STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495305	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marcella Post Acute	305 Marcella Road Hampton, VA 23666

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on staff interviews, clinical record reviews and facility document reviews, the facility staff failed to treat one resident with respect and dignity. Specifically, the facility failed to protect and promote the rights of one resident, Resident #181 (R181) by applying multiple briefs with incontinence care, out of a survey sample of 42 residents. The findings included:The facility staff failed to ensure one resident received individualized incontinence care by applying multiple briefs at one time for R181. On 5/18/26 at 3:45 pm, an interview was conducted with a certified nursing assistant, CNA13. She said, I didn't double brief him. CNA13 stated that when she went into the room R181 was doubled briefed and she told the daughter that she did not put two briefs on him. CNA13 stated she had never seen his daughter do incontinent care on R181 and the only supplies the daughter would ask for was a towel to wipe off his face at times. CNA13 said, when they came to me about this double brief it made me cry I don't do that but don't know how it was there I didn't put it on him. On 5/19/26 at 10 am, a telephone interview was conducted with a licensed practical nurse, LPN14. She stated that the previous shift had to do the double briefing. LPN14 stated that she hadn't seen anyone go into R181's room from second shift. She stated she was standing at the medication cart in the hallway right outside R181's room. LPN14 said, when I went in the room he was double briefed I removed the outer brief from the resident I didn't want to tamper with evidence so I left the soiled brief that was against his skin that was under the outer brief and told the aide he needed to be changed. She stated that she didn't give the daughter any incontinent supplies and when she entered the room R181's daughter was just sitting in the room. LPN14 said, the brief against his skin was soiled could see it and he had not received care from out shift. She stated that she was in orientation, so she reported it to the charge nurse that evening. LPN14 said, the daughter was really upset management was looking into the incident but never asked me any questions about it. On 5/19/26, a clinical record review was conducted. A progress note was reviewed that LPN14 had written on 2/25/26. She had wrote that the daughter was upset that R181 had two briefs on and that she had went in the room and assisted the daughter to remove the outer brief and then had the CNA to go to his room and do incontinence care. On 5/19/26, a facility document was reviewed. The facility documentation titled, Activities of Daily Living (ADL), Supporting, read in part, .Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLS). Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. On 5/19/26 at 2:42 pm, an end of day meeting was conducted with the administrator, director of nursing, vice president of operations, vice president of clinical services, and the regional director of clinical services. They were informed of the above concerns. No additional information was provided prior to exit conference.

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

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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. Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a clean, comfortable and homelike environment for 2 of 33 current sampled residents, Resident #3 and Resident #111.The findings included: 1. For Resident #3, the facility staff failed to repair the overbed light resulting in the light remaining on from 5/13/26 until 5/18/26 affecting the resident's sleep. An undated facility policy titled, Maintenance Service, specified The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. An admission Record indicated the facility admitted Resident #3 on 10/19/23. According to the admission Record, the resident had a medical history that included schizophrenia, post-traumatic stress disorder, panic disorder, and insomnia. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/22/26, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident had intact cognition. During an interview on 5/17/26 at 11:27 AM, Resident #3 stated the cord to her overbed light had broken off and the light would not turn off and had been on for a couple of days. Resident #3 stated it was hard for her to sleep with the light on at night. She stated the nurses had turned in a maintenance order. Upon observation, the overbed light was on and the cord was detached and laying on the overbed table. On 5/18/26 at 8:30 AM, the overbed light was still on and the pull cord remained on the overbed table. The facility Maintenance Director (FMD) was interviewed on 5/18/26 at 8:53 AM. The FMD stated he had a maintenance request to repair Resident #3's overbed light. The FMD provided a copy of Work Order #1301 which indicated the work order was created on 5/13/26 at 2:24 PM for a light string behind bed missing. On 5/19/26 at 5:02 PM, the facility administrative staff including the Administrator and Director of Nursing were notified of the concern regarding Resident #3's overbed light. The Regional Director of Operations stated when the FMD went to the resident's room on Friday, the light was off. The FMD was interviewed again on 5/20/26 at 9:29 AM. The FMD stated he went into Resident #3's room on Friday afternoon (5/15/26) to fix the light and then realized the entire switch was pulled out. FMD stated it was at the end of the day and due to the number of items in the room and the resident had to be out of bed, it was too late in the day, and he did not have time to fix it. Resident #3 was interviewed again on 5/20/26 at approximately 9:55 AM and stated there was no way to turn the light off after the cord broke and she had a heck of a time sleeping. No further information was presented prior to the exit conference on 5/20/26. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #111 (R111) room was unclean. Diagnoses for R111 included diabetes, respiratory failure, peripheral vascular disease, and hemiplegia. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/16/26. R111 was assessed with a cognitive score of 13 indicating cognitively intact. On 5/17/2026 at 11:24 a.m. R111 was interviewed. During the interview it was noted R111's floor had food wrappers and food crumbs under the bed and near to a trashcan under the sink, a sticky dried liquid substance was on the floor next to the bed, a white powder substance was on the floor behind the head of the bed, and R111's over-bed table had food debris and was stained with dried liquids. R111 verbalized one of the housekeepers (described as a male) does a very good job of cleaning, but other housekeepers barely mop the floor and the overbed table hasn't been cleaned in months. R111 verbalized trying to keep the overbed table wiped off but does not have any cleaning items and uses a paper towel. On 5/18/26 at 10:45 a.m. the room was observed again and noted the same concerns as the day before. R111 said that housekeeping had not touched her room and they don't clean on weekends. (5/17/2026 was a Sunday). On 5/18/2026 at 3:50 p.m. R111's room was observed and had been cleaned except for the white powder on the floor behind the head of the bed. R111 commented that the housekeeper cleaned the overbed table which never gets done. On 5/18/2026 at 5:39 p.m. the above finding was presented to the administrator, director of nursing (DON), and regional director of operations. On 5/19/2026 at 9:41 a.m. the regional director verbalized R111 doesn't want room decluttered and refuses to allow housekeeping to mess with anything in the room. R111's care plan was then reviewed and did not indicate behaviors of refusals to clean room. The regional director verbalized that there is another care plan and would get the care plan. The regional director presented a copy of the care plan (not on the active/current care plan). The care plan indicated R111 refuses care indicating R111 refused to go to a scheduled dental appointment. The care plan did not document refusals to clean room or had interventions for refusing to clean room. No other information was presented prior to exiting the facility on 5/20/26.

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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 staff interview, clinical record review, and facility document review, the facility staff failed to maintain documentation that an alleged violation of neglect was thoroughly investigated for one (1) of 42 sampled residents, Resident #63. The findings included:A facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a revision date of 04/2021, specified, Residents have the right to be free from.neglect. Under the heading, Policy Interpretation and Implementation Item #1 specified, Protect residents from.neglect.by anyone including.a. facility staff. Item #2 read, .Implement policies and protocols to prevent and identify.b. neglect of residents. Item #6 specified, Provide staff orientation and training/orientation programs that include topics such as.identification and reporting of abuse. Item #8 read, Identify and investigate all possible incidents of.neglect. Item #9 specified, Investigate and report any allegations within timeframes required by federal requirements. Item #11 specified, Establish and implement QAPI (quality assurance performance improvement) review and analysis of reports, allegations or findings of.neglect. Resident #63's diagnosis list indicated diagnoses that included, but were not limited to, adult failure to thrive, dementia severe with mood disturbance, Parkinson's disease, and major depressive disorder. The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 02/24/2026, assigned the resident a brief interview for mental status (BIMS) summary score of 5 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of Resident #63's clinical record disclosed the following: A nursing fall progress note dated 05/19/2025 at 11:05 PM, revealed a CNA notified the nurse that Resident #63 was on the floor and assistance was needed. The resident was observed on the floor lying face down. The resident was turned over and lacerations were noted to the resident's forehead, right knee and right hand. Requested a facility synopsis of events. On 05/18/2026 at 3:51 PM, the Director of Nursing (DON) stated they did not have a FRI (facility reported incident) because the resident's medical condition was the cause of the fall. On 05/20/2026 at 12:47 PM, the DON provided two facility documents titled, Fall Investigation and Incident/Accident Report and stated they could not locate the witness statement forms and were only able to locate the fall investigation and incident/accident summary for the incident. A review of these facility documents disclosed the resident fell out of bed during ADL (activities of daily living) care on 05/19/2025 and it was noted the resident was sent to the ER (emergency room at hospital) for further evaluation. Interventions that were implemented after the incident were noted as environmental changes and staff education. A review of a medical provider fall investigation summary note dated 05/20/2025 read in part, .fall from bed with injury to forehead and femur fx (fracture).staff providing care to resident and rolled [resident] to the side and positioned [resident] in the middle of the bed and while cleaning [resident] began shaking and rolled out of bed.Staff Interviews: See attached statement forms.roommate interviewed.[Resident across the hall name omitted] was interviewed.See attached statement for interview. Witness statements could not be located for further review. A review of a hospital Discharge Summary dated 05/28/2025 read in part, .was in a nursing home and had a fall from there. Seems the bed was elevated when [resident] was being changed then [resident] fell from an elevated position and hit.head where had a laceration that required suturing and suffered a right femoral neck fracture and required hemiarthroplasty (a surgical procedure that replaces only half of a hip joint with a prosthetic implant). On 05/20/2026 at 12:55 PM, Certified Nursing Assistant #10 (CNA#10) was interviewed and stated she assisted after the resident's fall. CNA#10 recalled Resident #63 was a one-person assist at the time and she recalled the bed being at approximately stomach height to a CNA when she entered the room. CNA#10 stated that she wrote a statement after the incident that night. CNA#10 did not recall Certified Nursing Assistant #11 (CNA#11) (the resident's assigned CNA during the incident) leaving the room to collect supplies. She recalled that CNA#11's statement read that CNA#11 was facing the resident's back and providing care (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the back/bottom area of the resident. Attempted to contact Certified Nursing Assistant #11 (CNA#11) who was assigned to the resident on 05/19/2025 and was caring for the resident at the time of the fall. A voicemail and call-back number were provided to CNA#11's voice messaging service. A returned call was not received. Requested and received evidence of CNA#11's education after the incident as noted in the Fall Investigation summary. The Director of Nursing (DON) provided evidence CNA#11 received education on Perineal Care on 06/04/2025. The DON stated the Licensed Practical Nurse assigned to Resident #63 at the time of the fall was no longer employed by the facility. No other facility staff who cared for Resident #63 in May 2025 continued to be employed by the facility at the time of the investigation and/or were available for interview. This concern was discussed at the pre-exit meeting on 05/20/2026 at 2:38 PM with the Regional Director of Operations (RDO), Administrator, Director of Nursing, Assistant Director of Nursing #1, Assistant Director of Nursing #2, Regional Nurse, Staff Development Coordinator, and Assistant Administrator. The RDO stated when the new company went into place, a concern had been identified for the facility not maintaining completed investigation files for incidents/facility reported incidents and a QAPI (quality assurance performance improvement) had been completed for a plan of correction and implemented to address this issue. The Plan of Correction (POC) had a completion date of 03/13/2026 and read as follows: 1.Statement Regarding Change of Ownershipa. The current ownership was not involved in the clinical operations, staffing practices, or systems in place prior to this date. (Date of Ownership Change: 09/11/2025) Therefore, while we acknowledge the survey findings related to pressure injuries/wounds occurring under prior ownership, the current entity cannot retroactively correct deficient practices that may have occurred before the acquisition date.b. Post transition the facility conducted a comprehensive operational and clinical review to assess compliance with federal participation requirements and to implement systems necessary to ensure resident safety and regulatory compliance. 2.Coorective Measures Implementeda. Staff Education i. Education topics included: 1. Definition of reportable incidents 2. Federal and State reporting timelines 3. Immediate notification requirements 4. Documentation standards 5. Investigation initiation and completion requirements 6. Protection of residents during investigations 7. Administrator/Director of Nursing reporting requirements 3. Monitoring and Quality Assurance [NAME]. Audit Processi. The Administrator or designee will audit incident reports weekly to ensure timely identification and completion of facility reported incidents.ii. The Administrator or designee will audit reportable events and investigation files weekly to ensure completion and accuracy of facility reported incidents.b. Quality Assurance Performance Improvement (QAPI) Oversight i. The results of the audits will be reviewed during monthly QAPI Committee meetings. ii. The QAPI committee will review and make recommendations to address the findings of the audits. iii. The audits will continue until the QAPI Committee has determined that there is substantial compliance at which time they may decreased the frequency of the interviews or resolve them. iv. An Ad Hoc QAPI Committee Meeting has been held to review this QAPI Plan. v. This QAPI Plan has been reviewed with the Medical Director 4. Conclusiona. Current ownership cannot retroactively correct clinical practices that occurred prior to acquisition.b. Systems necessary to ensure compliance related to facility reported incidents and management were implemented by the alleged date of compliance, and monitoring mechanisms are in place to ensure ongoing compliance and sustained performance improvement. 5. Allegation of Compliancea. The facility alleges compliance with this plan on 03/13/2026. A review of the credible evidence for the POC on 05/20/2026 disclosed education had been completed addressing reportable events, internal investigations, maintenance of investigation files, and utilization of a Red Folder Reportable Investigation Content Checklist. Further review of the credible evidence disclosed weekly audits were performed from 03/11/2026 through 04/15/2026 for facility incidents/investigations and that proper protocol/procedures were implemented for maintenance of documentation files. On 05/20/2026 at 5:59 PM the Regional Director of Operations (RDO), Administrator (ADM), Regional Nurse (RN), and Director of Nursing (DON) were interviewed. The ADM stated that the Abuse Coordinators for the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility are the Administrator, Director of Nursing, and Regional Nurse. The ADM stated there is a two-hour window when incidents occur and staff contact the ADM, initiate a FRI (facility reported incident) and contact law enforcement if warranted. The ADM stated the DON and RDO are called at the time of the investigation. The DON stated they look at the staff schedule and depending on the allegations, statements are obtained if necessary and residents, resident roommate(s), and family/visitors are interviewed if the need is indicated. The DON stated they will also check things in the system and facility cameras if needed. The ADM and DON both concurred before a five-day follow-up is completed, they call the team to discuss the incident and they have a check list, Red Folder they utilize. They check the employee files, inform regional support, and the file is sent to the regional team. Education will typically follow and they utilize a risk tracker system on the computer and maintain a hard copy of the incident file. The ADM and DON both agreed they attended a master training class when the facility changed ownership, which was a two-day training event. During this training, education and process expectations were reviewed and received for implementation of the incident/investigation processes, Red Folder Reportable Investigation Content Checklist, and maintenance of completed investigations/files. No further information was provided prior to exit on 05/20/26. This deficiency was cited as past non-compliance.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on staff interview and clinical record review, the facility staff failed to provide written notification regarding the reason(s) for transfer and/or discharge to the resident and/or the resident's representative(s) and failed to offer a bed hold for 1 of 42 residents, Resident #175.The findings include: Resident #175 was transferred to a higher level of care on 06/24/2024. The facility staff were unable to provide documentation showing written notification of the reason(s) for transfer and/or discharge was provided to the resident and/or resident representative. In addition, the facility staff could not provide evidence that a bed hold was offered. This was a closed record review.Resident #175's diagnoses included pneumonitis, atrial fibrillation, acute kidney failure, alcohol dependence, clostridium difficile, gastro-esophageal reflux disease, benign prostatic hyperplasia, hypotension, gout, diabetes, and protein-calorie malnutrition. Section C (cognitive patterns) of Resident #175's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/13/2024 included a Brief Interview for Mental Status (BIMS) score of 3, indicating severe impairment in cognitive skills for daily decision making.The clinical record included a progress note dated 06/24/2024 stating Resident #175 had been transferred to a local hospital.During the record review, the surveyor was unable to locate documentation showing written notification of the reason(s) for transfer or discharge was provided to the resident and/or resident representative, or documentation indicating a bed hold had been offered.On 05/20/2026 at 9:50 AM, during an interview, the Regional Nurse stated they did not have any paperwork for this individuals discharge.During a meeting on 05/20/2026 at 2:38 PM that included the Administrator, Director of Nursing, Regional [NAME] President of Operations, Assistant Director of Nursing, Regional Nurse, and Staff Development Coordinator the above findings were reviewed.No additional information regarding this issue was provided to the survey team prior to the exit conference.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide activities of daily living care for 3 of 42 residents, Residents #55, #149 and #36. The findings include:1. For Resident #55, the facility staff failed to provide nail care. Resident #55 was observed to have fingernails that were excessively long and jagged. Resident #55's diagnoses included hemiplegia and hemiparesis following cerebral infarction, dysphagia, and diabetes. Section C (cognitive patterns) of Resident #55's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 02/16/2026 included a Brief Interview for Mental Status (BIMS) score of 3, indicating Resident #55 was severely impaired in cognitive skills for daily decision making. Section GG (functional status) was coded to indicate the resident was dependent on staff for personal hygiene. Section I (active diagnoses) documented a contracture of the left hand. Resident #55's comprehensive care plan identified a self-care performance deficit related to activities of daily living. On 05/18/2026 at 9:05 AM, the surveyor, Staff Development Coordinator (SDC), and Certified Nursing Assistant (CNA) #1 observed Resident #55's fingernails on both hands to be long and jagged. The SDC confirmed the resident's fingernails needed trimming. During an end of the day meeting on 05/18/2026 at 5:35 PM with the Administrator, Director of Nursing, Regional Director of Operations, Staff Development, Infection Preventionist, Assistant Director of Nursing, Assistant Administrator, and Regional Nurse the concern regarding Resident #55's nail care was reviewed. On 05/18/2026 at 6:56 PM, the SDC documented that the resident's nails had been trimmed and cleaned. Facility policy titled Activities of Daily Living (ADL), Supporting read in part, .Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene . No additional information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #149, the facility staff failed to provide nail care. Resident #149 was observed to have fingernails that were long and jagged. Resident #149's diagnoses included end stage renal disease, diabetes, and depressive disorder. Section C (cognitive patterns) of Resident #149's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 02/25/2026 included a Brief Interview for Mental Status (BIMS) score of 8, indicating the resident was moderately impaired in cognitive skills for daily decision making. Section GG (functional abilities) indicated the resident required supervision or touching assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #149's comprehensive care plan identified the area activities of daily living self-care performance deficit. On 05/17/2026, Resident #149's fingernails were observed to be long, jagged, and contain visible debris. The resident stated he did not have nail clippers available. On 05/18/2026 at 10:06 AM, Resident #149 was observed seated in his wheelchair with fingernails that remained long and jagged. On 05/19/2026 at 9:25 AM, Resident #149 stated facility staff had cut his nails and that he had also received a shave. During an end of the day meeting on 05/18/2026 at 5:35 PM with the Administrator, Director of Nursing, Regional Director of Operations, Staff Development, Infection Preventionist, Assistant Director of Nursing, Assistant Administrator, and Regional Nurse the issue regarding Resident #149's nail care was reviewed. Facility policy titled Activities of Daily Living (ADL), Supporting read in part, .Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene . No additional information regarding this issue was provided to the survey team prior to the exit conference. 3. The facility staff failed to provide scheduled showers and shaving services for Resident#36 (R36). On 5/17 at 11:45 am, an observation was made of R36 while he was in his room. He was observed with hair that appeared to be oily looking, white flake like material was in his hair, and R36 said, I have been itching all over. R36 had not been shaved, and nails were long and dirty. It appeared that he was not showered recently. 5/17/26 at 11:30 am, an interview was conducted with R36. R36 said, I hadn't got a shower in a long time and that the aide [CNA12] would not give him a shower and stated he didn't have anything to do with the shower. On 5/18/26 at 3:00 pm, an observation was made of R36 while he was in his room. He was observed with hair that appeared to be oily looking, white flake like material was in his hair, had not been shaved, and nails were long and dirty. It appeared that he was not showered recently. On 5/18/26 at 4:11 pm, an interview was conducted with a certified nursing assistant, CNA12. During the interview, CNA12 said, that night I said I did not have anything to do with showers because the dinners came out too late and I didn't have time to give a shower. He stated that he does not work that side of the unit often. CNA12 said, I told him I was [NAME] it was a joke. CNA12 stated that it was after 9:00 pm, when dinner trays were served and he was to get off at 10:30 pm and said, I did not have time to give a shower. On 5/18/26, a clinical record review was conducted. During the review, R36's activities of daily living (ADL) was reviewed and for two weeks it was documented that no shower was given to R36. R36's quarterly Minimum Data Set (MDS) was reviewed. The MDS was dated 3/26/26 and R36 was coded in (continued on next page)

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Marcella Post Acute	305 Marcella Road Hampton, VA 23666

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section GG of the MDS assessment that he was dependent with showers and personal hygiene. On 5/18/26, a review of a facility document was conducted. The facility policy titled, Activities of Daily Living (ADL), Supporting, read in part, .Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLS). Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. On 5/18/26 at 5:35 pm, an end of the day meeting was conducted with the Administrator, Director of Nursing, Regional Director of Operations, Staff Development, Infection Preventionist, Assistant Director of Nursing, Assistant Administrator, and Regional Nurse and the above concerns about R36's showers and personal hygiene was discussed. On 5/19/26, a review of his clinical record was conducted. R36 had received a shower, shaved and nail care was performed the evening of 5/18/26. On 5/19/26, an observation of R36 was conducted. He was clean shaven, nails clean, and hair was clean no oily appearance, and it appeared that he was showered and provided personal hygiene. No additional information was provided prior to exit conference.

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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. Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure the highest practicable well-being for 8 or 42 residents, Residents #29, #55, #165, #175, #15, #3, #4, and #72. The findings include: 1. For Resident #29, the facility staff failed to administer provider ordered medications. These medications were available at the facility in the over the counter (OTC) mediation supply or available in the Med Bank (back up supply) for administration. Resident #29's diagnoses included quadriplegia, anxiety disorder, paralytic ileus, neuromuscular dysfunction of bladder, and cervical disc disorder. Section C (cognitive patterns) of Resident #29's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 02/17/2026 included a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The Resident's comprehensive care plan included an intervention to administer medications as ordered. Review of the clinical record revealed that the nursing staff documented the code 22 on the Medication Administration Records (MARs) indicating Drug/Treatment Not Administered, for the following medications: 03/18/2026, Melatonin. Mag Oxide, Vitamin B12, and Thera-M multivitamin. 03/19/2026, Melatonin, Mag Oxide, Vitamin B 12, Thera-M multivitamin, and Lorazepam. 03/21/2026, Melatonin and Lorazepam. 03/22/2026, Melatonin and Lorazepam. 03/24/2026, Simethicone. On 03/20/2026, Lorazepam was marked on the MAR as administered; however, corresponding nursing progress notes documented the medication was on order. On 04/19/26, Simethicone was documented on the MAR as administered, while nursing notes indicated the medication was .waiting on arrival. Additional nursing documentation revealed the following: On 03/19/2026 the nursing staff documented Vitamin B12 was not available, physician aware. On 03/22/2026 the nursing staff documented Melatonin was not available. On 03/24/2026 the nursing staff documented Simethicone was not available. Review of the facility's OTC medication list and Med Bank inventory provided to the survey team confirmed the above medications were available in the OTC supply of Med Bank backup supply. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/20/2026 at 2:38 PM during a meeting that included the Administrator, Director of Nursing, Regional [NAME] President of Operations, Assistant Director of Nursing, Staff Development Coordinator, and Regional Nurse, the issue regarding Resident #29's medications not being administered while being available in the OTC supply or Med Bank was reviewed. The facility policy titled Administering Medications stated, in part, .Medications are administered in accordance with prescriber orders. No additional information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #55, the facility staff failed to administer provider ordered medications. These medications were available at the facility in the over the counter (OTC) mediation supply or available in the Med Bank (back up supply) for administration. Resident #55's diagnoses included, dysphagia, diabetes, depression, and vascular dementia. Section C (cognitive patterns) of Resident #55's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 02/16/2026 included a Brief Interview for Mental Status (BIMS) score of 3, indicating severe impairment in cognitive skills for daily decision making. The Resident's comprehensive care plan included an intervention to administer medications as ordered. A review of the clinical record revealed that the nursing staff documented the code 22 on the Medication Administration Records (MARs) indicating Drug/Treatment Not Administered, for the following medications: O3/18/2026, Cholecalciferol and Levothyroxine, 03/19/2026, Cholecalciferol. 03/22/2026, Carvedilol. 03/28/2026, Levothyroxine, Carvedilol, and Sertraline. 03/29/2026, Carvedilol. The MARs had been coded with an 11 for Vitals Outside of Parameters for the following medications: 03/22/2026, Sertraline and Levothyroxine. There was no provider ordered parameters for either of these medications. Corresponding nursing documentation revealed the following: 03/18/2026, Cholecalciferol and Levothyroxine, medication(s) unavailable. 03/19/2026, Cholecalciferol, not available, physician aware. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/22/2026, Carvedilol, Sertraline, and Levothyroxine, medication(s) not available, reordered from pharmacy. 03/28/2026, Levothyroxine, Sertraline, and Carvedilol medication not on cart. During an end of the day meeting on 05/18/2026 at 5:35 PM, that included the Administrator, Director of Nursing, Regional [NAME] President of Operations, Nurse Consultant, and Assistant Director of Nursing the issue with Resident #55's provider ordered medications not being administered was reviewed. The facility policy titled Administering Medications stated, in part, .Medications are administered in accordance with prescriber orders. No additional information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #165, the facility staff failed to administer provider ordered medications. These medications were available at the facility in the over the counter (OTC) medication supply or available in the Med Bank (back up supply) for administration. Resident #165's diagnoses convulsions, diabetes, and spondylolisthesis. Section C (cognitive patterns) of Resident #165's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/03/2026 included a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The Resident's comprehensive care plan included an intervention to administer medications as ordered. Review of the clinical record revealed that the nursing staff documented the code 22 on the Medication Administration Records (MARs) indicating Drug/Treatment Not Administered, for the following medications: 03/18/2026, Calcium with Vitamin D and Mag Oxide. 03/19/2026, Calcium with Vitamin D and Mag Oxide. 03/20/2026, Calcium with Vitamin D. 03/21/2026, Calcium with Vitamin D, Thera-M Multivitamin, and Oxycontin extended release. 03/22/2026, Calcium with Vitamin D and Oxycontin extended release. 03/23/2026, Calcium with Vitamin D. 03/26/2026, Calcium with Vitamin D. 03/30/2026, Calcium with Vitamin D. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Corresponding nursing documentation revealed the following: 03/18/2026, Mag Oxide waiting on delivery, Nurse Practitioner aware. 03/19/2026, Mag Oxide awaiting delivery. 03/20/2026, Calcium with Vitamin D not available. 03/21/2026, Calcium with Vitamin D waiting on arrival from pharmacy. 03/22/2026, Calcium with Vitamin D medication unavailable at this time. 03/22/2026, Calcium with Vitamin D medication unavailable at this time. For the medication Famotidine the MARs had been coded with a 2 for Drug/Treatment Refused on 03/18/2026 at 4:00 PM. On 03/18/2026 at 4:56 PM the nursing staff documented Famotidine.waiting on delivery, np [Nurse Practitioner] aware. During an end of the day meeting on 05/18/2026 at 5:35 PM, that included the Administrator, Director of Nursing, Regional [NAME] President of Operations, Nurse Consultant, and Assistant Director of Nursing the issue with Resident #165's provider ordered medications not being administered was reviewed. The facility policy titled Administering Medications stated, in part, .Medications are administered in accordance with prescriber orders. No additional information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #175, the facility staff failed to complete physician ordered blood sugar (BS) monitoring and failed to obtain weekly weights as ordered. This was a closed record review. Resident #175's diagnoses included Clostridium difficile, diabetes, and protein-calorie malnutrition. Section C (cognitive patterns) of Resident #175's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/13/2024 included a Brief Interview for Mental Status (BIMS) score of 3, indicating severe impairment in cognitive skills for daily decision making. The comprehensive care plan identified the areas of potential for weight change and diabetes. The clinical record included the following provider orders: 06/07/2024: Sliding scale Lispro insulin four times daily. 06/08/2024: Weigh resident on admission and weekly for four weeks. 06/08/2024: Glucometer checks four times daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Medication Administration Records (MARs) and Treatment Administration Records (TARs) revealed nursing staff had placed a = in the administration blocks for the weights on 06/11/2024 and 06/18/2024. In addition, for insulin administration and BS monitoring, nursing staff documented a = in the administration blocks on 06/10/2024 at 4:30 PM. The clinical record did not contain supporting documentation that would have corresponded with the code of = or to indicate why the weights and/or BS were not completed. On 05/20/2026 at 8:20 AM, the surveyor requested additional information from the Regional Nurse regarding the missing weights and BS checks. At 9:50 AM, the Regional Nurse stated the weights had not been obtained and they did not know why the BS was not obtained on 06/10/2024. On 05/20/2026 at 2:38 PM during a meeting attended by the Administrator, Director of Nursing, Regional [NAME] President of Operations, Assistant Director of Nursing, Staff Development Coordinator, and Regional Nurse, the issue regarding Resident #175's missing weights and BS monitoring was reviewed. No additional information regarding this issue was provided to the survey team prior to the exit conference. 5. For Resident #15, the facility staff failed to apply a Lidocaine pain patch as ordered by the medical provider on two separate occasions. A Lidocaine patch is a medicated topical patch used to treat pain and discomfort by numbing the area. A facility policy titled, Unavailable Medication, dated June 2021, specified In the event that a medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed, nursing staff shall a. Contact the pharmacy regarding the unavailable medication. B. Attempt to obtain the medication from the facility's automated medication dispensing system or emergency kit. An admission Record indicated the facility admitted Resident #15 on 2/03/22. According to the admission Record the resident had a medical history that included Alzheimer's Disease, adult failure to thrive, and unspecified pain. A significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/09/26, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 indicating the resident was severely cognitively impaired. Resident #15's comprehensive person-centered care plan included a focus dated 2/13/26, that indicated the resident had potential for pain related to contractures and being bedbound. Interventions directed staff to administer analgesia as per orders. Resident #15's medical provider orders included an order dated 12/10/25 for a Lidocaine 4% patch to the right knee topically every 24 hours for pain. A review of Resident #15's April 2026 Medication Administration Record (MAR) revealed a Lidocaine 4% patch was not applied to the resident's right knee on 4/24/26 and 4/25/26. A nursing progress note dated 4/24/26 at 2:18 PM indicated that the Lidocaine 4% patch was not applied because facility ran out. A 4/25/26 10:10 AM nursing progress note indicated the Lidocaine 4% patch was not available. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing (DON) was interviewed on 5/19/26 at 9:35 AM. The DON stated the Lidocaine patch was absolutely available and the nurse knew that. The DON stated Lidocaine patches are part of the house stock medications. The DON provided the facility over the counter (OTC) house stock medication inventory list which included Lidocaine 4% Pain Patches. On 5/19/26 at 5:02 PM, the facility administrative team including the Administrator and DON were informed of the concern regarding staff failing to apply Resident #15's Lidocaine 4% patch as ordered on 4/24/25 and 4/25/26. No further information was provided prior to the exit conference on 5/20/26. 6. For Resident #3, the facility staff failed to follow up on a medical provider order for Keflex 500mg in a timely manner. The order was received during an emergency room visit on 5/14/26 and was not addressed until 5/17/26. The facility staff also failed to administer medications as ordered by the medical provider on multiple occasions during the months of March 2026 and April 2026. An admission Record indicated the facility admitted Resident #3 on 10/19/23. According to the admission Record, the resident had a medical history that included chronic obstructive pulmonary disease (COPD), insomnia, vitamin D deficiency, hypomagnesemia, chronic kidney disease, atherosclerotic heart disease, and type 2 diabetes mellitus. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/22/26, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident had intact cognition. During an interview on 5/17/26 at 11:34 AM, Resident #3 stated she went to the emergency room last week after a fall and found out she had a UTI (urinary tract infection). The resident stated she has not received an antibiotic since the ER visit. An Encounter Summary for 5/14/26 indicated Resident #3 was seen at a local emergency department following a fall and complained of dysuria without fever, hematuria and urgency. Resident #3 was diagnosed with acute cystitis with hematuria and given Keflex 500 mg in the ED and prescribed Keflex 500 mg by mouth every 6 hours for 7 days. A nursing progress note dated 5/14/26 at 8:19 AM specified Resident returned from the ED [emergency department] at 0600 [6:00 AM]. Resident returned with new orders for a dx [diagnosis] UTI. Licensed Practical Nurse (LPN) #7, the writer of the 5/14/26 progress note was interviewed on 5/20/26 at approximately 1:00 PM. LPN #7 stated she called and left a message for the on-call PACE provider around 7:45 AM on 5/14/26 but failed to document in the clinical record. LPN #7 stated she passed the information along in report to the next shift. According to Resident #3's clinical record, the order for Keflex was not followed up on again until 5/17/26. A 5/17/26 1:11 PM nursing progress note indicated PACE on call was contacted regarding order for Keflex 500 mg for UTI. On call stated they would call the provider about the order and have them review it. A nursing progress note dated 5/18/26 at 11:37 AM indicated a follow-up call was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	placed to PACE and an order for Keflex 500 mg three times a day for 10 days was received. Resident #3 received the first administration of Keflex following the 5/14/26 ER visit on 5/18/26 at 1:50 PM. Resident #3's comprehensive person-centered care plan included a focus area dated 5/14/26 indicating the resident was on pain medication therapy. Interventions directed staff to administer medications as ordered. Resident #3's medical provider orders included an order dated 6/09/25 for Gabapentin 100 mg by mouth three times a day related to pain. A review of Resident #3's March 2026 and April 2026 Medication Administration Records (MARs) revealed Gabapentin was not administered on 3/22/26 12:00 PM, 3/22/26 9:00 PM, 3/23/26 12:00 PM, 4/09/26 12:00 PM, 4/10/26 12:00 PM, and 4/11/26 6:00 AM. Corresponding nursing progress notes on 3/22/26, 3/23/26, 4/10/26, and 4/11/26 indicated the staff needed a new script and/or were awaiting the arrival of the medication from the pharmacy. Resident #3's medical provider orders included an order starting 12/03/25 and discontinued on 5/08/26 for Melatonin 10 mg by mouth at bedtime related to insomnia. A review of Resident #3's March 2026 MAR revealed Melatonin was not administered 3/18/26 and 3/22/26. Corresponding nursing progress notes indicated Melatonin was not available for administration. Resident #3's medical provider orders included an order with a start date of 12/03/25 for Montelukast 10 mg by mouth one time a day for COPD and allergic rhinitis. A review of the April 2026 MAR revealed Montelukast was not administered on 4/13/26. A corresponding nursing progress note indicated Montelukast was not administered because staff were awaiting the arrival of the medication from the pharmacy. Resident #3's medical provider orders included orders starting on 12/03/25 for Mag Oxide 400 mg by mouth one time a day related to hypomagnesemia, Vitamin D3 1,000 units by mouth one time a day related to vitamin D deficiency, and Nitrofurantoin 100 mg by mouth one time a day for UTI prophylaxis. A review of the March 2026 MAR revealed Mag Oxide, Vitamin D3, and Nitrofurantoin were not administered on 3/18/26. Corresponding nursing progress notes indicated staff were waiting on delivery from the pharmacy. A review of the in-house facility medication supply (Med Bank) inventory list indicated Gabapentin 100 mg, Montelukast 10mg, and Nitrofurantoin 100 mg were available in the facility for administration. The facility in-house Over the Counter (OTC) house stock supply inventory list indicated Melatonin 10 mg, Mag Oxide 400 mg, and Vitamin D3 1,000 were present in the facility for resident administration. A facility policy titled, Unavailable Medication, dated June 2021, specified In the event that a medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed, nursing staff shall a. Contact the pharmacy regarding the unavailable medication. B. Attempt to obtain the medication from the facility's automated medication dispensing system or emergency kit. On 5/19/26 at 5:02 PM the facility administrative staff including the Administrator and Director of Nursing, were informed of the concerns regarding the delay in addressing Resident #3's Keflex order and multiple medications that were available but not administered. (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 regarding these concerns was provided prior to the exit conference on 5/20/26. 7. For Resident #4 (R4), the facility staff failed to follow the medical providers order for the administration of the oral medication Metoprolol Tartrate, used to treat elevated blood pressure (BP). An admission Record indicated the facility admitted R4 on 10/02/25. According to the admission Record, the resident had a medical history that included heart failure unspecified, chronic atrial fibrillation and atherosclerotic heart disease. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/9/2026, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident had intact cognition. R4's current medical provider orders included an order dated 4/29/2026 for Metoprolol Tartrate tablet 100mg (milligrams), give 1 tablet by mouth two times a day for elevated blood pressure, hold for systolic blood pressure (SBP) <110 (less than 110); pulse<60 (less than 60). A review of R4's May 2026 Medication Administration Record (MAR) revealed Metoprolol Tartrate was administered on three separate occasions when R4's systolic blood pressure was less than 110. Metoprolol Tartrate was administered on 5/04/26 evening shift with a BP of 109/73, 5/06/26 evening shift with a BP of 106/84, and 5/14/26 with a BP of 102/68. A facility policy titled, Administering Medications, with a revision date of April 2019, specified 12. When indicated, validate physician ordered parameters prior to medication administration. On 5/20/26 at 2:38 PM during a meeting with the facility administrative staff including the Administrator and Director of Nursing, the facility was informed of staff failing to follow the medical provider orders for the administration of Metoprolol Tartrate. No further information was presented prior to the exit conference on 5/20/26. 8. For Resident #72, the facility staff failed to administer the medication Hydralazine PRN (as needed) for blood pressure (BP) greater than 160 as ordered by a medical provider. Resident #72's diagnoses list included a diagnosis of essential (primary) hypertension. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 04/09/2026 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A medical provider orders dated 12/02/2025 indicated Resident #72 was prescribed Hydralazine 10 mg (ten milligrams) 1 (one) tablet by mouth every 6 (six) hours as needed for elevated BP SBO (Systolic Blood Pressure) (the top number in a blood pressure reading that measures the pressure in your arteries when your heart beats) >160 (greater than one-hundred sixty). A review of the April 2026 MAR (medication administration record) disclosed Resident #72's BP readings were noted as follows on the following dates: 04/20/2026-172/79 - Hydralazine was not administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/21/2026-161/72 - Hydralazine was not administered. 04/22/2026-161/72 - Hydralazine was not administered. 04/27/2026-161/72 - Hydralazine was not administered. 04/28/2026-168/59 - Hydralazine was not administered. A review of the May 2026 MAR disclosed Resident #72's BP readings were noted as follows on the following dates: 05/04/2026-168/71 - Hydralazine was not administered. 05/10/2026-165/82 - Hydralazine was not administered. 05/11/2026-165/82 - Hydralazine was not administered. On 05/19/2026 at 10:48 AM, the Director of Nursing was interviewed and stated the expectation is for the provider orders to be followed for medication administration. This concern was discussed at the end-of-day meeting on 05/19/2026 at 5:02 PM with the Administrator, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing #1, Assistant Director of Nursing #2, Regional Nurse, [NAME] President of Clinical Services, and Assistant Administrator. A facility policy titled, Administering Medications with a revision date of 04/2019 specified, Medications are administered.as prescribed. Under the heading Policy Interpretation and Implementation item #4 read in part, Medications are administered in accordance with prescriber orders. Item #11 read in part, The following information is checked/verified for each resident prior to administering medications.b. Vital signs, if necessary. No further information was provided prior to exit on 05/20/2026.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure effective pain management was provided for one resident, Resident #28 (R28), out of a survey sample of 42 residents. Specifically, the facility failed to administer the resident's prescribed pain medication as ordered. As a result, R28 experienced withdrawal symptoms, causing actual harm and discomfort. The findings included:On 5/17/26 at 10:30 am, an interview was conducted with R28. During the interview R28 stated, my morphine was not available to be given so oxycodone was ordered one time in the morphine place but that didn't help my pain like the morphine did and I had withdrawal symptoms because I went without the morphine. R28 stated that his morphine order had to be changed because morphine extended release 15mg tablets were not available and were on back order with the pharmacy. On 5/19/26 a clinical record review was conducted. R28's care plan was reviewed and read in part, .Administer analgesia as per orders. Observe for effectiveness and s/sx [signs and symptoms] of side effects. Report abnormal findings to practitioner. Document findings and interventions. Date Initiated: 01/16/2026. R28's progress notes were reviewed. On 1/20/26 a progress note was written and read in part, MORPHINE SUL TAB 15MG ER [extended release] Give 1 tablet by mouth two times a day related to PAIN, UNSPECIFIED.Resident given 10mg of oxycodone PRN [as needed]. A progress note that was written by the NP and was dated 2/26/26 read in part, .Previously, the patient [R28] experienced an acute opioid withdrawal episode on 01/20/2026 when his MS Contin 15 mg twice daily supply was interrupted and he went without medication for 44 hours, presenting with diaphoresis and withdrawal symptoms. He was bridged with oxycodone until his MS Contin refill arrived from the pharmacy. At pain management follow-up on 01/22/2026, all withdrawal symptoms had resolved, and his pain was well-controlled on MS Contin 15 mg twice daily and Lyrica 25 mg at night along with over-the-counter alpha lipoic acid supplement for radicular pain. R28's medication administration records were reviewed for January 2026. R28 was not administered his pain medication, MS Contin 15 mg on January 19th or 20th. R28 missed four doses and was without his MS Contin for 48 hours. R28 received a dose on January 18th at bedtime and received the next dose on January 21st at 8:00 am. While R28 was without his pain medication, MS Contin 15 mg twice daily the NP gave a onetime order dated 1/20/26 at 1:01 pm, which read in part, .oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug* Give 2 tablet by mouth one time a day for Pain One time dose. On 5/17/26 at 10:45 am, an interview was conducted with the Director of Nursing (DON). The DON stated R28's morphine extended release was on back order so a different morphine was ordered, The DON said, there was a gap when we couldn't get the morphine and was working to get another pain med [medication]. On 5/19/26 at 11:00 am, an interview was conducted with the nurse practitioner (NP). The NP said, I expect them to get pain medication from stat box and if not available to let me know we will get something if they are in pain right now my goal is to get the medicine right now. The NP stated that the new pharmacy was more difficult; however, the NP stated, the facility does have a big enough stat box and if the stat box does not have enough, I will order something else until their medications arrive. The NP stated that R28 is followed by pain management. The NP said, I don't expect anyone on schedule pain management to go without medications. The nurses brought it to my attention and R28 just kept saying he didn't want to go into withdrawal; however, the NP said, I don't know if he actually had symptoms. The NP stated that the staff needs to make sure his medications were available because he likes to have his medications. The NP said, I was told that the pharmacy delivery was a two-day turnaround, but you may want to check with the staff about that. On 5/19/26, a facility document review was conducted. The facility document titled, Pain Assessment and Management, read in part, The purposes of this procedure are to help the staff identify pain in the resident, develop interventions consistent with the resident's goals and needs, and address the underlying causes of pain. Evaluate for possible physiological signs of pain, including a. increased blood pressure; b. (continued on next page)

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	495305	A. Building B. Wing	05/20/2026

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Marcella Post Acute	305 Marcella Road Hampton, VA 23666

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F 0697 Level of Harm - Actual harm Residents Affected - Few	tachycardia; c. increased respirations; d. diaphoresis; e. anorexia; or f. somnolence. Establish a treatment regimen that is specific to the resident based on consideration of the following: a. The resident's medical condition; b. Current medication regimen; c. History of addiction or opioid use disorder; d. Nature, severity, and cause of the pain; e. Course of the illness; and f. Treatment goals. The facility documentation titled, Pain - Clinical Protocol, read in part, .The provider and staff will identify individuals who have pain or who are at risk for having pain. This includes reviewing known diagnoses and conditions that commonly cause pain, for example, degenerative joint disease, rheumatoid arthritis, osteoporosis (with or without vertebral compression fractures), diabetic neuropathy, oral or dental pathology, and post-stroke syndromes. b. It also includes a review for any treatments the resident currently is receiving for pain, including complementary and non-pharmacologic treatments. 3. Staff will provide a comfortable environment and appropriate physical and complementary interventions, example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain. 4. If the some provider determines opioid medication is an appropriate option for managing acute, sub-acute, or cases chronic pain in the resident, the lowest possible effective dose is prescribed for the shortest time possible with ongoing staff monitoring for effectiveness and adverse effects. 5. Combining opioids and benzodiazepines is avoided. If prescribed concomitantly, the resident will be carefully monitored for respiratory depression, risk of falling, cognitive impairment/confusion, daytime fatigue, and delirium. On 5/19/26 at 2:42 pm, a meeting was held with administrator, director of nursing, vice president of operations, vice president of clinical services, and the regional director of clinical services. They were informed of the above concerns. They were made aware of the pain medication that was not administered due to unavailability, pharmacy could not fill the medications, the morphine order had to be changed, R28 went 2 days without the pain medication and had withdrawal symptoms. No additional information was provided prior to the exit conference.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to maintain adequate staffing levels to consistently meet resident needs. The findings include: The facility staff failed to ensure consistent adequate staffing levels to meet individual resident needs. Review of payroll-based journal (PBJ) staffing data for quarter one 2026 (October 1-December 1, 2025) revealed the facility triggered for one star staffing and excessively low weekend staffing. This data is collected and reported to The Centers for Medicare & Medicaid Services (CMS) by the facility staff on a quarterly basis. During the survey process, interviews were conducted with cognitively intact residents and resident representatives. Concerns were expressed regarding facility staffing and delayed response times when answering call lights. Resident council minutes for 03/2026-05/2026 documented concerns related to staff using personal phones while providing care, staff speaking in an unprofessional manner, daily care interactions with aides, and one resident reportedly being asked to make their own bed. On 05/18/2026 at 10:00 AM, during an interview, Certified Nursing Assistant (CNA) #4 stated they were expected to pass ice/water twice a shift; however, there were occasions when this task could not be completed due to not having enough help. A resident group meeting was conducted on 05/18/2026 at 2:09 PM. Residents reported that when the facility changed ownership several staff left, those that remained were burned out, some don't care, and evening shift was the worst. The group shared concerns about having a difficult time having their briefs changed at night. The CNA's say give me a minute and do not return. If you are a transfer and require use of the Hoyer lift you have to be the last one to be put to bed. Residents also stated that they hardly ever receive ice water, often requiring resident to request it or obtain it independently. On 05/18/2026 at 4:11 PM, during an interview with CNA #12 regarding showers, CNA #12 stated there was one incident where dinner trays did not come out until 9:00 PM and they did not have time to give showers as their shift ended at 10:30 PM. Resident #107 had reported that on a night shift in May 2026 there was a delay in receiving their pain medication, and their call light was not answered in a timely manner. During an interview with the Director of Nursing (DON) on 05/19/2026 at 9:15 AM the DON stated they had a nurse to call out that would have been assigned to this hallway on night shift, they usually have two nurses on this hallway. There was a three-hour window between 2:00 AM and 5:00 AM where there was only one nurse, it was during this timeframe that the call light to Resident #107's room went off several times requesting pain medication. The DON stated it had been reported that no one would come to the room or answer the call light. The staff were re-educated on call light responseOn 05/19/2026 at 3:09 PM, during an interview, CNA #8 stated sometimes it was hectic, meals were delayed, so you don't know when or when not to do a shower, a couple months ago the residents were getting dinner around 7:00 or 7:30 PM. CNA #8 stated a couple of residents may not have been changed, last round not being completed due to meals being late, we have to feed people, document etc . CNA #8 reported this occurred in the fall around October and November during the transition from one company to another and stated, I guess it was hectic for them. On 05/19/2026 at 5:00 PM, during an end of the day meeting with the administrative staff the concerns regarding inconsistent access to water and ice were discussed. The Director of Nursing (DON) stated water, and ice are passed every shift. Throughout the survey, no staff member was observed to pass ice/water to the residents of the facility. Each unit did include a functioning water bottle filling station available for resident/staff use. On 05/20/2026 at 9:40 AM, during an interview regarding staffing concerns, the DON stated they had a weekly call with Human Resources to discuss strategies, advertisements, employee surveys, and use social media platforms such as LinkedIn and Indeed. The DON also stated referral bonus had increased, shift incentives were offered, they did not utilize agency staff as it appeared to affect the regular staff. On 05/19/2026 at 5:40 PM and again on 05/20/2026 at 2:38 PM, meetings were conducted that included the Administrator, DON, Regional (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[NAME] President of Operations, Assistant Director of Nursing, Assistant Administrator, Regional Nurse, and Staff Development Coordinator the issue with staffing was reviewed. Review of the facility assessment Appendix B staffing guidelines indicated staffing levels were adjusted based on multiple factors, including shifts in resident census, acuity, outbreaks, and admission or discharge volume. At the time of entrance, the census was 165. Staffing levels on 05/17/2026 (entrance) were noted to be within the facility's stated guidelines. No additional information regarding staffing concerns was provided by the facility staff prior to the exit conference.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure provider ordered medications were available for administration for 5 of 42 residents, Residents #29, #50, #55, #165, and #3. 1. For Resident #29, the facility staff failed to ensure the provider ordered medications Peridex, Saccharomyces, and Benefiber were available for administration. Resident #29's diagnoses included quadriplegia, anxiety disorder, paralytic ileus, neuromuscular dysfunction of bladder, and cervical disc disorder. Section C (cognitive patterns) of Resident #29's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 02/17/2026 included a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The Resident's comprehensive care plan included an intervention to administer medications as ordered. Clinical record review revealed facility nursing staff documented code 22 on the Medication Administration Records (MARs) indicating Drug/Treatment Not Administered, for the following medications: Peridex Mouth/Throat Solution, 03/11/2026, 03/28/2026, and 03/29/2026. Saccharomyces probiotic, 03/18/2026. Benefiber, 04/15/2026, 04/20/2026, 04/30/2026, and 05/05/2026. Review of the over-the-counter medication list and Med Bank list revealed these medications were not listed as being available for administration. Additional nursing documentation revealed the following: 03/18/2026: Peridex medication not on cart, reordered. 03/29/2026: Peridex reorder pending. 04/15/2026: Benefiber waiting on delivery. On 05/20/2026 at 2:38 PM during a meeting that included the Administrator, Director of Nursing, Regional [NAME] President of Operations, Assistant Director of Nursing, Staff Development Coordinator, and Regional Nurse, the concern regarding Resident #29's medications not being administered due to unavailability was reviewed. The facility policy titled Administering Medications stated, in part, .Medications are administered in accordance with prescriber orders. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy titled, Unavailable Medication stated in part, In conjunction with the contracted pharmacy, the facility will make every effort to ensure that a medication ordered for the resident is available to meet their needs. No additional information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #50, the facility nursing staff failed to ensure the provider ordered medication Alfuzosin extended-release tablet was available for administration. Resident #50's diagnoses included Parkinson's disease and benign prostatic hyperplasia. Section C (cognitive patterns) of Resident #50's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 05/04/2026 included a Brief Interview for Mental Status (BIMS) score of 3, indicating severe impairment in cognitive skills for daily decision making. The Resident's comprehensive care plan included an intervention to administer medications as ordered. Clinical record review revealed that the nursing staff documented code 22 on the Medication Administration Records (MARs) on 05/09/2026 indicating Drug/Treatment Not Administered, for the following medication: Alfuzosin extended-release oral tablet. A corresponding nursing progress note dated 05/09/2026 documented that Alfuzosin was not available in Pixis (back up supply), awaiting supply from pharmacy. Review of the over-the-counter medication list and Med Bank list revealed this medication was not listed as being available for administration. On 05/20/2026 at 2:38 PM during a meeting that included the Administrator, Director of Nursing, Regional [NAME] President of Operations, Assistant Director of Nursing, Staff Development Coordinator, and Regional Nurse, the concern regarding Resident #50's medication not being administered due to unavailability was reviewed. The facility policy titled Administering Medications stated, in part, .Medications are administered in accordance with prescriber orders. Facility policy titled, Unavailable Medication stated in part, In conjunction with the contracted pharmacy, the facility will make every effort to ensure that a medication ordered for the resident is available to meet their needs. No additional information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #55, the facility nursing staff failed to ensure the provider ordered medications Januvia and Lantus insulin were available for administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #55's diagnoses included diabetes and vascular dementia. Section C (cognitive patterns) of Resident #55's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 02/16/2026 included a Brief Interview for Mental Status (BIMS) score of 3, indicating severe impairment in cognitive skills for daily decision making. The Resident's comprehensive care plan included an intervention to administer medications as ordered. Clinical record review revealed nursing staff documented code 22 on the Medication Administration Records (MARs) indicating Drug/Treatment Not Administered, for the following medications: Lantus insulin on 03/02/2026 Januvia on 03/28/2026 A corresponding nursing progress note dated 03/28/2026 documented that Januvia was not on the medication cart and had been reordered by the nurse. Review of the over-the-counter medication list and Med Bank list revealed these medications were not listed as being available for administration. During an end of the day meeting on 05/18/2026 at 5:35 PM, that included the Administrator, Director of Nursing, Regional [NAME] President of Operations, Nurse Consultant, and Assistant Director of Nursing the issue with Resident #55's provider ordered medications not being available for administration was reviewed. The facility policy titled Administering Medications stated, in part, .Medications are administered in accordance with prescriber orders. Facility policy titled, Unavailable Medication stated in part, In conjunction with the contracted pharmacy, the facility will make every effort to ensure that a medication ordered for the resident is available to meet their needs. No additional information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #165, the facility staff failed to ensure the provider ordered medication Oxcarbazepine was available for administration. Resident #165's diagnoses included convulsions and diabetes. Section C (cognitive patterns) of Resident #165's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/03/2026 included a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The Resident's comprehensive care plan included an intervention to administer medications as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed that the nursing staff documented code 22 on the Medication Administration Records (MARs) indicating Drug/Treatment Not Administered, for the following medication: Oxcarbazepine, 03/18/2026 and 03/19/2026. Additional nursing documentation revealed the following: 03/18/2026: Oxcarbazepine medication not on cart and waiting on delivery, Nurse Practitioner made aware. 03/19/2026: Oxcarbazepine on order. Review of the over-the-counter medication list and Med Bank list revealed this medication was not listed as being available for administration During an end of the day meeting on 05/18/2026 at 5:35 PM, that included the Administrator, Director of Nursing, Regional [NAME] President of Operations, Nurse Consultant, and Assistant Director of Nursing the issue with Resident #165's provider ordered medication not being available for administration was reviewed. The facility policy titled Administering Medications stated, in part, .Medications are administered in accordance with prescriber orders. Facility policy titled, Unavailable Medication stated in part, In conjunction with the contracted pharmacy, the facility will make every effort to ensure that a medication ordered for the resident is available to meet their needs. No additional information regarding this issue was provided to the survey team prior to the exit conference. 5. For Resident #3, the facility staff failed to ensure insulin Glargine YFGN, Buspirone, and Calcium Citrate D3 200-25 Petites were available for administration. Insulin Glargine YFGN is a long-acting insulin used to lower blood sugar, Buspirone is used to treat anxiety, and Calcium Citrate D3 is a supplement used to prevent and/or treat low blood calcium and support bone health. An admission Record indicated the facility admitted Resident #3 on 10/19/23. According to the admission Record, the resident had a medical history that included type 2 diabetes mellitus, generalized anxiety disorder, vitamin D deficiency, hypocalcemia, and chronic kidney disease. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/22/26, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident had intact cognition. Resident #3's current comprehensive person-centered care plan included focus areas that indicated the resident used anti-anxiety medication, anti-depressant medication and had diabetes mellitus. Interventions directed staff to administer anti-anxiety medication, anti-depressant medication and diabetes medication as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3's medical provider orders included an order starting 12/03/25 for Glargine YFGN 100 units/ml inject 40 units subcutaneously at bedtime related to diabetes mellitus. A review of Resident #3's March 2026 Medication Administration Record (MAR) revealed Glargine YFGN was not administered on 3/24/26. A corresponding nursing progress note dated 3/24/26 at 10:18 PM indicated the medication was reordered. Resident #3's medical provider orders included an order dated 3/25/26 for Buspirone 7.5 mg by mouth three times a day for major depressive disorder. A review of Resident #3's April 2026 MAR revealed Buspirone was not administered on 4/18/26 at 12:00 PM. A corresponding nursing progress note dated 4/18/26 at 11:17 AM documented staff were waiting on arrival from the pharmacy. Resident #3's medical provider orders included an order starting 12/03/26 for Calcium Citrate plus D3 200-250 Petites for hypocalcemia. A review of Resident #3's March 2026 MAR revealed Calcium Citrate plus D3 was not administered on 14 occasions, 3/18/26 morning and evening, 3/19/26 morning and evening, 3/20/26 morning and evening, 3/21/26 morning, 3/22/26 morning and evening, 3/23/26 morning and evening, 3/24/26 evening, 3/26/26 morning, and 3/27/26 evening. Corresponding nursing progress notes on 3/18/26, 3/19/26, 3/20/26, 3/21/26, 3/22/26, 3/23/26, 3/26/26, and 3/27/26 indicated the medication was unavailable for administration. On 5/20/26 at 2:38 PM the facility administrative staff including the Administrator and Director of Nursing, were informed of the concerns regarding the multiple medications that were not administered as ordered. No further information regarding these concerns was provided prior to the exit conference on 5/20/26.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and facility document review, the facility staff failed to employ sufficient staff to safely and effectively carry out the functions of food and nutrition services. The findings included:On 5/17/2026 at 9:05 AM during the initial kitchen tour the staff were still on the tray line. The dietary aide #1 stated they were prepping cart #7 of 9 carts. At 9:25 AM the dietary aide stated they were prepping the last cart. When asked about tray delivery times the aide stated, Our goal is to have the last cart out the door by 9:00 AM but that doesn't always happen, it depends on what else we have going on day to day and sometimes it just takes longer. The last tray cart left the kitchen at 9:50 AM. This cart was for the 400 hall. When asked about staffing the aide stated, We usually have three aides and one cook. When asked if that is the normal number of staff they stated, Yes, that's what we have every day. There was three aides and one cook working. The cook was asked what time the tray line for lunch starts and he stated to return at 11:30 AM in order to observe the tray line for lunch. On 5/17/26 at 11:25 AM there were three residents on the [NAME] unit still eating breakfast and several other residents still had breakfast trays in their room.On 5/17/26 at 11:30 AM there were four additional staff members in the kitchen at this time. A District Manager, another corporate employee, the Dietary Manager and a fourth aide. The tray line was not ready. The District Manager stated they needed 15 more minutes. At 12:05 PM the tray line was still not ready. The District Manager stated to return at 12:30PM. The tray line was not ready until 12:40PM. The last cart was finished and loaded at 2:00 PM. On 5/18/26 at 2:38 PM another member of the survey team observed the residents on the 400 hall still did not have lunch trays. This surveyor spoke to the Administrator who stated, I just went down there. The trays were on the cart outside the kitchen door, no one pushed them up there, I guess they were busy doing something else. The last tray on the cart was passed at 2:48 PM leaving many residents on the unit still eating lunch after 3:00 PM. On 5/18/26 the Dining Services District Manager was interviewed at 2:00 PM. When asked about staffing they stated, Our goal is to have four aides and one cook on each shift. Unfortunately, that is rarely happening, we don't have enough people. We did just have a job fair and had a lot of interest so we are hopeful that staffing will improve soon. The District Manager stated the department had been short staffed since she took over the building in March. On 5/18/26 at 2:40 PM the Administrator was interviewed. When asked if they were aware of a staffing problem in the Dietary Department they stated, I am aware of those concerns, and they did recently have a job fair with over 60 applicants, so they are actively working on the issue.5/18/26 at 4:11 PM Certified Nursing Assistant C.N.A. #12 was interviewed and stated that one night there had been a night that he was unable to give showers because the dinner trays didn't get served until 9:00 PM and his shift ended at 10:30PM. On 5/18/26 at 5:35 PM the survey team met with the Administrator, Director of Nursing, Assistant Directors of Nursing, the Regional Director of Clinical Services and the Regional [NAME] President of Operations. This concern was discussed with them at that time. On 5/19/26 the lunch trays arrived on the 400 hall at 1:36 PM. 05/19/2026 at 3:09 PM C.N.A #8 was interviewed. They stated that staffing was sometimes hectic, meals are often really late, so you don't know when or when not to do a shower. They stated a couple of months ago, they were getting dinner trays around 7 or 7:30 PM. No further information was provided to the survey team prior to the exit conference.

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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 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 observation, interview and facility document review, the facility staff failed to ensure each resident receives three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. The findings included:On 5/17/2026 at 9:05 AM during the initial kitchen tour the staff were still on the tray line. The dietary aide #1 stated they were prepping cart #7 of 9 carts. At 9:25 AM the dietary aide stated they were prepping the last cart. When asked about tray delivery times the aide stated, Our goal is to have the last cart out the door by 9:00 AM but that doesn't always happen, it depends on what else we have going on day to day and sometimes it just takes longer. The last tray cart left the kitchen at 9:50 AM. This cart was for the 400 hall. When asked about staffing the aide stated, We usually have three aides and one cook. When asked if that is the normal number of staff they stated, Yes, that's what we have every day. There were three aides and one cook working. The cook was asked what time the tray line for lunch starts and he stated to return at 11:30 AM in order to observe the tray line for lunch. On 5/17/26 at 11:25 AM there were three residents on the [NAME] unit still eating breakfast and several other residents still had breakfast trays in their room. Two of the three residents stated it was fairly normal for breakfast to be that late and that when it was that late, each consecutive meal would be late as well. We probably won't get supper until 8:00 or after.On 5/17/26 at 11:30 AM there were four additional staff members in the kitchen at this time. A District Manager, another corporate employee, the Dietary Manager and a fourth aide. The tray line was not ready. The District Manager stated they needed 15 more minutes. At 12:05 PM the tray line was still not ready. The District Manager stated to return at 12:30PM. The tray line was not ready until 12:40PM. The last cart was finished and loaded at 2:00 PM.On 5/18/26 at 2:38 PM another member of the survey team observed the residents on the 400 hall still did not have lunch trays. This surveyor spoke to the Administrator who stated, I just went down there. The trays were on the cart outside the kitchen door, no one pushed them up there, I guess they were busy doing something else. The last tray on the cart was passed at 2:48 PM leaving many residents on the unit still eating lunch after 3:00 PM. On 5/18/26 the Dining Services District Manager was interviewed at 2:00 PM. When asked about staffing they stated, Our goal is to have four aides and one cook on each shift. Unfortunately, that is rarely happening, we don't have enough people. We did just have a job fair and had a lot of interest so we are hopeful that staffing will improve soon. The District Manager stated the department had been short staffed since she took over the building in March. The District Manager provided a Cart Delivery Log. When asked if the log was current and accurate they stated, It is and we are definitely really late today. The log stated that the last breakfast trays should be delivered to the 400 hall by 8:55 AM and the last lunch trays should be delivered by 1:10 PM daily. For the dinner meal, the last trays should be delivered by 6:15 PM each evening.On 5/18/26 at 2:40 PM the Administrator was interviewed. When asked if they were aware of a staffing problem in the Dietary Department they stated, I am aware of those concerns, and they did recently have a job fair with over 60 applicants, so they are actively working on the issue.5/18/26 at 4:11 PM Certified Nursing Assistant C.N.A. #12 was interviewed and stated that one night there had been a night that he was unable to give showers because the dinner trays didn't get served until 9:00 PM and his shift ended at 10:30PM. On 5/18/26 at 5:35 PM the survey team met with the Administrator, Director of Nursing, Assistant Directors of Nursing, the Regional Director of Clinical Services and the Regional [NAME] President of Operations. This concern was discussed with them at that time.On 5/19/26 the lunch trays arrived on the 400 hall at 1:36 PM.05/19/2026 at 3:09 PM C.N.A #8 was interviewed. They stated that staffing was sometimes hectic, meals are often really late, so you don't know when or when not to do a shower. They stated a couple of months ago, they (continued on next page)

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	495305	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marcella Post Acute	305 Marcella Road Hampton, VA 23666

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were getting dinner trays around 7 or 7:30 PM.No further information was provided to the survey team prior to the exit conference.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and facility document review, the facility staff failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the facility kitchen and in two of three nutrition rooms ([NAME] and [NAME]). The findings included:1.The facility policy entitled, Food Storage: Cold Foods with a revision date of 02/2023 was reviewed and read in part, 5. All foods will be stored wrapped or in covered containers, labeled and dated and arranged in a manner to prevent cross contamination. On 05/17/2026 at 10:43 AM during the initial kitchen tour the walk-in cooler was checked. A raw purple onion cut in two pieces was stored in a food storage bag that was not labeled or dated. The onion was in a box with four stacks of sandwich cheese each wrapped in plastic wrap. One of the packages of cheese was not labeled or dated. There was a large bag of chopped lettuce that had been cut or torn open and left open, it was not sealed. The lettuce was wilted and brown around the edges. The manufacturer date on the bag read, packed date 04/28/2026. There was no label indicating when the bag was opened or when it was due to be discarded. There was a cole slaw kit that was not opened with a best by date of 5/15/26. There was a bundle of fresh parsley that was not in a bag or any type of container with a label on it that read 05/08/2026 use by 05/15/2026. There was a box containing eight (8) sausage patties with a use by date of 05/15/2026. In the dry storage area, there was a bag of sandwich bread that had been secured by tying a knot in the bag but below the knot the bag had been ripped open, and the bread was exposed to the air. The bread was hard. There was no label on the bread. The policy entitled, Food Storage: Dry Goods with a revision date of 2/2023 was provided and read in part, All packaged and canned food items will be kept clean, dry and properly sealed. The employee who identified themselves as the cook stated they were in charge. The cook was shown the above items and stated they would discard all the items. The cook agreed that the onion and the cheese should have been labeled and the other items were out of date. The cook was shown the bread and stated it should not have been ripped open, it should have been sealed and stated it would be discarded. On 5/18/26 at 5:35 PM the survey team met with the Administrator, Director of Nursing, [NAME] President of Operations, Regional Director of Clinical Services and Assistant Directors of Nursing. The above concerns were discussed with them at that time. No further information was provided to the survey team prior to the exit conference. 2. The facility policy entitled Foods Brought by Family/Visitors with a revision date of March 2022 was reviewed and read in part, 5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility prepared food. a. non-perishable foods are stored in re-sealable containers with tight fitting lids. Intact fresh fruit may be stored without a lid. b. Perishable foods are stored in resealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. 6. The nursing staff will discard perishable foods on or before the use by date. 7. The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example mold growth, past due package expiration dates). On 5/18/2026 at 9:45 AM the resident refrigerator in the [NAME] nutrition room was checked. The top shelf of the refrigerator was covered in brown and purple sticky substances that had leaked down the back of the refrigerator to the bottom and settled under the drawers. There was a white birthday cake with a resident name on it dated 5/13, a brown bag with a resident name on it dated 5/9/26, a white Styrofoam food box with writing that was not legible. Certified Nursing Assistant (C.N.A.) #2 was interviewed and stated they did not know who was responsible keeping the refrigerator clean or for discarding out of date items, but the policy is after three days, the food is to be discarded. C.N.A. #2 stated she was going to discard the questionable items and clean the refrigerator. Licensed Practical Nurse (LPN) #13 was interviewed and stated it is (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the nursing departments responsibility to make sure the refrigerator is kept clean and that outdated food is discarded. There isn't one person assigned to it, we should all be checking it and making sure it's clean. On 5/18/26 at 10:15 AM, the resident refrigerator in the [NAME] nutrition room was checked. There was a Subway bag that was sealed with no date or name on it. There was an Olive Garden bag with a receipt attached that was dated 5/12/26. There was a freezer bag with what looked like cheesecake with no name or date and a grocery bag that was tied up dated 5/4-5/7. LPN #5 was interviewed and stated, Nursing is responsible to make sure everything is dated and thrown away after three days. LPN #5 discarded the items of concern. On 5/18/26 at 5:35 PM the survey team met with the Administrator, Director of Nursing, [NAME] President of Operations, Regional Director of Clinical Services and Assistant Directors of Nursing. The above concerns were discussed with them at that time. No further information was provided to the survey team prior to the exit conference.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, policy review, and clinical record review, the facility staff failed to ensure each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized for one of five residents sampled for immunizations, resident #134.The findings included: A facility policy entitled, Pneumococcal Vaccine with a revision date of August 2025 read in part, 1. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. An admission Record for resident #134 indicated the facility admitted the resident on 10/30/25. According to the admission Record resident #134 had a medical history that included the diagnoses of stroke, end stage renal disease, chronic obstructive pulmonary disease, diabetes, and chronic respiratory failure. Resident #134's vaccination record was reviewed. The record revealed that the resident received PPSV23 on 12/26/2016. There was no other documentation of any pneumococcal vaccines being offered to the resident since admission to the facility. According to the Centers for Disease Control (CDC) for a resident over [AGE] years of age and who previously received only PPSV23: 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21 at least 1 year after the last PPSV23 dose should have been offered to complete the pneumococcal vaccine series. On 5/18/26 at 3:17 PM the Infection Preventionist (IP) was interviewed. When asked to review resident #134's pneumococcal vaccine status and if the series was up to date the IP stated, No, (resident) is not up to date, (resident) needs the PCV20 or 21. I feel like (resident) refused it when I offered the COVID vaccine, but it isn't in there (immunization record). On 5/18/26 at 5:35 PM the survey team met with the Director of Nursing, Administrator, Assistant Directors of Nursing, Regional [NAME] President of Operations, and the Regional Director of Clinical Services. This concern was discussed with them at that time. No further information was provided to the survey team prior to the exit conference.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, staff interview, policy review and facility document review, the facility staff failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition. The findings included:The facility policy titled, Personal laundry Handling and Processing Policy with a reviewed date of 2/1/25 read in part, Lint traps should be checked, brushed and cleaned at least every hour unless state/local requirements prescribe more frequent attention. Lint trap cleanings should be documented on the Lint Trap Cleaning Log.The facility synopsis of events was reviewed and read in part, .concerning the fire that occurred Thursday January 22, 2026, there were no negative outcomes/injuries resulting from this incident. At approximately 9:22 AM Thursday January 22, 2026, the fire alarm went off. Maintenance Director went directly to the fire alarm panel to see where the alarm was originating from. Staff alerted Maintenance Director on the way to the fire and when entering the laundry room, there was smoke coming from dryer #3. Maintenance Director quickly grabbed the fire extinguisher and opened the lint trap doors to see embers of lint. The lint embers were extinguished and an all clear was notified. In the conclusion, the report stated, Following the incident, the excess of lint build up was found to be the result of new linen towels and washcloths being laundered at the facility. This required more frequent cleaning of the lint trap. (Environmental Services District Manager) also implemented 2-hour rounds completed by the Environmental Services Director. A new wiring harness was purchased and installed, tested without issues. On 5/17/26 at 4:10 PM The Maintenance Director was interviewed and stated, The lint trap hadn't been cleaned like it was supposed to. They are supposed to clean it or empty it every hour. There were no flames or anything, just heavy smoke, the fire alarm sounded and the fire department responded, all of that went smoothly and as it should have. The Maintenance Director stated the laundry staff are supposed to empty the trap every hour and his department takes it apart and thoroughly cleans it each week. On 5/17/26 at 4:24 PM the Director of Environmental Services was interviewed. She stated the lint trap is supposed to be emptied every hour. She stated, The one working that morning didn't do it. We have this log we fill out every time we do it, and she had filled out the log for her whole shift which was 5:00 am to 1:00 PM and it was only 9:40 AM. She was terminated. Now the staff check it every hour and I check it every two hours. When asked to clarify if she is checking the lint traps or the log she stated she is checking both. She provided the log for the surveyor to review and opened each lint trap on the three dryers for observation as well. No concerns were identified. The area behind the machines was checked as well with no concerns identified. On 5/17/26 at 4:43 PM the District Manager for the company was interviewed and stated, During orientation, new employees get educated on the process of checking the lent traps. Since the fire all the laundry staff received corrective actions, and the manager is to check the traps at least every 2 hours and ensure the log is being kept accurately. On 5/18/26 at 5:35 PM the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Regional [NAME] President of Operations and Regional Director of Clinical Services. This concern was reviewed with them at that time. No further information was provided to the survey team prior to the exit conference.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, family interview, staff interview, and facility document review, the facility staff failed to maintain an effective pest control program to address and prevent the presence of insects throughout the facility. The findings included: The facility staff failed to maintain an effective pest control program to address the presence of cockroaches, ants, and other insects within resident care areas. On 05/17/2026 at 10:05 AM, during an interview on the [NAME] unit with Resident #59, the surveyor observed a brown insect near the resident's bed. The insect crawled toward the closet and disappeared. The resident reported issues with cockroaches, gnats, flies, and ants. During this observation, a second insect was observed crossing the floor across from the area where the first insect had been observed. The surveyor was able to capture the insect in a napkin. Resident food items were observed to be covered or stored in their original containers. The Director of Nursing (DON) was shown the insect and stated she could not confirm what type of insect it was. On 05/17/2026 at 10:35 AM, during an interview, Resident #29 stated they had water bugs and roaches, and they had previously requested facility staff to pull the bed from the wall to prevent an insect from crawling into the bed. During initial tour on 05/17/2026, Resident #149 reported concerns regarding insects in their room. On 05/17/2026 at 11:27 AM, Resident #3 stated they had observed roaches a few nights prior and little, tiny ants had come out with their meal tray. The residents stated that the ants had been killed; however, they were not provided a replacement meal tray. On 05/17/2026 at 2:20 PM, during an interview with a family member of Resident #50, this family pointed out a dead brown insect in the air conditioning unit on the wall and behind the bed. The family member also reported observing ants in the windowsills and stated they did not believe the residents' room had been cleaned enough. On 05/18/2026, during a resident council meeting, residents expressed concerns regarding insects being in ice machines and stated at night you can hear creatures in the ceiling, and they are in the vents. The resident council also stated there were issues with ants. On 05/18/2026 at 1:12 PM, the surveyor observed small ants on a snack cart brought from the kitchen the previous day and placed in the conference room. On 05/18/2026 at 2:30 PM, on the [NAME] unit a live water bug was observed in the bed with Resident #111 by Licensed Practical Nurse (LPN) #4. The resident was observed to be yelling and the Assistant Director of Nursing assisted with getting the insect from the resident's bed. On 05/19/2026 at 10:56 AM, the surveyor observed a live brown insect resembling a cockroach that measured 1 and 1/4 inches in length underneath the ice machine on the [NAME] unit. On 05/19/2026 at 12:00 PM, during an interview with the facility exterminator, this staff identified the insect found under the ice machine as an American cockroach. The exterminator stated the facility received weekly extermination services with additional services as needed. Regarding live activity this staff stated he saw water bugs (American cockroaches), and ants on some of the units in the windowsills. The exterminator stated logs were maintained at each nurse's station and reviewed during service visits. Review of the pest control invoices revealed that an exterminator had provided services to the facility twenty-one times between 02/04/2026-05/13/2026 and treatment had been provided for roaches and/or ants. Random review of pest control log sheets revealed documented reports of ants, spiders, and water bugs. On 04/18/2026 the facility staff documented roaches above curtain, ceiling, and walls. Additional entries included reports of ants on dressers, inside dressers, on all the walls and behind the baseboards. On 04/19/2026 the facility staff documented roaches, spiders, and ants in whole room. Review of the 04/22/2026 pest control invoice revealed the facility had been treated for insects using Suspend Polyzone, Nibor D Foam + IGR, Vendetta Roach Bait, First Strike Soft Bait, and Optigard. The most recent pest control invoice provided to the survey team was dated 05/13/2026, four days prior to the survey team entering the facility. Documentation indicated the facility had been treated with Suspended Polyzone, Contrac Bait Blox, Vendetta Roach Bait, Niban Granular Bait, and Advion Ant (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Gel. These concerns were discussed with the facility's administrative staff throughout the survey process. No additional information regarding these concerns was provided to the survey team prior to the exit conference.