STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtland Rehabilitation and Healthcare Center	23020 Main Street Courtland, VA 23837

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interviews, clinical record review, and review of facility documents, the facility staff failed to provide adequate supervision to prevent accidents for 1 of 51 residents (Resident #98), in the survey sample which constituted harm.The findings included: 1. The facility staff failed to provide adequate supervision to ensure Resident #98 was safe from falling while transferring, which constituted harm.Resident #98 was no longer a resident of the facility; therefore, a closed record review was conducted. Resident #98 was admitted to the facility on [DATE] after a hospital stay. The resident's diagnoses included Alzheimer's Disease, essential hypertension, major depressive disorder, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/12/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 00 out of a possible 15. This indicated Resident #98's cognitive abilities for daily decision making were severely impaired.A synopsis of an event dated 8/30/23 revealed that Resident #98 had a witnessed fall while a Certified Nursing Assistant (CNA) was transferring Resident #98 from a wheelchair to the bed. Resident #98 and the CNA lost their balance and both fell to the floor. Resident #98 was transferred to the hospital on 8/30/23 and was diagnosed with the following: facial laceration, closed fracture of nasal bone, and closed nondisplaced fracture of second cervical vertebra.A review of section GG (Functional Abilities and Goals) dated 8/15/23 of Resident #98's Minimum Data Set (MDS) coded the resident as dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair or wheelchair). A review of Resident #98's Occupational Therapy Treatment Encounter Note dated 8/25/23 read: stand pivot transfer to wheelchair total assist. On 1/28/26 at 2:15 PM an interview was conducted with the Director of Nursing (DON). The DON stated that due to Resident #98 being coded as dependent for chair/bed-to-chair transfers, the CNA should have had her hands on Resident #98 at all times or should have had the assistance of another staff member. On 1/28/26 at 3:55 PM an interview was conducted with the Director of Rehabilitation. The Director of Rehabilitation stated that Resident #98 was coded as total assist with transfers. The Director of Rehabilitation also stated that the CNA should have had hands on the resident at all times during a transfer from the wheelchair to the bed.A review of Resident #98's nurses note dated 8/30/23 at 4:45 PM read: Called to residents room by CNA, resident was noted to be on the floor on her left side. Blood was noted on the floor. Laceration was noted to middle of residents forehead. She was assessed for further injury and was assisted to the bed. Pressure was applied to forehead to stop bleeding. 911 was called and resident was transported to ER via ambulance. She was sent with her transfer paperwork and bedhold policy. Residents daughter was made aware of fall.A review of Resident #98's nurses note dated 8/30/23 at 10:25 PM read: Resident returned from hospital via ambulance. She has aspen collar intact to her neck. She returned with diagnosis of facial laceration, closed fracture of the nasal bone, and closed nondisplaced fracture of the second cervical vertebra, unspecified fracture morphology. Residents daughter made aware. She (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	stated that she would be at the facility first thing in the morning.A review of Resident #98's Emergency Department documentation dated 8/30/23 read: Final Impression- 1. Facial laceration, initial encounter 2. Closed fracture of nasal bone, initial encounter 3. Closed nondisplaced fracture of second cervical vertebra, unspecified fracture morphology, initial encounter (HCC).A review of Post Fall Review documentation dated 8/30/23 at 10:25 PM read: Fall during transfer with CNA. Resident became combative and lost her balance and fell to the floor.A review of an Incident Report dated 8/30/23 at 4:45 PM read, Nursing Description: This nurse was passing meds when called to residents room by CNA, resident was laying on her left side. Blood was noted on the floor. Resident was assisted back to bed with 2 person assist and pressure was applied to forehead laceration. EMS was called. Other Info: Per CNA when transferring resident from wheelchair to bed, resident began resisting care and was pushing against the CNA, both resident and CNA lost balance and both fell to the floor. Statement: Her hand went up towards my face, she was saying something and jerking away from me, and then I fell to the side because I tripped over the leg rest. I'm not sure how she ended up falling forward but she fell face forward to the ground. I called for help, I did not move her, then (Nurse's name) and (CNA name) came in to help. (Nurse's name) assessed her and then we got (Resident #98's name) into bed.On 1/28/26 at 5:30 p.m. a final interview was conducted with the Administrator, Director of Nursing, and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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(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 - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and a review of clinical records, the facility staff failed to notify the resident and/or the resident representative of changes for 2 of the 51 residents in the survey sample (Residents #37 and #88). The findings included:1. The facility's staff failed to notify Resident #37 of her test/laboratory results. Resident #37 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses include diabetes, atrial fibrillation, and renal insufficiency. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 12/21/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scored 10 out of a possible 15. This indicated Resident #37's cognitive abilities for daily decision making were moderately impaired. In section GG0130. Self-Care: the resident was coded as requiring setup or clean-up assistance with eating; partial/moderate assistance with oral hygiene and upper-body dressing; dependent assistance with toileting; lower-body dressing; putting on/taking off footwear; showering/bathing; and personal hygiene. In section GG0170. Mobility: the resident was coded as independent with rolling in bed, requiring partial/moderate assistance with sit-to-lying, lying-to-sitting, and transfers. On the initial tour with Resident #37 on 1/20/26 at approximately 1:31 PM. The resident stated that she had not been feeling well and was awaiting the results of the test conducted the day before, because the nurse suspected she might have the flu and a urinary tract infection (UTI). On 1/22/26, another interview was conducted with Resident #37, who stated that she had been asleep most of the day because she was still unwell. The resident further stated she had no appetite and was nauseated. She stated that she was still awaiting the results of her test. On 1/23/26 at approximately 1:55 PM, the resident again stated that she was not feeling well and that she had not been notified by nursing of the status of her test or of what could be done for her ill feelings. An interview was conducted with Licensed Practical Nurse (LPN) #2 on 1/23/26 at approximately 2:25 PM. LPN #2 stated she had not been informed of any test results for Resident #37. LPN #2 reviewed the resident orders and identified the following orders dated 1/19/26: In-house COVID and flu test, one time only for 1 day, and a complete blood count, basic metabolic panel, urinalysis, and a urine culture and sensitivity, one time only for nausea/vomiting, dysuria for 2 days. LPN #2 stated that she would need to speak with Unit C Manager (UCM) to determine whether the tests ordered were completed and what the results revealed. LPN #2 later stated that UCM stated she would further investigate the identified concern and provide an update on the findings. On 1/28/26 at approximately 11:00 AM, Resident #37 stated that, shortly after our conversation on 1/23/26, a nurse came in and notified her that she had a yeast infection and would be started on a medication, and that she did not have COVID-19 or the flu. On 1/23/26, the Nurse Practitioner (NP) ordered the resident Fluconazole 150 MG: Give 1 tablet by mouth once daily for 7 days for a yeast UTI. On 1/23/26 at 5:23 PM, a late entry was documented in Resident #37's nurses' note for 1/19/26 at (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2:23 PM. The late entry note stated that the resident was assessed per the provider's order for COVID-19 and Influenza swabs due to cold-like symptoms, and the results were negative for COVID-19 and Influenza. The note further stated that the Provider was notified of negative results. An interview was conducted with the NP on 1/28/26 at approximately 3:20 PM. The NP stated that it was not her responsibility to notify the resident and/or the resident's representative of test results, as that was the responsibility of the direct care nurses. The NP stated she added an addendum to her 1/19/26 progress note on 1/23/26 to state that the nurse notified her of Resident #37's test results on 1/19/26. The NP also stated that she delayed initiating medication for the yeast infection to determine whether additional laboratory results would be reported. The bottom of the lab report stated that no further workup performed. On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing, and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information. They offered no additional information and voiced no concerns regarding the above information. 2. The facility staff failed to notify the resident representative of a change in room for Resident #88. Resident #88 was originally admitted to the facility on [DATE]. The current diagnoses included; Alzheimer's Disease with late onset and malignant neoplasm of prostate. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/30/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 03 out of a possible 15. This indicated Resident #88's cognitive abilities for daily decision making were severely impaired. An interview was conducted with the Director of Nursing (DON) on 1/28/26 at 2:05 PM. The DON stated that Resident #88 had a change in room on five (5) different occasions and the resident representative was not notified. The DON also stated that the dates and location of the room changes were the following: 1/1/24 to Unit 1 30-A, 1/2/24 to Unit 1 28-A, 7/17/24 to Unit 1 26-A, 12/6/24 to Unit 2 33-A, and 12/6/24 to Unit 1 16-A. A review of the Clinical Census documentation for Resident #88 read that the resident had room changes on the following dates and room locations: 1/1/24 to Unit 1 30-A, 1/2/24 to Unit 1 28-A, 7/17/24 to Unit 1 26-A, 12/6/24 to Unit 2 33-A, and 12/6/24 to Unit 1 16-A. On 1/28/26 at 5:30 p.m., a final interview was conducted with the Administrator, Director of Nursing, and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information. The Administrator stated, a resident or resident representative needs to be notified prior to the room change happening.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and interviews with residents and staff, the facility staff failed to ensure a homelike environment for 2 of the 51 residents in the survey sample (Residents #36 and #50). The findings included:1. The facility staff failed to maintain a homelike environment for Resident #36, free of a wandering resident.Resident #36 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses include a chronic left lower extremity blood clot, a stage 4 sacral wound, and an anxiety disorder. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 11/11/25, documented that the resident had completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated Resident #36's cognitive abilities for daily decision making were intact. On 1/20/26 at 12:06 PM, Resident #22 was observed in a wheelchair being pushed rapidly out of room [ROOM NUMBER], as the door slammed with great force, creating a loud noise that commanded attention; however, no one responded. Resident #22 was seen again at approximately 12:33 PM strolling on the opposite corridor of the unit, stopping at some doorways, and entering other rooms. She was observed asleep in her wheelchair in room [ROOM NUMBER], but the resident was out. At approximately 12: 46 PM, the resident was observed entering a dependent resident's room, who was asking her to leave the room, but Resident #22 continued to stroll about the room with no regard for the dependent resident's plea for her to leave. On 1/21/26 at approximately 10:13 AM, Resident #22 was observed again strolling along in the corridor and entering rooms that were not hers. There was no staff redirection, and when residents called for assistance to redirect her, she would be gone by the time staff responded to the call light. On 1/28/26 at 10:55 AM, an interview was conducted with Resident #36. Resident #36 stated that this is not a home because, if it were, you would be able to lock your doors to keep people out. Resident #36 also stated that the wanderers come in regardless of whether you are in or out, for they don't care. The resident stated that before leaving his room, he must ensure that all his mail, documents, cell phones, and personal items on the table are put away. The resident further stated that he must strategically position his bed and use other items to block wanderers from approaching the side of his bed where he keeps many personal effects, because he has had items removed from his room that were never recovered.The wandering concern was discussed with the facility staff on 1/22/26 at 4:35 PM, and the DON asked for recommendations for managing residents with wandering behaviors. The DON was directed to the facility's leadership.On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information, but no concerns were voiced. 2. The facility staff failed to maintain a homelike environment for Resident #50, free of a wandering resident.Resident #50 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses include Parkinson's disease, heart failure, and macular degeneration. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 12/2/25, coded that the resident had completed the Brief Interview for Mental Status (BIMS) and scored 14 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were intact. On 1/20/26 at 12:06 PM, Resident #22 was observed in a wheelchair being pushed rapidly out of room [ROOM NUMBER], as the door slammed with great force, creating a loud noise that commanded attention; however, no one responded. Resident #22 was seen again at approximately 12:33 PM strolling on the opposite corridor of the unit, stopping at some doorways, and entering other rooms. She was observed asleep in her wheelchair in room [ROOM NUMBER], but the resident was out. At approximately 12:46 PM, the resident was observed entering a dependent resident's room, who was asking her to leave the room, but Resident #22 continued to stroll about the room with no regard for the dependent resident's plea for her to (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	leave. On 1/21/26 at approximately 10:13 AM, Resident #22 was observed again strolling along in the corridor and entering rooms that were not hers. There was no staff redirection, and when residents called for assistance to redirect her, she would be gone by the time staff responded to the call light. An interview was conducted with Resident #50 on 1/28/26 at 11:15 AM. Resident #50 stated that, because she has poor vision, she is unable to see all that the wandering resident is doing when the resident comes into her room. She said she asked the resident to leave, but it didn't result in her leaving. Resident #50 stated on one occasion that there was a book on tape at the bedside, and the resident picked it up. Resident #50 stated she used a bag of popcorn to bargain with the resident to prevent her from leaving with the audiobook. Resident #50 further stated that it is a problem to have the resident wandering into the room because she doesn't appear to understand what's said to her, and she fears she will take the items she keeps on the over-the-bed table.The wandering concern was discussed with the facility staff on 1/22/26 at 4:35 PM, and the DON asked for recommendations for managing residents with wandering behaviors. The DON was directed to the facility's leadership.On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information, but no concerns were voiced.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on information from the resident council task, resident interviews, staff interviews, and review of facility documents, the facility staff failed to educate the residents on how to file a grievance and resolve grievances as well as keeping the residents appropriately apprised of progress toward resolution for 4 of 51 residents (Resident #14, Resident #16, Resident #10, and Resident #76) in the survey sample.The findings included: 1. On 1/22/26 at 3:00 PM while conducting the resident council task, residents voiced that they do not know how to file a grievance or what the process is for resolving a grievance. Residents also voiced that they have never been educated on the process for filing a grievance. On 1/22/26 at 4:45 PM an interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. The Administrator stated that the residents are educated on the grievance process. The question was asked to the Administrator, how are the residents educated on the process to file a grievance? The Administrator stated, I'm not sure. The Administrator then stated, it is done during the admission process. On 1/28/26 at 11:18 AM an interview was conducted with the Recreation Director. The Recreation Director stated that she conducts the monthly Resident Council Meetings with the Residents. The Recreation Director also stated that she reviewed the monthly Resident Council meeting minutes from the time span of April 2023 to today's date and the residents have not been educated on the process of how to file a grievance during this time period. The Recreation Director further stated that she was under the impression that the residents knew how to file a grievance but agreed that if they are not educated, they probably do not know what the process is for filing a grievance.On 1/28/26 at 12:45 PM an interview was conducted with the Social Services Director. The Social Services Director stated that she is the Grievance Officer. The Social Services Director also stated that she has never educated the residents on the process of how to file a grievance. The Grievance Officer also stated that she does not know about any other staff members educating the residents on the process of how to file a grievance. On 1/28/26 at 5:30 p.m. a final interview was conducted with the Administrator, Director of Nursing, and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with residents and staff and a review of the clinical record, the facility staff failed to protect 1 of the 51 residents in the survey sample (Resident #14) right to be free from physical abuse.Resident #14 was initially admitted to the facility on [DATE] following an acute-care hospital stay. The residents' current diagnoses include dementia, major depressive disorder, and atrial fibrillation. The annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 12/24/25, coded that the resident had completed the Brief Interview for Mental Status (BIMS) and scored 10 out of a possible 15. This indicated that Resident #14's cognitive abilities for daily decision making were moderately impaired. In section GG0130. Self-Care: the resident was coded as independent with eating, oral hygiene, upper-body dressing, toileting, lower-body dressing, putting on/taking off footwear, and personal hygiene, and requiring partial/moderate assistance with showers/bathing. In section GG0170. Mobility: the resident was coded as independent with rolling in bed, sit-to-lying, lying-to-sitting, transfers, and walking.An interview was conducted with Resident #14 on 1/21/26 at 12:20 PM. The resident stated that she prefers not to eat in the dining room due to concerns about COVID-19 and influenza. The resident then stated her primary reason for not enjoying meals in the dining room was that a woman who wandered the hallways and into rooms had attacked her in the dining room. Resident #14 stated that she was in the dining room for the meal, and suddenly she was karate chopped 4 to 5 times from behind on her previously fractured right arm by the wandering woman. The resident stated that a man inside the kitchen rescued her from the woman. She stated that it was when she realized the severe pain in her right arm.A progress note written by the mental health NP dated 7/17/25 stated that during the visit, the resident continued to complain of right arm pain, and she discussed the attack. The mental health NP stated that the resident said that if she had her cane when she was attacked, she would have hit the person who attacked her in the head. The mental health NP stated the resident was redirected not to use violence but to inform staff so that they can handle the situation. She was encouraged to continue socializing with others, but to sit on the opposite side of the room from the person who attacked her.A review of the resident's nurse's notes revealed a progress note dated 7/16/25 at 12:40 PM, which stated the resident reported the attack and the pain she was experiencing. The nurse's note stated the resident reported a pain level of 8 to 10. The Nurse Practitioner's (NP) progress note dated 7/18/25 stated that the x-ray report showed no new findings, and the previous fracture was not completely healed. Over the days of the survey, 1/20/26 through 1/23/26 and 1/26/26 through 1/28/26. The resident who attacked Resident #14 was observed to wander from corridor to corridor and room to room with no interventions by the staff unless a resident called for assistance. Resident #14 stated that the attacker appears to be calmer, but she moves out of her way whenever she sees her coming.On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. The Administrator stated that she did not complete a Facility-Reported Incident document because she believed it was not an abuse event, because it was not a willful act. The Administrator stated that she believed the other resident wanted Resident #14's attention.An example of a deliberate (willful) action would be a cognitively impaired resident who strikes out at a resident within his/her reach. (SOM - Appendix PP, page 74)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and a review of clinical records, the facility staff failed to include the discharge-preference information for 2 of 51 residents (Resident #67 and #25) in the survey sample. The findings included: 1. The facility staff failed to include Resident #67's discharge preference in the comprehensive person-centered care plan.Resident #67 was initially admitted to the facility on [DATE], after an acute care hospital stay. The residents' diagnoses included dementia, colitis, and high blood pressure. The quarterly MDS assessment, with an assessment reference date (ARD) of 1/15/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scored 11 out of a possible 15. This indicated that Resident #67's cognitive abilities for daily decision making were moderately impaired. A review was made of Resident #67's quarterly MDS assessment dated [DATE], section Q0400. Discharge Plan. The MDS was coded that active discharge planning was not underway to return the resident to the community. At Q0500. Return to Community. The MDS was coded that the resident, or another designated person, does not want to discuss the possibility of leaving this facility to return to the community to live and receive services.The residents' person-centered care plan, with a revision date of 10/26/25, had a problem that the length of stay was to be determined. The goal stated (name of resident) to work with staff to obtain her maximum potential to return home through the next review on 4/15/26. The intervention dated 10/14/25 stated that (name of the resident) will work with staff to go home alone. An interview was conducted with Resident #67 on 1/20/26 at 2:22 PM. Resident #67 stated that she wanted to move to a town closer to her friend so her friend would not have to travel 40 minutes to visit. The resident stated that her care plan conference was scheduled for 1/21/26, but the Interdisciplinary Team did not come to get her as they said they would, causing her to miss the conference. Resident #67 stated she wants the Team to work towards her goal of discharging to a facility closer to her friend.An interview was conducted with the Social Worker (SW) on 1/28/26 at approximately 1:50 PM. The SW stated that Resident #67 changes her mind frequently, and without the friend's input, they had not set an achievable goal. The SW stated that the resident's home had been foreclosed on and that she had nowhere to go because her friend's apartment was no longer an option. The SW stated that she was assessing the residents' finances before making any further decisions about where she could possibly reside. The SW stated she was not aware that the comprehensive care plan was to be developed and implemented to meet the residents' preferences and goals, regardless of the barriers. On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to provide additional information, but they did not, and no concerns were voiced regarding the above information. 2. The facility staff failed to include Resident #25's preference to return to the community on the comprehensive person-centered care plan.Resident #25 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses include hypertension and chronic anemia. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 1/11/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scored 15 out of a possible 15. This indicated Resident #25's cognitive abilities for daily decision making were intact. A review was made of Resident #25's quarterly MDS assessment dated [DATE], section Q0400. Discharge Plan. The MDS was coded that active discharge planning was not underway to return the resident to the community. At Q0500. Return to Community. The MDS was coded that the resident, or another designated person, does not want to discuss the possibility of leaving this facility to return to the community to live and receive services. Section Q0610. Referral. It was also coded that a referral had not been made to the Local Contact Agency because it was not wanted.The residents' person-centered care plan, with a revision date of 1/14/26, failed to address (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the residents' preferences and their goal of returning to the community. An interview was conducted with Resident #25 on 1/21/26 at 11:10 AM. Resident #25 stated that he desired vision and dental services, but his greatest goal was to get out of the facility, for as long as he resided in the facility, he would not get to go fishing or have a relationship with a woman. An interview was conducted with the Social Worker (SW) on 1/28/26 at approximately 1:50 PM. The SW stated that Resident #25's brother interrupted the discharge plan for the resident's discharge to his home on 8/25. The SW further stated that the resident cannot return to the group home he previously resided in due to the condition it was left in, and that his income was too low to afford most places. The SW stated the resident recently approached her about discharging him to Union Mission, and she stated she would follow up on his suggestion after the bad weather passes. The SW stated she was not aware that the comprehensive care plan was to be developed and implemented to meet the residents' preferences and goals, regardless of the barriers. On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to provide additional information, but they did not, and no concerns were voiced regarding the above information.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations during the Medication Storage and Labeling and Medication Administration tasks, staff interviews, and a review of clinical records, the facility failed to ensure that medications were safe for administration. The findings included: 1. The facility staff failed to ensure that unscored medications were not split.On 1/22/26 at approximately 9:22 AM, during the Medication Administration task, Licensed Practical Nurse (LPN) #2 was observed cutting an unscored Fluphenazine HCl 10 MG Oral Tablet to obtain a dose of 15 MG. The physician's Order Summary stated to administer Fluphenazine HCl Oral Tablet 15 MG by mouth two times a day for Schizophrenia/Psychosis. The label on the medication stated to administer 10 MG, but the dosage was changed on 12/25/25 to 15 MG.This medication carries a boxed warning. Black box warnings are added only when substantial clinical data show the drug can cause severe harm, hospitalization, or death. (What Is a Black Box Warning? | John Hopkins | [NAME] School of Public Health)An interview was conducted with LPN #2, who stated that a new medication package had not been sent to the facility since the change in dosage and that the pharmacy had not been notified of what they had on hand to administer the ordered dosage. She continued to split the pill to obtain the ordered dose.In the facility's Nursing Care Center Pharmacy Policy and Procedure Manual dated 2007. The manual instructed users to answer the following question to determine whether a pill could be split: Question #2 asked whether the tablet was scored (i.e., had an indented line in the center). If it is not, don't split the pill.An interview was conducted with the Director of Nursing (DON) on 1/23/26 at approximately 1:40 PM. The DON stated that the pharmacy had been notified of the need to split the medication to obtain the ordered dosage so they could send an appropriate medication to the facility. The DON further stated that the pharmacy sent the same medication to the facility, and the facility's staff would address the concern directly with the Pharmacist. On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information. They had no comments and voiced no concerns regarding the above information. 2. The facility staff failed to ensure that multi-dose vials, which were accessed, were dated when opened.On 1/22/26, the medication storage task was conducted at approximately 1:50 PM with LPN #3. An observation was made of an opened vial of Tuberculin, purified protein derivative, in the refrigerator. The date the vial was opened was not on the vial or box. LPN #3 stated she did not know when it had been opened or for whom it was opened for since neither the box nor the vial was dated. LPN #3 stated that if the date was on the vial stated when it was opened, it could be used for 28 days. LPN #3 returned the undated multi-dose vial of Tuberculin, purified protein derivative, to the refrigerator with medications that were safe for administration. On 1/23/25 at approximately 2:30 PM, the Director of Nursing stated that the undated multi-vial of Tuberculin, purified protein, had been removed from use and discarded because the date it was opened was unknown.On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information. They had no comments and voiced no concerns regarding the above information. INDICATIONS AND USAGE - TUBERSOL Tuberculin Purified Protein Derivative (Mantoux) is indicated to aid the diagnosis of tuberculosis infection (TB) in persons at increased risk of developing active disease. (https://www.fda.gov/media/74866/download) STORAGE - Store at 2 to 8 C (35 to 46 F). (20) Do not freeze. Discard product if exposed to freezing.Protect from light. Tuberculin PPD solutions can be adversely affected by exposure to light.The product should be stored in the dark except when doses are actually being withdrawn fromthe vial. (21)A vial of TUBERSOL which has been entered and is in use for 30 days should be discarded. (https://www.fda.gov/media/74866/download)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and a review of clinical records, the facility staff failed to ensure resident care equipment was maintained in a safe operating condition for 1 of 51 residents (Resident #3) in the survey sample. The findings included: Resident #3 was initially admitted to the facility on [DATE], after a stay in another long-term care facility. The residents' diagnoses included diabetes and heart failure. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 12/2/25, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 12 out of a possible 15. This indicated Resident #3's cognitive abilities for daily decision making were moderately impaired. In section GG0130. Self-Care: the resident was coded as independent for eating and personal hygiene; dependent on upper-body dressing, lower-body dressing, toileting, removing footwear, and showering/bathing. In section GG0170. Mobility: the resident was coded as requiring partial/moderate assistance with rolling in bed, and as dependent for sit-to-lying, lying-to-sitting, and transfers.On 1/20/26 at 1:15 PM, the resident was interviewed in her room during the initial tour. Resident #3 stated the over-the-bed table had fallen on her knees again, and she needed pain medication to tolerate the discomfort. The resident also stated that she has knee pain, but they hurt more often since she was being hit by the over-the-bed table multiple times each day. The resident stated she has had the over-the-bed table since her admission to the facility and has complained to staff that it falls onto her knees without warning. She stated the nurses had tried to work on it, but it continued to drop down and hit her knees. An observation of the resident's knees on 1/20/26 at approximately 1:21 PM. Both knees were mildly reddened, and the right had a small purplish bruise. The resident stated that they may not look like they hurt, but they hurt, and to try having a table fall on your knees multiple times each day. Shortly after leaving the resident's room, the Rehabilitation Director was observed entering the resident's room with another over-the-bed table and later going down the corridor with another over-the-bed table. On 1/28/26, at approximately 3:09 PM, an interview was conducted with the Rehabilitation Director. She stated she overheard the resident complaining about the over-the-bed table. She attempted to repair it, but once her personal items were placed on the table, it would suddenly drop. The Rehabilitation Director stated that she obtained another over-the-bed table and replaced the defective one. She stated the defective table was given to the Maintenance Director for repair.On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing, and the Regional Clinical Director. The above concerns were addressed, and an opportunity was offered for the facility's staff to provide information they considered pertinent to the findings. They had no comments and voiced no concerns

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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 observation, staff interview, and clinical record review, the facility staff failed to maintain dignity during mealtime for 1 of 51 residents (Resident #88), in the survey sample.The findings included: The facility staff failed to maintain dignity during mealtime by standing over a resident while feeding the resident. Resident #88 was originally admitted to the facility on [DATE]. The current diagnoses included; Alzheimer's Disease with late onset and malignant neoplasm of prostate.The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/30/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 03 out of a possible 15. This indicated Resident #88's cognitive abilities for daily decision making were severely impaired.In section GG (Functional Abilities) the resident was coded as setup or clean-up assistance with eating.On 1/22/26 at approximately 12:21 pm, a dining observation was made in the dining room. The Assistant Director of Nursing (ADON) was observed standing over Resident #88 while feeding the resident. The ADON continued to stand over Resident #88 for 9 (nine) minutes while continuing to feed the resident. On 1/23/26 at 2:35PM an interview was conducted with the ADON. The ADON stated that she should not have been standing over Resident #88 while she was feeding him. The ADON also stated that she knows this was wrong due to this being a dignity issue.On 1/28/26 at 5:30 p.m. a final interview was conducted with the Administrator, Director of Nursing, and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and a review of facility documents, the facility staff failed to thoroughly investigate a report of missing personal property for 1 of 51 residents (Resident #14) in the survey sample.The findings includedResident #14 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses include dementia, major depressive disorder, and atrial fibrillation. The annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 12/24/25, coded that the resident had completed the Brief Interview for Mental Status (BIMS) and scored 10 out of a possible 15. This indicated that Resident #14's cognitive abilities for daily decision making were moderately impaired. In section GG0130. Self-Care: the resident was coded as independent with eating, oral hygiene, upper-body dressing, toileting, lower-body dressing, putting on/taking off footwear, and personal hygiene, and requiring partial/moderate assistance with showers/bathing. In section GG0170. Mobility: the resident was coded as independent with rolling in bed, sit-to-lying, lying-to-sitting, transfers, and walking.An interview was conducted with Resident #14 on 1/21/26 at 12:20 PM. The resident stated that a [NAME] watch her daughter had gifted to her was taken from her bedside table one night. The resident further stated that she recalled placing the watch in the drawer along with her cellphones before going to bed; however, when she opened the drawer the next morning, the phones were present, but the watch was absent. Resident #14 stated she reported to the nurse that her watch was missing. The resident also stated she believed she knew who had taken her watch from her drawer, but that person denied it.On 1/22/26 at approximately 3:35 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she searched under the mattress and other areas of the resident's room for the watch but did not find it. The DON also stated that she spoke with the resident's daughter regarding the missing watch, and the daughter was not concerned. The DON stated that the daughter said that the resident was known to misplace items and was unable to locate them later. A grievance report dated 7/29/25 was completed following the resident's report that her watch was missing. The grievance report stated that the resident's daughter said the watch was worth approximately $250.00, and she described it as a brown [NAME] watch with fake diamonds around the face. The grievance report was resolved on 8/5/25, but the watch was not located. and only the DON had actively attempted to locate it. No documentation was available from any other facility staff.An interview was conducted with the resident's daughter on 1/23/25 at approximately 10:14 AM. The daughter stated she had given the [NAME] watch to the resident and did not believe her mother had misplaced it.On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information, but they did not.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and a review of the clinical records, the facility staff failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 51 residents (Resident #52) in the survey sample.The findings included: Resident #52 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' diagnoses included GI bleeds, stroke, and high blood pressure. The quarterly MDS assessment, with an assessment reference date (ARD) of 1/4/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scored 12 out of a possible 15. This indicated that Resident #52's cognitive abilities for daily decision making were moderately impaired. An interview was conducted with Resident #52 on 1/20/26 at 2:44 PM. Resident #52 stated that the only assistance he sought was an eye examination and dentures. The resident stated that he had not received any dental services since admission to the facility. He opened his mouth to show that he had no natural teeth or dentures.A review of the comprehensive MDS assessment dated [DATE] at section L0200 (Dental), the resident was coded as having obvious or likely cavity or broken natural teeth.The Social Worker was informed of the resident's desires for a dental consultation for dentures on 1/28/26 at approximately 1:50 PM. The SW returned later and provided a document stating that the dentist would see the resident on 2/9/26. An interview was conducted with the MDS Coordinator on 1/28/26, at approximately 3:35 PM. The MDS Coordinator confirmed that the MDS assessment was not coded accurately and would modify it to reflect the resident's oral status: no natural teeth or fragments; edentulous. A copy of the modified MDS assessment was provided.On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to provide additional information. They had no comments and voiced no concerns regarding the above information.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and facility documentation, the facility staff failed allow the residents' involvement in the care plan conference for 1 resident (Resident #67) in the survey sample of 51 residents.The findings Include:The facility staff failed to allow the residents' involvement in the care plan conference on 1/21/26.Resident #67 was initially admitted to the facility on [DATE], after an acute care hospital stay. The residents' diagnoses included dementia, colitis, and high blood pressure. The quarterly MDS assessment, with an assessment reference date (ARD) of 1/15/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scored 11 out of a possible 15. This indicated that Resident #67's cognitive abilities for daily decision making were moderately impaired. An interview was conducted with Resident #67 on 1/22/26 at 3:14 PM. Resident #67 stated that she did not like the activities the facility offered and wanted to move to a town closer to her friend so she would not have to travel 40 minutes to visit. The resident stated that her care plan conference was scheduled for 1/21/26, but the Interdisciplinary Team did not come to get her as they said they would, causing her to miss the conference.The resident had a letter in her possession that stated: Dear Resident/Representative, Your next Care Conference is scheduled for 1/21/26, at 11:15 AM. LOCATION: Please go to your resident's room; we will come and get you. The interdisciplinary team will meet to review your comprehensive plan of care. The meeting will take about 15 minutes, and you are encouraged to attend and participate in the planning of your care/your loved one's care. If you plan to attend, please RSVP by calling (name of the SW) at (phone number and extension).An interview was conducted with the Social Worker (SW) on 1/28/26 at approximately 1:50 PM. The SW stated that the resident came to her office before her conference was scheduled to begin. She instructed the resident to wait in her room, and that when her friend arrived, she would come to get her. The SW stated the resident's friend had called to confirm she would attend, but she did not show. The SW stated the Team wanted the friend present because Resident #67 changes her mind frequently, and the friend would help her set achievable goals. The SW stated that when the resident's friend did not show up, they did not go to get the resident to attend her care plan conference. The SW stated that, after discussing the concern, she recognized that the Team made a mistake by not involving the resident in participation.On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to provide additional information, but they did not, and no concerns were voiced regarding the above information.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility staff failed to provide Activity of Daily Living (ADL) care to one dependent Resident (Resident #10) in a survey sample of 51 Residents.The findings include: Resident #10 was originally admitted to the facility 9/19/2015 and re-admitted from an acute care facility on 7/11/25. The current diagnoses included; Pressure Ulcer Right Hip, Stage 4, Pressure Ulcer other site Stage 4 and Acquired absence of the Right Knee, above.The quarterly review Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/22/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #10 cognitive abilities for daily decision making were intact. In Section GG Functional Abilities coded resident as dependent with showers/bathe self, toileting and personal hygiene. Resident coded as independent with eating.The person-centered care plan dated 4/25/25 read that the resident has an Activity of Daily Living (ADL) self-care performance deficit r/t paraplegic, limited ROM/contracture of left lower extremity and right AKA. The Goal for the resident was he will maintain current level of function, to be clean, odor free, well-groomed, appropriately dressed, well hydrated, and nourished throughout the review period through the review date. One of the Interventions was Bathing/showers: Per resident request bed bath only (revised on 1/22/2024).On 1/27/26 at approximately 11:18 am., a telephone interview was conducted with the resident's daughter with concerns that he was burned on his leg while staff was giving him a shower in 2023. 1/21/26 at approximately 1:57 pm., during the initial tour, an interview was conducted with Resident #10. Resident #10 said that he would like more showers, but they're saying they need more help due to being short-staffed.On 1/28/26 at approximately 10:57 am, a brief interview was conducted with Resident #10 concerning showers and the incident that his daughter alleges he was burned in the shower. Resident #10 said that he was never burned while taking a shower, but he did bump his leg against a wheelchair, causing his leg to bleed. The resident also reported that he showered last night. The resident also said that the staff had always told him that he couldn't take a shower due to the leg wound. The resident reports feeling much better since taking a shower. On 1/28/26 at approximately 2:00 pm., a brief interview was conducted with Licensed Practical Nurse (LPN) #3. She can't recall if the resident refused showers or was scalded in the shower. On 1/28/26, a brief interview was conducted at 3:00 pm. with Certified Nursing Assistant (CNA) #1 concerning Resident #10. CNA #1 said that Resident #10 get offered showers on the 11-7 shift on Thursdays and Sundays but will often refuse them.A review ADL (Activities of Daily Living) document reveal Resident #10 received a shower on the following days: 1/15/26 (Thursday), 1/22/26 (Thursday) and 1/28/26 (Wednesday).A review of the medical record revealed no shower refusals.On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information. The DON said that the resident refuses showers but no shower refusals were found in the medical record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family interview, staff interview, clinical record review and review of facility documentation the facility staff failed to ensure the necessary treatment, care and services were initiated for a Stage 2 pressure ulcer for 1 of 51 residents (Resident #96), a closed record resident, in the survey sample.The findings include: Resident #96 was originally admitted to the facility 06/09/23 and discharged to an acute care facility on 6/28/23. The current diagnoses included; Quadriplegia and Pressure induced deep tissue damage of the sacrum. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/16/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #96 cognitive abilities for daily decision making were intact.In sectionGG(Functional Abilities) the resident was coded as dependent toileting hygiene, lower body dressing, putting on/taking off footwear. Requires substantial/maximal assistance with upper body dressing and shower/bathe self. Coded as set-up or clean-up assistance with eating. In section M (Skin Conditions) coded as having an unstageable deep tissue pressure injury on admission.The above section M Skin conditions was not coded until in the MDS until 6/16/23. June 2023 Order Summary:Standard Pressure Ulcer Redistribution Mattress.AIR MATTRESS, verify function and settings per weight q shift every shift for to aid in wound healing Verbal Active 06/27/2023 06/27/2023AIR MATTRESS every shift for to aid in wound healing Verbal Active 06/15/2023 06/15/2023WEEKLY SKIN ASSESSMENT every evening shift every Thu for ROUTINE Phone Active 06/09/2023 06/15/2023 A review of the Hospital Discharge summary dated [DATE] read that the resident has a sacral wound requiring wound care with a foam border dressing. A review of the medical records on 6/09/23 through 6/12/23 revealed no wound care admission assessment had been completed on the resident until 6/13/23 by the Wound Care Nurse Practitioner (WCNP) reading Deep Tissue Injury (DTI).A review of the Baseline care plan dated 6/10/23 read Stage 2 sacrum. The BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK: dated 6/09/23 rated resident as a moderate risk, scoring a 14.0. SCORING:AT RISK 15-18MODERATE RISK 13-14HIGH RISK 10-12VERY HIGH RISK 9 or below. SENSORY PERCEPTION=Very limited. MOISTURE=occasionally moist. ACTIVITY=Chair Fast. MOBILITY=Very Limited. NUTRITION =Adequate. FRICTION &SHEAR=Potential Problem.The wound evaluation revealed dated 06/13/2023 revealed resident had a wound on her sacrum measuring Length: 2.0 cm. Width: 5.0 cm Depth 0.50 cm, Severity: DTI. Date wound acquired 6/09/23, present on admission with 50-74% epithelial, 50-74%granulation, 0% slough or eschar, Subcutaneous tissue with edges attached, fragile peri wound, scant amount of serosanguineous exudate, no odor. The Treatment: change dressing daily, cleanse with wound cleanser, treat with Medical grade honey with bordered foam dressing.A review of the Treatment Administration Record (TAR) for June 2023 revealed wound care treatments were initiated on 6/13/23 for Deep Tissue Injury (DTI). Prior to 6/13/23, no wound care treatment was observed in the Medication Administration Record (MAR) and TAR. A review of the June 2023 MAR/TAR revealed the following orders: Weekly skin assessment every shift on Thursdays beginning 6/09/23. Initialed on 6/16/23.Cleanse sacrum with normal saline, apply medihoney, cover with borderedgauze daily. every day shift for wound care dated 6/12/23, initial on 6/13/23. A review of medical records revealed Resident #96 was admitted to the facility on [DATE] from the hospital with a sacral wound requiring wound care. The Baseline care plan completed at the Long-Term Care (LTC) facility dated 6/10/23 revealed the resident had a stage 2 sacrum. The WCNP assessed the wound 3 days later indicating the resident was admitted with a DTI. The above assessments to include wound care, MDS documentation on wounds and wound care treatments were not assessed in a timely manner and treated until the WCNP had initiated treatment. On 1/26/26 at approximately 7:45 pm., a returned phone call was received by the resident's son (complainant). The family member said that the facility staff failed to keep his loved one from getting pressure ulcers by not providing care and treatment. He (continued on next page)

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	495296	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtland Rehabilitation and Healthcare Center	23020 Main Street Courtland, VA 23837

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said that his mother was not aware that she had a stage 3 or 4 pressure ulcer when she was admitted to the facility. On 1/28/26 at approximately 10:10 am., an interview was conducted with the Wound Care Nurse Practitioner (WCNP). The WCNP said that she conducted the wound assessment on 6/13/23 as a Deep Tissue Injury (DTI). The WCNP also said that a stage 3 or 4 pressure ulcer was present on admission.On 1/28/26 at approximately 2:00 pm., an interview was conducted with Licensed Practical Nurse (LPN) #3 concerning Resident #96. LPN #3 said that she did the admission assessment and assessed the resident as a stage 2 pressure ulcer but don't remember the resident being that it was in 2023. LPN #3 also said that the Wound Care Nurse will come out the next day to assess the residents once notified if there's a wound.The Policy on Pressure Ulcers/Skin Breakdown-Clinical Protocol reads: The nursing staff and or practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. In addition, either the nurse, medical provider, or wound care provider, shall describe and document/report the following: Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. The physician will assist the staff to identify the type and characteristics of an ulcer. Deep Tissue Injury (DTI)- Deep tissue pressure injury remains one of the most serious forms of pressure injury. The pressure is exerted at the muscle-bone interface, but due to the resiliency of the skin, the color change is not immediate, in contrast to a bruise. The process leading to deep tissue pressure injury precedes the visible signs of purple or maroon skin by about 48 hours. Then about 24 hours later, the epidermis lifts and reveals a dark wound bed. This phase of deep tissue injury evolution is often confused with skin tears. Within another week, the wound bed is often necrotichttps://npiap.com/news/546664/Evolution-of-Deep-Tissue-Pressure-Injury.htmOn 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information. The Regional Clinical Director mentioned that a Performance Improvement Plan (PIP) dated 6/18/25 to 9/18/25 had been completed. The resident in question, Resident #96, was not included in the PIP. The DON said that nursing staff are not allowed to stage wounds and that the wound should have been assessed sooner.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, and clinical record review, the facility staff failed to maintain ongoing records of communication between the facility and the dialysis center for 1 of 51 residents (Resident #11), in the survey sample.The findings include:Resident #11 was originally admitted to the facility 5/23/24 and readmitted on [DATE] The current diagnoses included end stage renal disease requiring dialysis. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/23/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #11 cognitive abilities for daily decision making were intact. The person-centered care plan dated 7/28/25 read that Resident #11 receive hemodialysis Monday, Wednesday and Friday (M/W/F) related to End Stage Renal Disease (ESRD). The Goal for the resident is resident will have immediate intervention should any s/s of complications from dialysis occur through the review date. The Interventions are to check dressing over dialysis port to ensure dry and intact every shift and to check vascular access monitoring every shift. A review of Resident #11's dialysis communication book and medical record revealed no dialysis communication notes from the dialysis center were available for review on 10/27/25 and 10/29/25. On 1/22/26 at approximately 3:58 pm., a brief interview was conducted with Resident #11 concerning her dialysis communication book. The resident stated she received dialysis services on Mondays, Wednesdays and Fridays from 11:00 am to 4:00 pm. The resident stated that the dialysis communication book is given to her to take to dialysis to communicate her care.On 1/22/26 at approximately 4:05 pm., a brief interview was conducted with Licensed Practical Nurse (LPN) #5 concerning the dialysis communication book. LPN #5 said that the communication book goes with the resident to dialysis and should have communication documentation in the book and in the Medical Records.On 1/28/26 at approximately 5:30 pm, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to provide additional information, but they did not, and no concerns were voiced regarding the above information.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and a review of clinical records, the facility staff failed to document the results of in-house COVID and influenza tests for 1 of the 51 residents in the survey sample (Resident #37). The findings included:Resident #37 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses include diabetes, atrial fibrillation, and renal insufficiency. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 12/21/25, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scored 10 out of a possible 15. This indicated Resident #37's cognitive abilities for daily decision making were moderately impaired. In section GG0130. Self-Care: the resident was coded as requiring setup or clean-up assistance with eating; partial/moderate assistance with oral hygiene and upper-body dressing; dependent assistance with toileting; lower-body dressing; putting on/taking off footwear; showering/bathing; and personal hygiene. In section GG0170. Mobility: the resident was coded as independent with rolling in bed, requiring partial/moderate assistance with sit-to-lying, lying-to-sitting, and transfers.On the initial tour with Resident #37 on 1/20/26 at approximately 1:31 PM. The resident stated that she had not been feeling well and was awaiting the results of the test conducted the day before, because the nurse suspected she might have the flu and a urinary tract infection (UTI). On 1/22/26, another interview was conducted with Resident #37, who stated that she had been asleep most of the day because she was still unwell. The resident further stated she had no appetite and was nauseated. She stated that she was still awaiting the test results. On 1/23/26 at approximately 1:55 PM, the resident again stated that she was not feeling well and that she had not been notified by nursing of the status of her test or of what could be done for her ill feelings. A review of the resident Physician's Order Summary identified the following order dated 1/19/26: In-house COVID-19 and influenza (flu) test, one-time, for 1 day. An interview was conducted with Licensed Practical Nurse (LPN) #2 on 1/23/26 at approximately 2:25 PM concerning Resident #37's results of the COVID and flu test ordered on 1/19/26. LPN #2 stated she had not been informed of the COVID and flu test results for Resident #37. LPN #2 stated that she would need to speak with Unit C Manager (UCM) to determine whether the tests ordered were completed and what the results revealed. LPN #2 later stated that UCM stated she would further investigate if the test had been completed, and if they were, what the results were, and whether the information was documented in the resident's record.On 1/23/26 at 5:23 PM, a late entry was documented in Resident #37's nurses' note for 1/19/26 at 2:23 PM. The late entry note stated that the resident was assessed per the provider's order for COVID-19 and Influenza swabs due to cold-like symptoms, and the results were negative for COVID-19 and Influenza. The note further stated that the Provider was notified of negative results.On 1/28/26 at approximately 11:00 AM, Resident #37 stated that, shortly after our conversation on 1/23/26, a nurse entered and informed her that she did not have COVID or the flu. Before the inquiry about the ordered in-house COVID and flu test, no documentation was in the resident's record.An interview was conducted with the NP on 1/28/26 at approximately 3:20 PM. The NP stated she added an addendum to her 1/19/26 progress note on 1/23/26 to state that the nurse notified her of Resident #37's test results on 1/19/26, but she was unaware of the direct care nurse's documentation. On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information, and the DON stated that it is the responsibility of the licensed nurse who conducted the in-house test to document the test results in the resident's record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and staff interviews the facility staff failed to follow infection control practices. Therefore, increasing the chances of spreading infections, illnesses and diseases for 1 of 51 residents, Resident #10 in the survey sample. The findings include: Resident #10 was originally admitted to the facility 9/19/2015 and re-admitted from an acute care facility on 7/11/25. The current diagnoses included; Pressure Ulcer Right Hip, Stage 4, Pressure Ulcer other site Stage 4 and Acquired absence of the Right Knee, above. The quarterly review Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/22/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #10 cognitive abilities for daily decision making were intact. In Section M skin conditions coded resident as dependent with showers/bathe self, toileting and personal hygiene. Resident coded as independent with eating.The person-centered care plan dated revised on 1/05/26 read resident has an actual impairment with potential for further skin impairment s/t decreased mobility/paraplegic, bowel incontinence. He prefers to always lay at a 45-degree angle or less at times in the bed. Resident is noncompliant with turning and repositioning. Actual wounds Stage 4 - Right Ischium, Stage 4 - Sacrum, Vascular- left lower leg. The Goal for the resident is Pressure wounds will show signs of improvement by review date. Vascular wound to left lower leg will resolve without complications through the next review date. The interventions are: Float left heel (as tolerated), Keep skin clean and dry and Observe location, size and treatment of skin injury, Report abnormalities, failure to heal, s/s of infection, maceration, etc. to MD and Treatments per orders.On 1/22/26 at approximately 11:00 am., wound care observation of Resident #10's Right Ischium was conducted with the Assistant Director of Nursing (ADON)/Infection Preventionist (IP). The ADON was observed providing wound care to the resident's right Ischium using the following steps: donned PPE (mask, glove and gown) washed hands, donned gloves, gathered supplies, placed supplies on the bedside table without sanitizing the table, removed old dressing, doff gloves, resident noticed to have an incontinent episode (BM), ADON left bedside, gathered briefs and incontinent wipes, doff gloves, donned gloves, provided incontinent care, kept gloves on and proceeded to provide wound care, doffed gloves, donned gloves, gathered supplies, placed soiled items in the trash can. Doffed gown, gloves, donned gloves took soiled items into soiled utility room, doffed gloves, washed hands.On 1/22/26 at approximately 4:32 pm., an end of day meeting was conducted with the Administrator, the Director of Nursing (DON) and with the Regional Clinical Nurse concerning the wound care observation concerns. No comments were made. On 1/28/26 at approximately 1:50 pm., a brief interview was conducted with the wound care nurse (WCN)/Assistant Director of Nursing (ADON). The WCN said that she should have washed her hands after providing incontinent care and should've had a barrier placed on the bedside table prior to providing wound care but that she became nervous and forgot.On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on staff interviews and a review of Infection Control documentation, the facility failed to maintain records of staff COVID-19 vaccinations. The findings included:On 1/28/26 at approximately 3:54 PM, the Infection Control task was completed with an interview with the Infection Preventionist (IP). The IP stated that education on COVID-19 vaccines is provided only to residents and/or their representatives. The IP also stated that there are no records of staff vaccinations because it is no longer a question asked of current or prospective hires. She stated she was recently employed by the facility and had not received the COVID-19 vaccine. The IP further stated that facility staff were not provided with education on the benefits and potential risks of the COVID-19 vaccine, nor were they offered the vaccine or information on how to obtain it. The facility's protocol, revised 7/25/23, titled Guidance and Protocol- COVID-19, stated under COVID-19 Vaccination that staff may be employed without providing evidence of COVID-19 vaccination. Vendors and contractors may provide services without evidence of COVID-19 vaccination, and the facility will offer vaccine education and vaccination to residents and staff.On 1/28/26 at approximately 5:30 PM, a final interview was conducted with the Administrator, Director of Nursing (DON), and Regional Clinical Director. An opportunity was offered to the facility's staff to present additional information. They had no comments and voiced no concerns regarding the above information.