicking, and even biting at the staff. Despite this RN (registered nurse) and a second person nursing assistance inquiring about how they could assist him, the aggression only intensified. The resident began yelling and kicking, complicating the situation further. Additionally, the resident continued to remove his clothes and briefs. In response, this RN and nursing assistant decided to step away from the resident while ensuring his safety, leaving the bed in the lowest position and the call bell within reach. - 7/28/2024 01:11 (1:11 a.m.) .Cognitive status assessed. Resident is cognitively intact. Oriented to person. Oriented to place. Oriented to time. Behavior/mood evaluated, and the resident is noted to be uncooperative . - 7/29/2024 01:51 (1:51 a.m.) .Cognitive status assessed. Resident is cognitively intact. Oriented to person. Oriented to place. Oriented to time. Behavior/mood evaluated, and the resident is noted to be uncooperative . The progress notes failed to evidence documentation of physical behaviors towards others or refusal of care on dates other than 7/26/24. The clinical record failed to evidence notification of the physician or the responsible party of the change in behavior with physical aggression towards staff observed on 7/26/24. On 4/2/25 at approximately 9:00 a.m., ASM (administrative staff member) #1, the administrator stated that the RN (registered nurse) who documented the progress note regarding the physical aggression observed on 7/26/24 no longer worked at the facility and could not be interviewed. On 4/2/25 at 6:09 a.m., an interview was conducted with CNA (certified nursing assistant) #6 who stated that they worked with R6 when they were at the facility. She stated that she remembered that R6 had become very confused and anxious when he woke up that morning and became very upset about something. She stated that when she went in the room he had started yelling, spitting and kicking and she had called for the nurse. She stated that they had not touched R6 and had made sure he was safe and left him in the room to calm down. On 4/2/25 at 11:20 a.m., an interview was conducted with LPN (licensed practical nurse) #7 who stated that the responsible party should be notified of changes in condition or anything out of the normal. She stated that when a resident refused medications or care they attempted at least and if they still refused, they let the physician, and the responsible party know. She stated that if a resident had a change in behavior, they would call the physician with concern for a urinary tract infection or if the resident was a new admission she would contact the family to discuss their normal behavior and see what was done to deescalate the behavior. On 4/2/25 at 1:28 p.m., ASM #2, the director of nursing stated that they did not have any evidence to provide that the RP or MD were notified of the refusal of the accuchecks or the behavioral incident on 7/26/24. She stated that there was no investigation completed into the behavioral incident on 7/26/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Change in a Residents Condition, documented in part, .The facility will promptly notify the resident, his or her physician/practitioner, and the representative of changes in the resident's medical/mental condition and/or status . The nurse will notify the resident's Attending Physician/practitioner or physician on call when there has been a(an) . d. significant change in the resident's physical, mental, or psychosocial status . Unless otherwise instructed by the resident, a nurse will notify the resident's representative when . b. There is a significant change in the resident's physical, mental, or psychosocial status . On 4/2/25 at 4:08 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations were made aware of the above concern. No further information was obtained prior to exit.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff/resident interviews facility document review and clinical record review, it was determined the facility staff failed to provide a safe/clean and homelike environment for three of 17 residents, R9, R11 and R15. The findings include: 1. The facility staff failed to maintain a clean and homelike environment for Resident #9. Resident #9 (R9) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: DM (diabetes mellitus), CHF (congestive heart failure), seizures and chronic respiratory failure with hypoxia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/14/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 1/18/25 revealed, FOCUS: The resident is at risk for weight loss, malnutrition or poor hydration status related to DM2, asthma, morbid obesity, HTN, heart failure, need for therapeutic diet. INTERVENTIONS: Identify and honor food preferences. On 3/31/25 at 12:30 PM observed R9's room. Room had peeling wallpaper at the seams, and behind headboard of bed two 8.5 x 11 inches and one approximately 3 x 18 inches of spackled dry wall. When ask about the room and wall spackling, R9 stated, they told me it was due to the bed rubbing on the wall. The plan is for them to renovate room [ROOM NUMBER], then move me to that room and renovate this room. An interview was conducted on 4/2/25 at 9:00 AM with OSM (other staff member) #6, the maintenance director. When shown R9's room with peeling wallpaper at seams and spackling compound over holes in walls behind headboard, OSM #6 stated, the renovation started with the halls and lobby. We will then move to resident rooms. Our plan is to renovate room [ROOM NUMBER], move this resident to that room, then renovate this room. When asked if this is a clean and homelike environment, OSM # stated, no, when you ask those questions, it is not. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. A review of the facility's Homelike Environment policy revealed, Residents will be provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. No further information was provided prior to exit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The facility staff failed to maintain a clean/homelike environment and provide linens for Resident #11. Resident #11 (R11) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: Parkinson's Disease, convulsions and chronic kidney disease. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/5/25, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the comprehensive care plan dated 3/31/25 revealed, FOCUS: The resident is frequently incontinent of bladder and bowels. INTERVENTIONS: Provide substantial/maximal assistance with toileting. On 3/31/25 at 1:30 PM observed R11's room. Room had peeling wallpaper at the seams on three walls. When ask about the room and wall spackling, R11 stated, yes, it has been like this for a while. An interview was conducted on 3/31/25 at 8:00 AM with OSM (other staff member) #1, the laundry aide. When asked if there is a stained or torn linen, OSM #1 stated, no, I would not put it out if it were stained or torn. I will be bringing linen out to the unit shortly. Observations on 3/31/25 at 8:20 AM revealed, Unit 1: 4 pillowcases and 1 blanket. Zero towels, washcloths, fitted or flat sheets or gowns; Unit 2: 2 pillowcases and 1 blanket. Zero towels, washcloths, fitted or flat sheets or gowns. An interview was conducted on 3/31/25 at 9:00 AM with CNA (certified nursing assistant) #1. When asked if they have the linen and supplies, they need, CNA #1 stated, no, we do not have enough linen and we run out of supplies. An interview was conducted on 3/31/25 at 10:35 AM when R11, who had rolled his wheelchair up to the nursing station to ask for a towel and washcloth. CNA #3 told R11, we do not have any right now, I will bring you some as soon as we have them. When R11 was asked how often there is not linen, towels/washcloths for him in the morning, R11 stated, it happens a lot, it is late morning before we have linen. An interview was conducted on 3/31/25 at 10:40 AM with CNA #3. CNA #3 was leaving the unit nourishment room. When asked about linens, CNA #3 stated, we are out of linen, and they have not delivered any this morning. We cannot bathe our residents or even provide incontinence care because there are no towels and washcloths. An interview was conducted on 4/2/25 at 9:00 AM with OSM (other staff member) #6, the maintenance director. When shown R11's room with peeling wallpaper at seams, OSM #6 stated, the renovation started with the halls and lobby. We will then move to resident rooms. Our plan is to renovate room [ROOM NUMBER], move a resident into that room and then go down the line in order to renovate the rooms. When asked if this is a clean and homelike environment, OSM # stated, no, when you ask those questions, it is not. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. A review of the facility's Homelike Environment policy revealed, Residents will be provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean bed and bath linens that are in a good condition. No further information was provided prior to exit. 3. The facility staff failed to provide linens for Resident #15. Resident #15 (R15) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: hereditary and idiopathic neuropathy, arthritis and chronic kidney disease. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/5/25, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the comprehensive care plan dated 9/12/24 revealed, FOCUS: The resident has FUNCTIONAL bladder incontinence related to weakness. INTERVENTIONS: Clean peri-area with each incontinence episode. An interview was conducted on 3/31/25 at 8:00 AM with OSM (other staff member) #1, the laundry aide. When asked if there is a stained or torn linen, OSM #1 stated, no, I would not put it out if it were stained or torn. I will be bringing linen out to the unit shortly. Observations on 3/31/25 at 8:20 AM revealed, Unit 1: 4 pillowcases and 1 blanket. Zero towels, washcloths, fitted or flat sheets or gowns; Unit 2: 2 pillowcases and 1 blanket. Zero towels, washcloths, fitted or flat sheets or gowns. Observations on 4/1/25 at 6:05 AM revealed, Unit 1: 2 pillowcases and 1 each fitted and flat sheet. Zero towels, washcloths or gowns; Unit 2: 15 pillowcases, 2 washcloths, 9 towels, 3 blanket and 1 gown. Zero fitted or flat sheets or blankets. An interview was conducted on 3/31/25 at 9:00 AM with CNA (certified nursing assistant) #1. When asked if they have the linen and supplies, they need, CNA #1 stated, no, we do not have enough linen and we run out of supplies. An interview was conducted on 3/31/25 at 10:40 AM with CNA #3. CNA #3 was leaving the unit nourishment room. When asked about linens, CNA #3 stated, we are out of linen, and they have not delivered any this morning. We cannot bathe our residents or even provide incontinence care because there are no towels and washcloths. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/1/25 at 5:40 AM with CNA #7. When asked if night shift had supplies, linen and snacks they need for the residents. CNA #7 stated a lot of the time we do not have linen for the residents. CNA #7 stated, there is a resident who wants to speak to the state about snacks and linen, CNA you talk with her. An interview was conducted on 4/1/25 at 5:45 AM with R15. R15 stated, this is the fifth day there has not been linen in the morning. I am so tired of this. I have had to use a pillowcase to wash and dry my face. They cannot clean you up, because there is no linen. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. A review of the facility's Homelike Environment policy revealed, The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean bed and bath linens that are in a good condition. No further 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff/resident interviews facility document review and clinical record review, it was determined the facility staff failed to develop the care plan for one of 17 residents in the survey sample, R9. The findings include: The facility staff failed to develop the comprehensive care plan for PICC (peripherally inserted central catheter) /midline care for R9. Resident #9 (R9) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: DM (diabetes mellitus), CHF (congestive heart failure), seizures and chronic respiratory failure with hypoxia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/14/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 1/18/25 revealed, FOCUS: The resident is at risk for weight loss, malnutrition or poor hydration status related to DM2, asthma, morbid obesity, HTN, heart failure, need for therapeutic diet. INTERVENTIONS: Identify and honor food preferences. There is no evidence of PICC/midline on R9's care plan. A review of the progress note dated 3/10/25 at 6:30 PM revealed, Received resident lying in bed on left side with eyes open. Resident informed that I would be removing her PICC line from her right upper arm. Dressing removed, PICC site cleansed, PICC line removed without difficulty. Catheter tip intact and measures 20cm. Resident denies pain or distress, tolerated well. Pressure dressing applied. Resident encouraged to notify charge nurse if site begins to bleed or is painful. Resident stated understanding. An interview was conducted on 3/31/25 at 9:30 AM with R9. When asked if she had any lines or catheters, R9 stated, there was a PICC line for antibiotics, but it was removed. An interview was conducted on 4/2/25 at 12:20 PM with LPN (licensed practical nurse) #8. When asked the care plan purpose, LPN #8 stated, it is so nursing staff know how to care for the resident. When asked if a midline should be on care plan, LPN #8 stated yes, special needs should be on the care plan. Here nursing team develops the care plan. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. No policy for care plan provided. No further information was provided prior to exit.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **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 follow professional standards of practice for three of 17 residents in the survey sample, Residents #1, #4, and #9. The findings include: 1. For Resident #1 (R1), the facility staff failed to follow the physician's order to call the physician for a blood sugar greater than 400, prior to administering insulin. A review of R1's clinical record revealed the following orders: -12/5/24-Insulin Glargine Solostar Subcutaneous Solution Pen-injector 300 UNIT/ML (milliliters). Inject 18 unit subcutaneously at bedtime for diabetes. -12/10/24-Insulin Lispro Subcutaneous Solution Pen-injector 100 UNIT/ML. Inject as per sliding scale before meals and at bedtime for diabetes: if (blood sugar) 150-199=8 units 200-249=9 units 250-299=10 units 300-349=12 units 350-399=15 unit Blood sugars over 400, call MD (medical doctor). A nurse's note dated 12/13/24 (at 12:25 a.m.) documented, Resident blood glucose recording HI (over 400), Rechecked several times. Insulin lispro 15 mls (milliliters) administered subcutaneously, and 18 units of glargine insulin administered. Glucose continued to read high 30 min later. Message sent to NP (nurse practitioner), order to administer an additional 12 units of lispro insulin and recheck the glucose 2 hours later received. On 4/2/25 at 11:19 a.m., the above lispro insulin sliding scale order was reviewed with LPN (licensed practical nurse) #7. LPN #7 stated some sliding scale insulin orders document to give a certain amount of insulin and call the physician for a blood sugar over a certain level, but that order did not. LPN #7 stated the above order documented to call the physician for a blood sugar over 400 so she would immediately call the physician before administering the insulin. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/2/25 at 2:23 p.m., an interview was conducted with RN (registered nurse) #3 (the nurse who documented the above nurse's note). RN #3 stated R1's blood sugar read, High so she administered insulin, gave time for the medication to respond, re-checked R1's blood sugar, then contacted the nurse practitioner. On 4/2/25 at 4:09 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, Medication and Treatment Orders documented, 1. Medications will be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. No further information was presented prior to exit. 2. For Resident #4 (R4), the facility staff failed to administer multiple medications in a timely manner. A review of R4's clinical record revealed the following physician's orders: 12/3/24-Gabapentin 100 mg (milligrams). Give one capsule by mouth three times a day for pain. 12/3/24-Furosemide 80 mg. Give one tablet by mouth one time a day for HTN (hypertension [high blood pressure]). 12/3/24-Novolog FlexPen 100 units/ml (milliliter). Inject 22 units subcutaneously one time a day for diabetes. 12/3/24-Tiotropium Bromide 18 mcg (micrograms). One capsule inhale orally one time a day to prevent bronchospasms. 12/3/24-Sennosides-Docusate Sodium 8.6-50 mg. Give one tablet by mouth one time a day for constipation. 12/3/24-MiraLax 17 gm (grams)/scoop. Give one scoop by mouth one time a day for constipation. 12/5/24-Clopidogrel Bisulfate 75 mg. Give 75 mg by mouth one time a day for CVA (cerebrovascular accident [stroke]). A review of a medication administration audit report for December 2024 revealed the following: -Gabapentin was scheduled at 9:00 a.m. and was administered at 3:25 p.m. on 12/13/24, 12:13 p.m. on 12/14/24, 1:11 p.m. on 12/15/24, and 1:00 p.m. on 12/16/24. -Furosemide was scheduled at 9:00 a.m. and was administered at 3:25 p.m. on 12/13/24, 12:14 p.m. on 12/14/24, 1:11 p.m. on 12/15/24, and 1:00 p.m. on 12/16/24. -Novolog was scheduled at 9:00 a.m. and was administered at 3:25 p.m. on 12/13/24, 12:13 p.m. on 12/14/24, 1:11 p.m. on 12/15/24, and 1:09 p.m. on 12/16/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Tiotropium bromide was scheduled at 9:00 a.m. and was administered at 3:25 p.m. on 12/13/24, 12:13 p.m. on 12/14/24, 1:12 p.m. on 12/15/24, and 1:11 p.m. on 12/16/24. -Sennosides-Docusate Sodium was scheduled at 9:00 a.m. and was administered at 3:25 p.m. on 12/13/24, 12:14 p.m. on 12/14/24, 1:12 p.m. on 12/15/24, and 1:09 p.m. on 12/16/24. -MiraLAX was scheduled at 9:00 a.m. and was administered at 3:25 p.m. on 12/13/24, 12:13 p.m. on 12/14/24, 1:12 p.m. on 12/15/24, and 1:09 p.m. on 12/16/24. -Clopidogrel Bisulfate was scheduled at 9:00 and was administered at 3:25 p.m. on 12/13/24, 12:13 p.m. on 12/14/24, 1:11 p.m. on 12/15/24, and 12:57 p.m. on 12/16/24. On 4/2/25 at 11:19 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated nurses should administer medications within one hour before or one hour after a medication is scheduled because that is when the medications are ordered. LPN #7 stated medications administered after one hour the medications are scheduled are late and kind of like a medication error. On 4/2/25 at 4:09 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 pharmacy policy titled, General Guidelines for Medication Administration documented, II. Administration: 12. Medications are administered within 60 minutes of the scheduled administration time . No further information was presented prior to exit. 3.The facility staff failed to meet professional standards by clarifying medication orders and administering medications timely for R9. A. Resident #9 (R9) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: DM (diabetes mellitus), CHF (congestive heart failure), seizures and chronic respiratory failure with hypoxia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/14/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 1/18/25 revealed, FOCUS: The resident is at risk for weight loss, malnutrition or poor hydration status related to DM2, asthma, morbid obesity, HTN, heart failure, need for therapeutic diet. INTERVENTIONS: Identify and honor food preferences. A review of the physician orders dated 10/15/24 revealed, Modafinil Tablet 200 MG Give 1 tablet by mouth one time a day for narcolepsy at 4:00 AM. Modafinil Tablet 200 MG Give 1 tablet by mouth one time a day for narcolepsy at 6:00 AM. An interview was conducted on 3/31/25 at 9:30 AM with R9. When asked if medications were administered timely, R9 stated, no, they are late, particularly the 6:00 AM and evening ones. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosedale Health & Rehabilitation	1719 Bellevue Avenue Richmond, VA 23227

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/2/25 at 6:15 AM with LPN (licensed practical nurse) #5. When asked about the medication order for Modafinil for R9, how to read it, LPN #5 stated, it is ordered to give it one time a day, but there are two different times for it to be administered. When asked if the order should be clarified, LPN #5 stated, yes, it should be clarified. When asked where evidence of the clarification would be, LPN #5 stated, we usually write it in the physician communication book or in the progress notes. The pharmacy has told us that we run out of the medication because we are giving too much. On 4/2/25 at 8:00 AM, a request of the facility to provide evidence of clarification of this order with the physician/nurse practitioner (NP). An interview was conducted on 4/2/25 at 10:00 AM with ASM (administrative staff member) #6, the nurse practitioner. When asked about the Modafinil order for once a day but ordered for two different times, ASM #6 stated, when she first got here, I changed the order for the Modafinil (treatment for narcolepsy) because she had bradycardia with the full dose. So, I ordered it as once a day at 4:00 AM and 6:00 AM, two hours apart, so I split the order so one at 4:00 AM and one at 6:00 AM. When asked if the order should be clarified, ASM #6 stated, yes, it could be ordered twice a day and specify the times of administration. That would be clearer. When asked if she was aware that per the nurse, pharmacy is not filling the medication to give two doses in one day as currently prescribed, ASM #6 stated, no, I was not aware of that. I will change the order. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. A review of the facility's General Guidelines for Medication Administration policy revealed, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer. No further information was provided prior to exit. B. A review of the physician orders dated 10/8/24 revealed, Acarbose Tablet 25 MG Give 1 tablet by mouth three times a day for diabetes. Metoprolol Tartrate Oral Tablet 50 MG, Give 1 tablet by mouth three times a day for HTN. A review of the physician order dated 10/14/24 revealed, Modafinil Tablet 200 MG Give 1 tablet by mouth one time a day for narcolepsy AND Give 1 tablet by mouth one time a day for narcolepsy. A review of the March 2025 MAR (medication administration record) reveals, Acarbose Tablet 25 MG Give 1 tablet by mouth three times a day for diabetes, scheduled for 9:00 AM, 2:00 PM and 6:00 PM; was administered at: 3/1-7:58 PM, 3/9-8:26 PM, 3/11 8:54 PM, 3/27 12:14 AM (for 6 PM dose 3/26). Metoprolol Tartrate Oral Tablet 50 MG Give 1 tablet by mouth three times a day for HTN, scheduled for 6:00 AM, 2:00 PM and 10:00 PM; was administered at: 3/14-11:41 PM, 3/23 12:57 AM (for 6 PM dose 3/22), 3/27 12:15 AM (for 6 PM dose 3/26). Modafinil Tablet 200 MG Give 1 tablet by mouth one time a day for narcolepsy, scheduled administration time 4:00 AM; was administered at: 3/1-5:45 AM, 3/5-5:56 AM, 3/11-5:32 AM, 3/22-5:50 AM, 3/23-5:20 AM, 3/24-5:35 AM, 3/25-5:36 AM and 3/28-5:26 AM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/2/25 at 11:20 AM with LPN (licensed practical nurse) #7. When asked the medication administration time frames, LPN #7 stated, the med should be given within one hour before or after the scheduled time of administration. When asked why, LPN #7 stated, because it is when it is ordered. Otherwise, it is late or given outside of order parameters. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. A review of the facility's General Guidelines for Medication Administration policy revealed, Medications are administered within 60 minutes of the scheduled administration time. No further information was provided prior to exit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident/staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide ADL (activities of daily living) care for a dependent resident for one of 17 residents, R8. The findings include: Resident #8 (R8) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: DM (diabetes mellitus), CVA (cerebrovascular accident) with hemiplegia, hemiparesis and vascular dementia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/5/24, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. The resident was coded as being dependent for turning. A review of the comprehensive care plan dated 8/21/24 revealed, FOCUS: The resident has an ADL (activities of daily living) self-care performance deficit due to history of CVA, dementia. He is dependent on staff for all ADL needs. INTERVENTIONS: BED MOBILITY: The resident is totally dependent on (X2) staff for repositioning and turning in bed and as necessary. A review of the ADL form for November and December 2024 revealed, the following dates and shifts of missing documentation: Day shift-11/6, 11/7, 11/14, 11/27, 12/14, 12/20, 12/24 and Evening shift-11/9, 11/25, 11/27 and 12/20; Night shift-11/3, 11/8, 11/14, 11/18, 11/29, 11/30, 12/22 and 12/25. An interview was conducted on 3/31/25 at 3:30 PM with CNA #4. When CNA #4 was asked where evidence of the resident being turned and positioned and head of bed elevated would be evidenced. CNA #4 stated, it is documented on the ADL form. When asked if there were blanks in the documentation, was the turning/positioning and head of bed elevated done, CNA #4 stated, no, it was not done. An interview was conducted on 4/1/25 at 5:30 AM with CNA #6. When asked about turning/positioning and head of bed being elevated, CNA #6 stated, we document on the ADL form and if it is not documented, it is not done. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. 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** 2.a. For Resident #1 (R1), the facility staff failed to administer a physician ordered intravenous antibiotic in a timely manner. A review of R1's clinical record revealed a urine culture report dated 11/11/24 that documented the resident presented with a urinary tract infection. Further review of R1's clinical record revealed a physician's order dated 11/11/24 for Ertapenem Sodium Solution- one gram intravenously every 24 hours for infection for seven days. Pharmacy alerts dated 11/11/24 documented a possible drug allergy and a possible drug interaction for Ertapenem. Administration notes dated 11/12/24 and 11/13/24 documented the nurses were waiting for the pharmacy to send Ertapenem. An administration note dated 11/14/24 documented, Pharmacy originally would not fill (Ertapenem) because of an allergy alert. Per NP (nurse practitioner) (name) it is ok for resident to take this drug, as she has been given it before. Per pharmacy medication will be delivered today. A review of R1's November 2024 medication administration record and a nurse's note dated 11/15/24 revealed R1 was not administered the first dose of Ertapenem until 11/15/24 (four days after the medication was ordered). A review of the Omnicell list revealed one-gram vials of ertapenem were available in the Omnicell (a machine in the facility that contains various medications). On 4/2/25 at 10:10 a.m., an interview was conducted with ASM (administrative staff member) #6 (the nurse practitioner). ASM #6 stated the importance of immediately starting an antibiotic is to prevent the resident from going septic. On 4/2/25 at 11:19 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that when a nurse activates orders in the computer system and there are possible allergy or drug interactions, the system alerts the nurse before she saves the orders. LPN #7 stated right then and there, the nurse should contact the pharmacy and immediately call the physician or nurse practitioner. On 4/2/25 at 4:09 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility pharmacy policy titled, General Guidelines for Medication Administration documented, II. Administration: 2. Medications are administered in accordance with written orders of the prescriber. No further information was presented prior to exit. 2.b. For Resident #1 (R1), the facility staff failed to obtain a blood sugar check per physician's order. A review of R1's clinical record revealed a nurse's note dated 12/13/24 (at 12:25 a.m.) that documented, Resident blood glucose recording HI (over 400), Rechecked several times. Insulin lispro 15 mls (milliliters) administered subcutaneously, and 18 units of glargine insulin administered. Glucose (blood sugar) continued to read high 30 min later. Message sent to NP (nurse practitioner), order to administer an additional 12 units of lispro insulin and recheck the glucose 2 hours later received. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 12/13/24 documented, Recheck blood glucose at 0200 (2:00 a.m.) A review of R1's December 2024 medication administration record revealed the resident's blood sugar was not re-checked on 12/13/24 until 3:59 a.m. On 4/2/25 at 11:19 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that if the nurse practitioner orders to re-check a resident's blood sugar at a certain time then the nurse should re-check the resident's blood sugar when the nurse practitioner says to re-check the blood sugar. On 4/2/25 at 2:23 p.m., an interview was conducted with RN (registered nurse) #3 (the nurse who documented the above note). RN #3 stated her shift ended at 11:30 p.m. so she had to give report to the on-coming nurse and go home. On 4/2/25 at 3:23 p.m., an interview was conducted with LPN #9 (the nurse who signed off re-checking R1's blood sugar at 3:59 a.m.) LPN #9 stated she did not remember R1. On 4/2/25 at 4:09 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, Insulin Administration documented, Check blood glucose per physician order . No further information was presented prior to exit. 3. For Resident #4 (R4), the facility staff failed to administer multiple medications per physician's orders. A review of R4's clinical record revealed the following physician's orders: 12/3/24-Basaglar KwikPen Solution Pen-injector 100 unit/ml (milliliters) (Insulin Glargine). Inject 75 unit subcutaneously at bedtime for diabetes. 12/3/24-Gabapentin 100 mg (milligrams). Give one capsule by mouth three times a day for pain. 12/5/24-Trazodone 100 mg. Give one tablet by mouth at bedtime for insomnia related to major depressive disorder. R4's December 2024 MAR (medication administration record) revealed the same physician's orders. Further review of R4's December 2024 MAR failed to reveal Basaglar was administered on 12/18/24 and 12/24/24, Gabapentin was administered on 12/24/24 at 9:00 p.m., and Trazodone was administered on 12/24/24, (as evidenced by blank spaces on the MAR). On 4/2/25 at 11:19 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that if a medication is not available for administration, then nurses should check the Omnicell (a machine containing various medications), and if the medication is available in the Omnicell, nurses should obtain the medication and administer it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Omnicell list revealed insulin glargine 100 unit/1ml, Gabapentin 100mg capsules, and Trazodone 50 mg tablets was available in the Omnicell. On 4/2/25 at 4:09 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 presented prior to exit. Based on resident interview, staff interview, clinical record review and facility document review it was determined that the facility staff failed to provide care and services to maintain a resident's highest level of well-being for five of 17 residents in the survey sample, Residents #3, #1, #4, #9 and #15. The findings include: 1. For Resident #3 (R3), the facility staff failed to administer medications as ordered for bowel prep prior to a colonoscopy appointment which were available in the facility in house stock resulting in the procedure being rescheduled and delayed. The physician orders for R3 documented in part, - May use OTC meds from house stock per facility policy. Order Date: 5/18/2024. - Patient has appt October 15th for colonoscopy, patient should have bowel prep on the 13th and 14th of October and also be on clear liquid diet on those days. patient, supervisor and relief nurse all notified. one time only until 10/15/2024 23:59. Order Date: 10/02/2024. Start Date: 10/13/2024. - Mix the entire bottle of Miralax powder (238 grams) with the Gatorade or 64 ounces of lemonade in a large container. Shake to dissolve and place in refrigerator one time only for colonoscopy prep until 10/14/2024 23:59. Order Date: 9/17/2024. Start Date: 10/14/2024. - Gavilax Powder (Polyethylene Glycol 3350) Give 238 gram by mouth every shift for colonoscopy prep for 1 Day drink 8 oz (1 cup) of prep solution every 15 minutes until you have finished half of the prep solution. Order Date: 09/17/2024. Start Date: 10/14/2024. - Gavilax Powder (Polyethylene Glycol 3350) Give 238 gram by mouth every shift for colonoscopy prep for 1 Day drink 8 oz (1 cup) of prep solution every 15 minutes until you have finished half of the prep solution. Order Date: 09/17/2024. Start Date: 10/15/2024. Review of the facility house stock medication list revised 12/13/2023 documented Polyethylene glycol 3350 (Miralax/clearlax) stocked in house at the facility. The eMAR (electronic medication administration record) for R3 documented the Miralax powder not mixed on 10/14/24 and not administered on 10/14/24 night shift. The eMAR documented Other/See Nurses Notes . The nurses notes for R3 documented in part, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 9/11/2024 13:57 (1:57 p.m.) Nursing note. Note Text: Resident made aware of future appts scheduled for Oct. 15, 16, and 17. Copies of the appt given to the resident. Also, instructions for the colonoscopy were given to the resident to be aware. - 10/14/2024 15:53 (3:53 p.m.) Administration note. Note Text: Mix the entire bottle of Miralax powder (238 grams) with the Gatorade or 64 ounces of lemonade in a large container. Shake to dissolve and place in refrigerator. one time only for colonoscopy prep until 10/14/2024 23:59. reorder. MD (medical doctor) made aware. - 10/15/2024 00:09 (12:09 a.m.) Administration note. Note Text: Gavilax Powder Give 238 gram by mouth every shift for colonoscopy prep for 1 Day drink 8 oz (1 cup) of prep solution every 15 minutes until you have finished half of the prep solution. medication did not arrive per previous nurse report, resident told 3-11 nurse his appointment was canceled. - 10/29/2024 15:03 (3:03 p.m.) Nursing note. Note Text: Writer spoke to the scheduling department with [Name of hospital] regarding rescheduling resident Colonoscopy. Per office no available appts for the rest of this year. Once new schedule opens up for Jan/2025 someone will contact the facility with appt date/time. [phone number]. On 4/2/25 at 6:38 a.m., an interview was conducted with LPN (licensed practical nurse) #5 who stated that she had received report from the evening shift nurse on 10/14/24 at R3's bowel prep had not arrived from the pharmacy, and it had not been started as scheduled. She stated that she spoke with R3 who told her the appointment had been canceled because the medication had not been sent from the pharmacy, and he was supposed to have started it the evening prior to her shift. On 4/2/25 at 11:20 a.m., an interview was conducted with LPN #7 who stated that medication was evidenced by signing it off on eMAR. She stated that if the medication was not available the nurse should notify the provider that the medication was not available and call the pharmacy. She stated that if it was a colonoscopy prep the pharmacy may be able to send the medication over stat if they did not have the medication in the stock medications. LPN #7 stated that normally the medication could be sent over in a couple of hours or the physician may change it to something else so the procedure would not have to be rescheduled or canceled. On 4/2/25 at 11:52 a.m., an interview was conducted with LPN #8 who stated that all the nurses should be aware of the in-house medications and how to access them. She stated that Miralax was stocked in the medication rooms and each nurse had access to the room with their medication cart keys. The facility policy Medication and Treatment Orders dated 10/1/21 documented in part, .The facility has sufficient staff and a medication distribution system to ensure safe administration of medication without unnecessary interruptions . If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit . On 4/2/25 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations were made aware of the concern. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit. 4.The facility staff failed to provide care and services to promote a resident's highest level of wellbeing by providing PICC/midline care for R9. Resident #9 (R9) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: DM (diabetes mellitus), CHF (congestive heart failure), seizures and chronic respiratory failure with hypoxia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/14/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 1/18/25 revealed, FOCUS: The resident is at risk for weight loss, malnutrition or poor hydration status related to DM2, asthma, morbid obesity, HTN, heart failure, need for therapeutic diet. INTERVENTIONS: Identify and honor food preferences. A review of the physician's order dated 11/21/24 revealed, Change PICC/Midline dressing q7days every day shift every 7 day(s). Physician's order dated 3/10/25 revealed, DC PICC one time only for ABX COMPLETED. A review of the progress note dated 3/2/25 at 10:36 PM revealed, Around 1900 patient called me in the room upset yelling and saying her line is contaminated, and it can't be used that I need to hurry up and find another kit to replace it. I was unsuccessful. I told her that I could not find another kit. A review of the progress note dated 3/10/25 at 6:30 PM revealed, Received resident lying in bed on left side with eyes open. Resident informed that I would be removing her PICC line from her right upper arm. Dressing removed, PICC site cleansed, PICC line removed without difficulty. Catheter tip intact and measures 20cm. Resident denies pain or distress, tolerated well. Pressure dressing applied. Resident encouraged to notify charge nurse if site begins to bleed or is painful. Resident stated understanding. An interview was conducted on 4/3/25 at 11:20 AM with LPN (licensed practical nurse) #7. When asked where evidence of PICC/Midline dressing change would be found, LPN #7 stated, it is either on the MAR or TAR. When asked if there is no documentation of the dressing changes, is there evidence of dressing changes being made, LPN #7 state, no, there is not evidence that it was done. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. The facility provided no policy regarding PICC/midline care. No further information was provided prior to exit. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. The facility staff failed to provide care and services to promote a resident's highest level of wellbeing by making GI (gastrointestinal) appointment for R15 Resident #15 (R15) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: hereditary and idiopathic neuropathy, arthritis and chronic kidney disease. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/5/25, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the comprehensive care plan dated 9/12/24 revealed, FOCUS: The resident has FUNCTIONAL bladder incontinence related to weakness. INTERVENTIONS: Clean peri-area with each incontinence episode. A review of the physician order dated 12/27/24 reveals, Appt with GI Date:12/30/24 Time: 12:30pm Pick up: 12:00pm Return ride. No evidence of R15 going out to GI appointment in progress notes or elsewhere in the medical record. An interview was conducted on 4/1/25 at 8:15 AM with R15. When asked if she had been out to any physician appointments, R15 stated, not that I remember. A request was made for evidence of R15's physician appointment and transportation. An 4/2/25 at 10:55 AM ASM #2 stated, I called the doctor's office tor R15, about the December 30, 2024, appointment. They did not have any appointment on their book for this resident. When asked if that indicated that the appointment was not made for this resident, ASM #2 stated, yes, it would seem that the appointment had not been made. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. Facility provided no policy related to appointments. No further information was provided prior to exit.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, facility document review, and clinical record review, the facility staff failed to provide care and services for a Foley urinary catheter (1) for one of 17 residents in the survey sample, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed to provide Foley catheter care during multiple shifts. R1's diagnoses included but were not limited to neuromuscular dysfunction of the bladder. A review of R1's clinical record revealed a physician's order dated 4/30/24 for catheter care every shift and as needed. A review of R1's TARs (treatment administration records) for September 2024 through November 2024 revealed the same physician's order. Further review of the TARs failed to reveal catheter care was provided on the following dates (as evidenced by blank spaces on the TARs): 9/24/24 during day shift. 9/27/24 during night shift. 9/28/24 during night shift. 10/9/24 during day, evening, and night shifts. 10/18/24 during night shift. 10/19/24 during evening shift. 11/13/24 during day shift. On 4/2/25 at 11:19 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated catheter care should be done at least once a shift and consists of cleaning around the catheter with soap and water, and emptying the catheter bag as often as needed. LPN #7 stated nurses evidence that catheter care was provided by signing it off on the TAR. On 4/2/25 at 4:09 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, Urinary Catheter Care documented, Infection Control: 2. Maintain clean technique when handling or manipulating the drainage system .Routine hygiene (e.g. cleansing of the meatal surface during daily bathing or showering) is appropriate .d. Empty the collection bag at least every eight (8) hours . Documentation- The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given . No further information was presented prior to exit. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: (1) A urinary catheter is a tube placed in the body to drain and collect urine from the bladder. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **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 respiratory care and services for two of 17 residents in the survey sample, Residents #4 and #9. The findings include: 1. For Resident #4 (R4), the facility staff failed to administer oxygen per physician's order on multiple shifts. R4's diagnoses included but were not limited to chronic obstructive pulmonary disease (lung disease). A review of R4's clinical record revealed a physician's order dated 12/5/24 for continuous oxygen at two liters per minute every shift. A review of R4's December 2024 TAR (treatment administration record) revealed the same physician's order. Further review of R4's December 2024 TAR failed to reveal oxygen was administered on the following dates (as evidenced by blank spaces on the TAR): 12/14/24 during night shift. 12/16/24 during day shift. 12/19/24 during day shift. 12/24/24 during evening shift. On 4/2/25 at 11:19 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated nurses should ensure residents are administered oxygen per physician's orders and should monitor residents' oxygen levels every shift. LPN #7 stated nurses evidence this care is provided by signing it off on the TAR. On 4/2/25 at 4:09 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, Oxygen Administration documented, Preparation- 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . Documentation: After completing oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed . No further information was presented prior to exit. 2. The facility staff failed to provide respiratory therapy per physician orders for R9. Resident #9 (R9) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: DM (diabetes mellitus), CHF (congestive heart failure), seizures and chronic respiratory failure with hypoxia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/14/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 1/18/25 revealed, FOCUS: The resident is at risk for weight loss, malnutrition or poor hydration status related to DM2, asthma, morbid obesity, HTN, heart failure, need for therapeutic diet. INTERVENTIONS: Identify and honor food preferences. A review of the physician orders dated 10/8/24 revealed, Oxygen 4 liters via NC (continuous) every shift may need more O2 with exertion. A review of the March 2025 TAR (treatment administration record) revealed, missing documentation of oxygen administration on following shifts: day shift-3/2, 3/7, 3/19, 3/21; evening shift-3/2, 3/3, ¾, 3/11, 3/16, 3/18, 3/29 and night shift-3/18, 3/25. An interview was conducted on 4/2/25 at 12:20 PM with LPN (licensed practical nurse) #8. When asked where oxygen administration per orders is evidenced, LPN #8 stated, it is documented on the TAR. When asked if the documentation is missing, is there evidence of administration, LPN #8 stated, no, there is no evidence. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. A review of the facility's Oxygen Administration policy revealed, Documentation-after completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: the rate of oxygen flow, route and rationale. No further information was provided prior to exit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide pharmacy services for one of 17 residents in the survey sample, Resident #4. The findings include: For Resident #4 (R4), the facility staff failed to obtain medications for administration. A review of R4's clinical record revealed physician's orders dated 12/3/24 for Verapamil 240 mg (milligrams)-one tablet by mouth at bedtime for high blood pressure and Prazosin 2 mg-one capsule by mouth at bedtime for HTN (hypertension [high blood pressure]). R4's December 2024 MAR (medication administration record) revealed the same physician's orders. Further review of R4's December 2024 MAR failed to reveal Verapamil and Prazosin was administered on 12/24/24 (as evidenced by blank spaces on the MAR). On 4/2/25 at 11:19 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that if a medication is not available for administration, then nurses should check the Omnicell (a machine containing various medications). LPN #7 stated that if the medication is not available in the Omnicell, then nurses should contact the pharmacy, re-order the medication, and call the provider (physician or nurse practitioner) to obtain an order for an alternative medication or put the medication on hold. A review of the Omnicell list revealed Verapamil and Prazosin was not available in the Omnicell. On 4/2/25 at 4:09 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 pharmacy policy titled, General Guidelines for Medication Administration documented, II. Administration: 2. Medications are administered in accordance with written orders of the prescriber. No further information was presented prior to exit.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence physician's response to the pharmacist's recommendations on the Medication Regimen Review (MRR) for one of 17 residents in the survey sample, R9. The findings include: The facility staff failed to ensure the physician's response to the pharmacist's recommendations for the 10/25/24 and 2/28/25 MRR for R9. Resident #9 (R9) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: DM (diabetes mellitus), CHF (congestive heart failure), seizures and chronic respiratory failure with hypoxia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/14/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 1/18/25 revealed, FOCUS: The resident is at risk for weight loss, malnutrition or poor hydration status related to DM2, asthma, morbid obesity, HTN, heart failure, need for therapeutic diet. INTERVENTIONS: Identify and honor food preferences. A review of the 10/25/24 MRR recommendation revealed, This resident has been taking antibiotic Fluconazole and Ketoconazole since 10/24. While sometimes indicated, it is recommended that all antibiotics given for a period of more than 30 days be evaluated for appropriateness and duration. No physician response found. A review of the 2/28/25 MRR recommendation revealed, This resident has been taking Protonix 40 mg QD since 10/2024 without a dose reduction. Please consider a trial reduction to 20 mg QD. No physician response found. An interview was conducted on 4/2/25 at 10:00 AM with ASM (administrative staff member) #7, the nurse practitioner. When asked the process for reviewing the MRR, ASM #7 stated, we review the recommendations and then respond to them. When asked where this is documented, ASM #7 stated on the MRR form. On 4/3/25 at 9:00 AM, ASM #1, the administrator, stated, there is nothing else to provide. On 4/2/25 at 4:00 PM, ASM #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. A review of the facility's Medication Regimen Review policy revealed, Recommendations are acted upon and documented by the facility staff and/or the prescriber. The prescriber accepts and acts upon recommendation or rejects and provides an explanation for disagreeing. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, it was determined that the facility staff failed to evidence radiology services as ordered for one of 17 residents, R8. The findings include: Resident #8 (R8) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: DM (diabetes mellitus), CVA (cerebrovascular accident) with hemiplegia, hemiparesis and vascular dementia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/5/24, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. The resident was coded as being dependent for turning. A review of the comprehensive care plan dated 8/21/24 revealed, FOCUS: The resident has an ADL (activities of daily living) self-care performance deficit due to history of CVA, dementia. He is dependent on staff for all ADL needs. INTERVENTIONS: BED MOBILITY: The resident is totally dependent on (X2) staff for repositioning and turning in bed and as necessary. A review of the physician's order dated 12/16/24 revealed, CXR one time only for productive cough for 1 day. A review of the progress notes dated 12/18/24 at 12:27 AM revealed, attempted to call to schedule a chest Xray but voice recording says to call back during regular business hours. Will pass this forward to 7-3p shift for action and follow-up with this call. A review of the progress notes dated 12/18/24 at 1:35 PM revealed, Call placed to Dispatch Health Imaging. Per representative, no longer takes new orders 24/7. Only able to place orders up until 11:00 PM. CXR ordered at this time. A review of the chest x-ray results obtained on 12/19/24 at 6:00 AM and resulted on 12/19/24 at 4:45 PM revealed, There has been no significant change compared with the prior exam. Impression: The lungs show no confluent airspace opacity. An interview was conducted on 4/2/25 at 10:35 AM with ASM (administrative staff member) #7, the nurse practitioner. When asked expected time frame for a chest x-ray completion, ASM #7 stated, normally we would get the x-ray and results within 24 hours. I do not know if the imaging calls for critical results. ASM #1, the administrator stated on 4/3/25 at 9:00 AM, there is nothing more to provide to you. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Radiology and Diagnostic Services policy revealed, Radiological and diagnostic testing services are provided by the facility to meet the needs of our residents. The services may be provided on-site or off-site through contracted services of a diagnostic testing provider that is approved to provide the services by Medicare. No further information was provided prior to exit.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 1.The facility staff failed to provide honor dietary and allergy preferences by serving resident products with gluten. Resident #9 (R9) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: DM (diabetes mellitus), CHF (congestive heart failure), seizures and chronic respiratory failure with hypoxia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/14/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 1/18/25 revealed, FOCUS: The resident is at risk for weight loss, malnutrition or poor hydration status related to DM2, asthma, morbid obesity, HTN, heart failure, need for therapeutic diet. INTERVENTIONS: Identify and honor food preferences. A review of the physician's order dated 10/10/24 revealed, Consistent Carbohydrate (CCD/CCHO) diet Regular texture, Regular/Thin consistency, ALLERGIES: Blueberries, Corn, Fish, Potato / Double protein, double vegetable with meals. A review of the 10/17/24 nutrition assessment revealed, Needs are increased d/t morbid obese BMI. RD spoke w/ resident on 10/16 to review diet, food preferences, weight, and PO intakes. Resident requesting double protein and double vegetable w/ meals to increase satiety. Order started and tray card updated accordingly. RD will continue to monitor and follow-up PRN. An interview was conducted on 3/31/25 at 9:30 AM with R9. When asked about her dietary preferences, R9 stated, there are many allergies, I cannot have gluten, and I am Jewish and follow Jewish dietary guideline. They do not seem to understand that and have told me I need to prove to them that I need a gluten free diet and do not understand my Jewish dietary needs. A review of R9's 3/31 lunch meal ticket revealed, ALLERGIES: Blueberries, Corn, Fish, Potato / Double protein, double vegetable with meals. Dislike pancakes, French toast, bread. On her lunch tray were 2 bowls of chicken noodle soup. R9 stated to CNA (certified nursing assistant) #3, I cannot each that soup with the noodles in it. CNA #3 stated, I will go bring you a new tray. CNA #3 came back with new tray with 2 bowls of chicken noodle soup. R9 said, never mind, I will eat something I have here. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/1/25 at 10:00 AM with OSM (other staff member) #3, the director of dietary services. When asked the process for determining a resident's food preferences, OSM #3 stated, the registered dietician and I visit with the resident when they are admitted , the nurse gets the diet order, and we enter it. The residents are told the menus and alternatives for each meal. Food allergies come across electronically and by resident interview. Dining Manager system- prints out meal tickets for residents, allergies and religious dietary restrictions should be on the meal tickets. Dislikes are printed separately. If the resident has an allergy to or Dislike of then we find something else to substitute. When asked if a resident is not to have gluten or is to have double protein are two bowls of chicken noodle soup meeting these requirements and are preferences being honored, OSM #3 stated, no, preferences not being met. On 4/2/25 at 4:00 PM during end of day conference, when told of concern regarding R9's food preferences being honored, ASM #1 the administrator, interrupted and stated, how do you know she is Jewish? Do you know she is Jewish? Did she tell you she was Jewish. We offered to send her to the hospital to have the test for Celiac (gluten) and she said no. When asked if it mattered whether she was Jewish or refused the Celiac test in order to honor her food preferences, ASM #1 stated, no. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. A review of the facility's Resident's Right to Make Personal Dietary, Food and Meal Choices policy revealed, The facility recognizes the resident's/ resident representative's right to make personal dietary, food and meal choices. The facility also recognizes the right of the resident to receive services in the facility with reasonable accommodations of individual needs and religious, cultural and ethnic preferences. No further information was provided prior to exit. 2. The facility staff failed to provide honor dietary preferences by serving resident eggs. Resident #15 (R15) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: hereditary and idiopathic neuropathy, arthritis and chronic kidney disease. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/5/25, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the comprehensive care plan dated 9/12/24 revealed, FOCUS: The resident has FUNCTIONAL bladder incontinence related to weakness. INTERVENTIONS: Clean peri-area with each incontinence episode. A review of the physician order dated 9/11/24 reveals, Regular diet Regular texture, Regular/Thin consistency, No Sausage Please Give Bacon. Yogurt QD in between meals for diet. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the nutritional risk assessment dated [DATE] revealed, Meal intakes 50-100% (~95%) + yogurt 1x/day = 2258kcal, 91g protein Estimated needs are skewed high r/t morbid obese BMI. Resident continues w/ good meal intakes. Estimated needs are likely being met. No s/s of dehydration noted. No sausage, give bacon. See tray card. No known food allergies. No information in 'special ethnic or cultural needs' or 'religious preferences' sections. An interview was conducted on 4/1/25 at 5:45 AM with R15. R15 stated, they do not serve me the food that I like. On 4/1/25 at 8:10 AM observed R15 breakfast tray and meal ticket. On tray were eggs, meal ticket-dislike eggs. An interview was conducted on 4/1/25 at 10:00 AM with OSM (other staff member) #3, the director of dietary services. When asked the process for determining a resident's food preferences, OSM #3 stated, the registered dietician and I visit with the resident when they are admitted , the nurse gets the diet order, and we enter it. The residents are told the menus and alternatives for each meal. Food allergies come across electronically and by resident interview. Dining Manager system- prints out meal tickets for residents, allergies and religious dietary restrictions should be on the meal tickets. Dislikes are printed separately. If the resident has an allergy to or Dislike of then we find something else to substitute. When asked if a resident is not to have eggs and they are served eggs, are preferences being honored, OSM #3 stated, no, preferences not being met. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. A review of the facility's Resident's Right to Make Personal Dietary, Food and Meal Choices policy revealed, The facility recognizes the resident's/ resident representative's right to make personal dietary, food and meal choices. The facility also recognizes the right of the resident to receive services in the facility with reasonable accommodations of individual needs and religious, cultural and ethnic preferences. No further information was provided prior to exit.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to provide snacks during the day and at bedtime for two of 17 residents in the survey sample, R11 and R15. The findings include: 1. The facility staff failed to provide snacks during the day and at bedtime for Resident #11. Resident #11 (R11) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: Parkinson's Disease, convulsions and chronic kidney disease. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/5/25, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the comprehensive care plan dated 3/31/25 revealed, FOCUS: The resident is frequently incontinent of bladder and bowels. INTERVENTIONS: Provide substantial/maximal assistance with toileting. Observations in the nourishment Unit 1 and Unit 2 on 3/31/25 at 8:20 AM, 11:15 AM, 3:30 PM and 4/1/25 at 6:10 AM revealed, no snacks available including milk, applesauce, ice cream, crackers, yogurt, peanut butter with exception of 2 milk and 2 yogurts found on Unit 2 at 8:25 AM on 3/31/25. Facility census was 120 on entrance 3/31/25. An interview was conducted on 3/31/25 at 10:35 AM when R11, when asked if he received snacks during the day and at bedtime, R11 stated, no, there are no snacks. We can buy some, but they do not give us any. An interview was conducted on 3/31/25 at 10:40 AM with CNA #3. CNA #3 was leaving the unit nourishment room. When asked if he had snacks for residents, CNA #3 stated, no there are no snacks for the residents on day or evening shift. An interview was conducted on 3/31/25 at 3:30 PM with CNA #4. When asked if she has snacks to provide to residents, CNA #4 stated, the kitchen sends down some PBJ (peanut butter jelly) and cheese sandwiches for the diabetic residents. There are no other snacks for the residents, no crackers, applesauce or milk. An interview was conducted on 4/1/25 at 5:40 AM with CNA #7. When asked if night shift had snacks, they need for the residents. CNA #7 stated, we have no snacks for the residents. Opened a cabinet door in nourishment room and stated, look at this, took out 12-ounce jar of peanut butter and opened it. Approximately one teaspoon of peanut butter in the bottom. CNA #7 stated, what do you do with this amount, and we have no crackers. (continued on next page)

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	495283	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosedale Health & Rehabilitation	1719 Bellevue Avenue Richmond, VA 23227

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/1/25 at 10:15 AM with OSM (other staff member) #3, the Director of Dietary Services. When asked what snacks are provided to the residents, OSM #3 stated we send out snack for bedtime, extra sandwiches, PBJ. We offer PBJ and grilled cheese at any time of the day. When asked if milk, applesauce, crackers are stocked for the residents during the day, OSM #3 stated, no, we have never had par levels for nourishment. I was not aware there was an issue. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. A review of the facility's Between Meal and Bedtime Snacks policy revealed, The purpose of this procedure is to provide the resident with adequate nutrition. No further information was provided prior to exit. 2. The facility staff failed to provide snacks during the day and at bedtime Resident #15. Resident #15 (R15) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: hereditary and idiopathic neuropathy, arthritis and chronic kidney disease. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/5/25, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the comprehensive care plan dated 9/12/24 revealed, FOCUS: The resident has FUNCTIONAL bladder incontinence related to weakness. INTERVENTIONS: Clean peri-area with each incontinence episode. Observations in the nourishment Unit 1 and Unit 2 on 3/31/25 at 8:20 AM, 11:15 AM, 3:30 PM and 4/1/25 at 6:10 AM revealed, no snacks available including milk, applesauce, ice cream, crackers, yogurt, peanut butter with exception of 2 milk and 2 yogurts found on Unit 2 at 8:25 AM on 3/31/25. Facility census was 120 on entrance 3/31/25. An interview was conducted on 4/1/25 at 5:45 AM with R15. R15 stated, there is no snacks for the residents. Nothing in between meals. An interview was conducted on 3/31/25 at 10:40 AM with CNA #3. CNA #3 was leaving the unit nourishment room. When asked if he had snacks for residents, CNA #3 stated, no there are no snacks for the residents on day or evening shift. An interview was conducted on 3/31/25 at 3:30 PM with CNA #4. When asked if she has snacks to provide to residents, CNA #4 stated, the kitchen sends down some PBJ (peanut butter jelly) and cheese sandwiches for the diabetic residents. There are no other snacks for the residents, no crackers, applesauce or milk. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/1/25 at 5:40 AM with CNA #7. When asked if night shift had snacks, they need for the residents. CNA #7 stated, we have no snacks for the residents. Opened a cabinet door in nourishment room and stated, look at this, took out 12-ounce jar of peanut butter and opened it. Approximately one teaspoon of peanut butter in the bottom. CNA #7 stated, what do you do with this amount, and we have no crackers. An interview was conducted on 4/1/25 at 10:15 AM with OSM (other staff member) #3, the Director of Dietary Services. When asked what snacks are provided to the residents, OSM #3 stated we send out snack for bedtime, extra sandwiches, PBJ. We offer PBJ and grilled cheese at any time of the day. When asked if milk, applesauce, crackers are stocked for the residents during the day, OSM #3 stated, no, we have never had par levels for nourishment. I was not aware there was an issue. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. A review of the facility's Between Meal and Bedtime Snacks policy revealed, The purpose of this procedure is to provide the resident with adequate nutrition. 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, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for one of 17 residents in the survey sample, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed to document the resident's blood sugar reading on 12/13/24 at 3:59 a.m. A review of R1's clinical record revealed a physician's order dated 12/13/24 that documented, Recheck blood glucose at 0200 (2:00 a.m.) A review of R1's December 2024 medication administration record revealed the resident's blood sugar was re-checked on 12/13/24 at 3:59 a.m. Further review of R1's clinical record (including the December 2024 medication administration record, nurses' notes, and blood sugar summary) failed to reveal documentation of the numerical reading of the resident's blood sugar when it was re-checked on 12/13/24 at 3:59 a.m. On 4/2/25 at 3:23 p.m., an interview was conducted with LPN #9 (the nurse who signed off re-checking R1's blood sugar at 3:59 a.m.) LPN #9 stated that when a nurse checks a resident's blood sugar, the number should be documented on the medication administration record. LPN #9 stated she did not remember R1. On 4/2/25 at 4:09 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 did not have a policy regarding a complete and accurate clinical record. No further information was presented prior to exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to implement infection control practices for the facility. The findings include: The facility staff failed to follow infection control practices for linen storage. On 4/1/25 at approximately 5:50 AM, ASM (administrative staff member) #1, the administrator and this surveyor were making round of the unit linen closets to review levels. ASM #1 stated, we have more linen than this. They start bringing out the linen cart at 6:45 AM. ASM #1 took me to linen/EVS area and stated, there is more linen on those shelves. Packs of blankets, wrapped in plastic were on shelves next to one blanket and one sheet on open shelf next to environmental services cart and mops. When asked if the linen should be unwrapped next to the environmental services cart, ASM #1 stated, no, it should not be. When asked if it is an infection control issue to have unwrapped linen next to environmental services cart, ASM #1 stated, yes, it is. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. No policy was provided by the facility. No further information was provided prior to exit.

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F 0907 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough space and equipment to meet each resident's needs **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to provide supplies, including urinals, gloves, cup tops for the for two of 17 residents in the survey sample, R11 and R15. The findings include: 1. The facility staff failed to provide supplies, including urinals, gloves, cup tops for Resident #11. Resident #11 (R11) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: Parkinson's Disease, convulsions and chronic kidney disease. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/5/25, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the comprehensive care plan dated 3/31/25 revealed, FOCUS: The resident is frequently incontinent of bladder and bowels. INTERVENTIONS: Provide substantial/maximal assistance with toileting. Observations in the supply/linen closets on Unit 1 and Unit 2 on 3/31/25 at 8:20 AM, 3:30 PM and 4/1/25 at 6:10 AM revealed, no urinals or gloves on 3/31 8:20 AM, at 3:30 PM there were 4 urinals and 2 boxes of gloves in each closet and on 4/1 at 6:10 AM there were 2 urinals and 2 boxes of gloves in each closet. Facility census was 120 on entrance 3/31/25. An interview was conducted on 3/31/25 at 9:00 AM with CNA (certified nursing assistant) #1. When asked if they have the supplies they need, CNA #1 stated, no, we run out of supplies. When asked what supplies, CNA #1 stated, sometimes urinals, adult briefs and gloves. We have to get gloves from different resident rooms at times or carry them in our pocket. An interview was conducted on 3/31/25 at 3:25 PM with CNA #5, when asked if she has supplies that she needs for evening shift, CNA #5 stated, no, we are short with gloves, adult diapers and urinals. We did not have urinals and only a few gloves any over the weekend. An interview was conducted on 3/31/25 at 3:30 PM with CNA #4. CNA #4 approached CNA #5 and I in the linen/supply room on Unit 1 and asked CNA #5 if she had found any gloves. CNA #4 stated, in several rooms there are no gloves, are there any here. When asked if they are short of supplies, CNA #4 stated, yes, gloves, urinals, towels, washcloths and sheets. An interview was conducted on 4/1/25 at 5:30 AM with CNA #6. When asked if night shift had any shortages of supplies, CNA #6 stated, we are okay last night with urinals but short on gloves. (continued on next page)

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F 0907 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/1/25 at 5:40 AM with CNA #7. When asked if night shift had supplies, CNA #7 stated, sometimes we are short on gloves and urinals. An interview was conducted on 4/1/25 at 10:57 AM with OSM (other staff member) #4, the central supply supervisor. When asked about the supply process for the facility, OSM #4 stated, the process for ordering supplies, is that the director of nursing goes through the system and orders it. I have only been in this role about 3 weeks. Usually diapers, gloves, wipes, are ordered. I come in everyday and see if we have it in the shed. Shipment came in yesterday; we did not receive any urinals in the order Friday, so they delivered it on Monday. I come to the floors and check the supply closets, if the nurses/aides tell me they need something, I go to shed and if we don't have it, come back in and talk with the DON or ADM to enter order. When ask what happens if there are zero of a needed item, like urinals or gloves, OSM #4 stated, we can do a rush order. Normally we order weekly. I work Monday through Friday. I typically stock Monday & Friday day shift. If they don't have something and I am not here, then they call me, but I try to make sure supplies are in central supply. An interview was conducted on 4/2/25 at 6:00 AM with CNA #7. When asked if there were supply shortages during the night, CNA #7 stated, see these bottles of water, we are giving the residents bottles of water because we have no lids for their water cups. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. No policy regarding supplies was provided by the facility. No further information was provided prior to exit. 2. The facility staff failed to provide supplies, including gloves, cup tops for Resident #15. Resident #15 (R15) was admitted to the facility on [DATE] with diagnosis that included but were not limited to: hereditary and idiopathic neuropathy, arthritis and chronic kidney disease. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/5/25, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the comprehensive care plan dated 9/12/24 revealed, FOCUS: The resident has FUNCTIONAL bladder incontinence related to weakness. INTERVENTIONS: Clean peri-area with each incontinence episode. Facility census was 120 on entrance 3/31/25. An interview was conducted on 3/31/25 at 9:00 AM with CNA (certified nursing assistant) #1. When asked if they have the supplies they need, CNA #1 stated, no, we run out of supplies. When asked what supplies, CNA #1 stated, sometimes urinals, adult briefs and gloves. We have to get gloves from different resident rooms at times or carry them in our pocket. (continued on next page)

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F 0907 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/31/25 at 3:25 PM with CNA #5, when asked if she has supplies that she needs for evening shift, CNA #5 stated, no, we are short with gloves, adult diapers and urinals. We did not have urinals and only a few gloves any over the weekend. An interview was conducted on 3/31/25 at 3:30 PM with CNA #4. CNA #4 approached CNA #5 and I in the linen/supply room on Unit 1 and asked CNA #5 if she had found any gloves. CNA #4 stated, in several rooms there are no gloves, are there any here. When asked if they are short of supplies, CNA #4 stated, yes, gloves, urinals, towels, washcloths and sheets. An interview was conducted on 4/1/25 at 5:30 AM with CNA #6. When asked if night shift had any shortages of supplies, CNA #6 stated, we are okay last night with urinals but short on gloves. An interview was conducted on 4/1/25 at 5:40 AM with CNA #7. When asked if night shift had supplies, CNA #7 stated, sometimes we are short on gloves and urinals. An interview was conducted on 4/1/25 at 5:45 AM with R15. When asked about supplies, R15 stated, they do not always have my size briefs. An interview was conducted on 4/1/25 at 10:57 AM with OSM (other staff member) #4, the central supply supervisor. When asked about the supply process for the facility, OSM #4 stated, the process for ordering supplies, is that the director of nursing goes through the system and orders it. I have only been in this role about 3 weeks. Usually diapers, gloves, wipes, are ordered. I come in everyday and see if we have it in the shed. Shipment came in yesterday; we did not receive any urinals in the order Friday, so they delivered it on Monday. I come to the floors and check the supply closets, if the nurses/aides tell me they need something, I go to shed and if we don't have it, come back in and talk with the DON or ADM to enter order. When ask what happens if there are zero of a needed item, like urinals or gloves, OSM #4 stated, we can do a rush order. Normally we order weekly. I work Monday through Friday. I typically stock Monday & Friday day shift. If they don't have something and I am not here, then they call me, but I try to make sure supplies are in central supply. An interview was conducted on 4/2/25 at 6:00 AM with CNA #7. When asked if there were supply shortages during the night, CNA #7 stated, see these bottles of water, we are giving the residents bottles of water because we have no lids for their water cups. On 4/2/25 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) ASM #3, the regional director of clinical operations was made aware of the findings. No policy regarding supplies was provided by the facility. No further information was provided prior to exit.