| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495315 | A. Building<br>B. Wing | 09/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Woodstock Valley Health and Rehabilitation | 803 South Main St<br>Woodstock, VA 22664 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observation, staff interview and clinical record review, it was determined that facility staff failed to promote a resident's dignity for one of 16 current residents in the survey sample, Residents #8 (R8). The findings include:For R8, facility staff stood while providing feeding assistance. R8 was admitted to the facility with diagnoses that included but were not limited to swallowing difficulties. On the most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 08/13/2025, R8 scored 3 (three) out of 15 on the BIMS (brief interview for mental status), indicating R8 was severely impaired of cognition for making daily decisions. GG0130 Self-Care coded R8 as being dependent for eating. 09/23/2025 at approximately 8:08 a.m., an observation revealed R9 in bed being fed by CNA (certified nursing assistant) #2. Further observations revealed CNA #2 standing next to the bed while feeding R8. Observation of R9's meal tray revealed food was p[placed in bowls. The comprehensive care plan for R8 dated 10/29/2018 documented in part, Focus. (R8) has an ADL self-care performance deficit r/t (related to) Vascular dementia (1), history of CVA (cerebral vascular accident) (2), and impaired cognition. Date Initiated: 10/29/2018. Under Interventions it documented in part, EATING: (R8) is dependent on staff for feeding Date Initiated: 10/29/2018. On 09/24/2025 at approximately 4:35 p.m. an interview was conducted with CNA (certified nursing assistant) #2. When asked to describe how she positioned herself when she fed R8 on 09/23/2025 during breakfast CNA #2 stated she was standing next to R8 while feeding her. She further stated that it was not dignified to be standing while assisting a resident with eating/feeding. The facility's policy Resident Rights documented in part, 4. Respect and dignity. The resident has a right to be treated with respect and dignity, including: c. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents. On 9/25/2025 at approximately 4:58 p.m. ASM (administrative staff member) #1, the executive director, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References:(1) A gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. Vascular dementia (VaD) is caused by a series of small strokes over a long period. This information was obtained from the website: https://medlineplus.gov/ency/article/000746.htm.(2) A stroke. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm. |

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

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

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, facility document review and clinical record review, the facility staff failed to maintain a resident's right to be treated with respect and dignity, including the right to retain their personal belongings for one of 16 residents in the survey sample, Resident #2. The findings include: For Resident #2 (R2), the facility staff failed to maintain the resident's right to display her personal belongings.The resident was admitted to the facility on [DATE], with diagnoses that included but were not limited to: diabetes, obesity, high blood pressure, sleep terrors, insomnia, depressive disorder, anxiety disorder, osteoarthritis, post-traumatic stress disorder, and pain. On the most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 8/3/25, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section E - Behavior, the resident was not coded as having any behaviors during the lookback period. The nurse's note dated 3/29/25 at 3:29 p.m. documented, Resident has been agitated and verbally inappropriate to staff this shift. Resident came up to med (medication) cart crying and stated that she was going through withdrawal, and she felt like she was dying and couldn't do this anymore. DON (director of nursing), NP (nurse practitioner), Police and EMS (emergency medical services) notified. Resident refused to cooperate with all party's (sic) involved.The Ombudsman's report dated 4/29/25, documented in part, Additionally, the DON removed the resident's personal signs from her door without her permission, and they were not an immediate harm to anyone. This both violated her right to maintain her personal possessions and escalated the mental anguish of the resident during this interaction. An interview was conducted with R2 on 9/23/25 at 10:00 a.m. The resident stated on 3/29/25, the DON at that time removed her signs, that she had made, from her door without her permission. R2 stated she just ripped them off the door stating it was a health department violation. R2 stated she didn't ask my permission to do so. When asked how that made her feel, R2 stated she was angry that she did that, they were her belongings. An interview was conducted with OSM (other staff member) #1, the social worker, on 9/24/25 at approximately 9:30 a.m. OSM #1 stated the resident was very upset that ASM (administrative staff member) #4 removed her signs off her door. She stated the resident was angry that ASM #4 did that. An interview was conducted with ASM #4, the former DON, on 9/24/25 at 10:22 a.m. When asked if she removed the resident's handmade signs off the door or walls, ASM #4 stated she did remove them as they were a health department violation due to infection control concerns.An interview was conducted with LPN #4 on 9/24/25 at 9:03 a.m. She stated the resident had posters on her door and clothing stating that she was being mistreated and wasn't getting her medications. ASM #4 ripped the signs off the door. LPN #4 stated she didn't hear ASM #4 ask permission to remove them off the door, stating it was a fire hazard. The facility policy, Resident Rights documented in part, Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . Respect and dignity. The resident has a right to be treated with respect and dignity, including: The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. ASM #1, the executive director and ASM # 6, the vice president of operations, were made aware of the above concern on 9/25/25 at 5:32 p. m. No further information was provided prior to exit. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to notify the emergency contact of changes in condition and the physician of medications not administered for two of 16 residents in the survey sample, Residents #3 and #4.The findings include:1) For Resident #3 (R3), the facility staff failed to A) notify the physician of medications not administered or held during dates in February, March and April of 2025 and B) notify the emergency contact of changes in condition on 3/10/2025 and 4/8/2025.On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/28/2025, the resident was assessed as being moderately impaired for making daily decisions. The assessment documented R3 receiving medications including insulin, antibiotic, diuretic, opioid, antiplatelet and hypoglycemic medication.The resident admission demographic information documented R3 being their own responsible party and having two family members as emergency contacts.A) Review of the eMAR (electronic medication administration record) for R3 dated 2/1/25-2/28/25 failed to evidence administration of the following medication on the dates listed below:Daptomycin-Sodium Chloride Intravenous Solution 500-0.9 MG (milligram)/50ML (milliliter)-% (Daptomycin-Sodium Chloride) Use 500 mg intravenously in the morning related to Sepsis, Unspecified Organism. On 2/9/25 and 2/21/25. (antibiotic to treat infection) (1). The eMAR for 2/9/25 was observed to be blank and 2/21/25 eMAR progress note documented ordered call to pharmacy. It failed to evidence notification of the physician of the medication not being administered.Epoetin Alfa-epbx Injection Solution 40000 UNIT/ML (Epoetin Alfa-epbx) Inject 1 ml subcutaneously one time a day every Fri for Anemia of Chronic disease. (to treat anemia) (2) On 2/14/25. The eMAR progress note documented Not available in omni cell, awaiting from pharmacy. It failed to evidence notification of the physician of the medication not being administered.Gabapentin Oral Capsule 100 MG (Gabapentin) Give 4 capsule by mouth in the morning for Neuropathy related to Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified. (to treat seizure/diabetic neuropathy) (3) Take 2 capsules twice daily. On 2/22/25, 2/23/25 and 2/24/25. The eMAR progress note dated 2/22/25 documented on order, 2/23/25 pharmacy to send and 2/24/25 pharmacy contacted. It failed to evidence notification of the physician of the medication not being administered. Gabapentin Oral Capsule 100 MG (Gabapentin) Give 8 capsule by mouth at bedtime for neuropathy. On 2/21/25, 2/22/25 and 2/23/25. The eMAR progress note dated 2/21/25 and 2/22/25 documented on order. The eMAR progress note dated 2/23/25 documented pharmacy to send. It failed to evidence notification of the physician of the medication not being administered.Neurontin Oral Capsule 400 MG (Gabapentin) Give 2 capsule by mouth every morning and at bedtime for neuropathy. On 2/27/25. The eMAR progress note dated 2/27/25 documented on order. It failed to evidence notification of the physician of the medication not being administered.Insulin Glargine Subcutaneous Solution (Insulin Glargine) Inject 8 unit subcutaneously in the morning related to Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified. (to treat diabetes) (4) On 2/9/25, the eMAR was observed to be blank.Pregabalin Oral Capsule 25 MG (Pregabalin) Give 25 mg by mouth every morning and at bedtime related to pain in unspecified joint. (to treat pain) (5) The 6:00 a.m. doses on 2/1-2/4/25, 2/6/25, 2/7/25, and 2/20/25 and the 9:00 p.m. doses on 2/1, 2/3, 2/5-2/9/25. The eMAR progress notes documented 2/1/25, 2/4/25, 2/6/25, 2/7/25, 2/9/25- on order, 2/2/25- ordered, 2/3/25- script needs to be wrote, 2/8/25- not available at this time and 2/20/25- new order wrote, has not arrived. It failed to evidence notification of the physician of the medication not being administered.Review of the eMAR for R3 dated 3/1/25-3/31/25 failed to evidence administration of the following medication on the dates listed below:Pregabalin Oral Capsule 300 MG (Pregabalin) Give 1 capsule by mouth every morning and at bedtime for neuropathy. On 3/8/25 at 9:00 a.m. The eMAR progress note documented, on order. On 3/20/25 at 9:00 p.m., the eMAR progress note documented, ordered. It failed to evidence notification of the physician of the medication not being administered.Carvedilol Oral Tablet 12.5 MG (Carvedilol) Give 1 tablet by mouth two times a day for Heart Failure. (to treat heart failure and high blood pressure) (6) On 3/30/25 at 5:00 p.m. the eMAR documented a code 7, the eMAR chart codes documented 7=sleeping. It failed to evidence notification of the physician of the medication not being administered.Entresto Oral Tablet 49-51 MG (Sacubitril-Valsartan) Give 1 tablet by mouth two times a day for DMT2 (diabetes mellitus type 2). (to treat heart failure) (7) On 3/30/25 at 5:00 p.m. the eMAR documented a code 7, the eMAR chart codes documented 7=sleeping. It failed to evidence notification of the physician of the medication not being administered.Review of the eMAR for R3 dated 4/1/25-4/30/25 failed to evidence administration of the |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>Based on staff interview, and facility document review, the facility staff failed to secure confidential resident clinical records for one of 16 residents in the survey sample, Resident #1. The findings include:For Resident #1 (R1), the facility staff failed to maintain confidentiality of a document from the resident's clinical record. An email from LPN (licensed practical nurse) #5 to ASM (administrative staff member) #1 (the executive director) dated 8/22/25 documented, This morning I was standing at my cart getting ready to start morning Med [sic] pass. A CNA (certified nursing assistant) came to me and stated that (LPN #6) wanted me to print off a progress note for her. I asked what progress note and CNA said something about (R1). I asked where she was, and she said in (OSM [other staff member] #2's [the former staffing coordinator's]) office. By the time I went to (OSM #2's) office (LPN #6) had left. I needed to speak to (OSM #2) about my schedule. And that's what we did. At the end of our conversation I asked where (LPN #6) was and if she was coming back in because she wanted me to print something. (OSM #2) then stated what (LPN #6) was needing/wanting to be printed. (OSM #2) stated she did not have access to it and (LPN #6) could not print it either. I did feel hesitant to print this but felt as though I didn't have an out. I printed it and gave it to (LPN #6) immediately. Who also wanted a copy to give to HR (human resources). As I was walking back down the hallway away from (LPN #6), she stated that she was covering her butt and that there was an open investigation and how people were sweeping things under the rug. I did not know about any of this at that time. Or that (R1) was no longer our resident. Had I been aware of the severity of the situation I would not have printed this. The only time I had the progress notes on [sic] my possession was to walk from the nurses [sic] station down to Rosewood (unit) to (LPN #6's) cart where note was handed to her. LPN #6 was not available for interview during the survey. On 9/24/25 at 5:22 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated she was made aware that LPN #5 had printed out documents from R1's clinical record and gave them to LPN #6. ASM #2 stated she confronted LPN #6 on that same day and LPN #6 stated she did not have any of R1's documents but she (ASM #2) later heard that LPN #6 was at the nurses' station saying the documents, were not in her shoe, implying they were. ASM #2 stated LPN #6 text her after she left the facility and stated she did have a copy of a document from R1's record printed out by another nurse. A printed copy of a text message from LPN #6 to ASM #2 (no date) documented, (ASM #2) i [sic] did have a paper that (LPN #5) printed out but I had tore [sic] it up and threw it away hours before yall [sic] had asked me about it. I am guilty of that. On 9/25/25 at 12:49 p.m., an interview was conducted with LPN #5. LPN #5 stated OSM (other staff member) #2 instructed her to print a specific progress note regarding backdated medication orders for R1. LPN #5 stated the orders were dated 8/10/25 but were created in the system several days later and could not recall the exact date the orders were created. LPN #5 stated OSM #2 told her LPN #6 needed the note to take to human resources, OSM #2 could not print the note because she no longer had access to the record since the new company took over, and it was fine for LPN #5 to print the note and give it to LPN #6. LPN #5 stated she printed the note and immediately gave it to LPN #6. On 9/25/25 at 1:54 p.m., an interview was conducted with ASM #1. ASM #1 stated that on 8/22/25, it was brought to her attention that LPN #6 asked LPN #5 to print out a progress note or order regarding R1. ASM #1 stated she was confused because LPN #6 could print the document out herself. ASM #1 stated LPN #5 admitted she printed the document out and gave it to LPN #6. ASM #1 stated LPN #6 stated she did not ask LPN #5 to print out the document but then later texted ASM #2 stating she did have the document but destroyed it. On 9/25/25 at 4:59 p.m., ASM #1 (the executive director) was made aware of the above concern. The facility document titled, Resident Rights documented, b. The resident has a right to secure and confidential personal and medical records. No further information was presented prior to exit. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to maintain a clean, comfortable, and homelike environment for one of 16 residents in the survey sample, Resident #7, three of three reusable bed pads observed in the laundry room, and in six of 27 resident rooms observed. The findings include:1. For Resident #7 (R7), the facility staff failed to maintain a blanket on the resident's bed in a clean and homelike manner. On multiple dates, a brown stain was observed on the blanket. Also, on 9/24/25, stains were observed on three of three washed bed pads in the laundry room.<br><br>On 9/22/25 at 3:34 p.m., 9/23/25 at 8:02 a.m., 9/23/25 at 3:16 p.m., and 9/24/25 at 9:01 a.m., an observation of R7's room was conducted. A white blanket was observed on the resident's bed and contained a large brown oval stain (approximately ten inches in diameter) on the left lower corner.<br><br>On 9/24/25 at 4:44 p.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 stated bed linens should be changed on shower days and as needed. CNA #2 stated a lot of facility linens are stained, even when they are washed and clean. At this time, three washed and dried reusable bed pads were observed with CNA #2 in the laundry room. All three bed pads contained large light brown and yellow stains.<br><br>On 9/24/25 at 5:53 p.m., an observation of the three bed pads was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1 stated the bed pads were not clean, comfortable, or homelike, and should not be in use.<br><br>On 9/25/25 at 1:38 p.m., an interview was conducted with OSM (other staff member) #3 (the account manager of environmental services). OSM #3 stated she used to have an overstock of linens in the past when the contracted environmental services company ordered linens, and the stained linens would have been thrown in the trash. OSM #3 stated the facility now orders linens and there have been issues with getting linens. OSM #3 also stated she has had issues with adding bleach to the washing machines and a representative from the washing machine company has had to come in and adjust the machines.<br><br>On 9/25/25 at 4:59 p.m., ASM #1 was made aware of the above concern.<br><br>The facility policy titled, Safe and Homelike Environment documented, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible .3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. 4. The facility will provide and maintain bed and bath linens that are clean and in good condition.<br><br>No further information was presented prior to exit.<br><br>2a. Facility staff failed to maintain the privacy curtains in a clean and sanitary manner in resident rooms 311, 313 and 338.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 09/23/2025 at approximately 9:45 a.m., observations of resident rooms [ROOM NUMBER] revealed the privacy curtains between the A-side and B-side of the rooms were dirty and stained.<br><br>On 09/24/2025 at approximately 9:40 a.m., observations of resident room numbers 313, 311, and 338 revealed the privacy curtains between the A-side and B-side of the rooms were dirty and stained.<br><br>On 09/24/2025 at approximately 2:35 p.m. an interview was conducted with OSM (other staff member) #3, account manager for environmental services. When asked about cleaning resident's privacy curtains she stated that all the privacy curtains in the resident's room are pulled down and cleaned once a month for every resident room and when they are dirty or soiled. She stated that the residents' privacy curtains are checked for cleanliness by the housekeepers during the daily cleaning and if the curtains are soiled or dirty, they are taken down and laundered. She also stated that any staff member can notify housekeeping if they find a resident's privacy curtain is dirty or soiled. At approximately 2:45 p.m. an observation of the privacy curtains between the A-side and B-side of the room in resident rooms [ROOM NUMBER] with OSM #3. She agreed with the findings of the privacy curtains described above and stated that the curtains needed to be taken down and cleaned and did not present a homelike environment.<br><br>On 9/25/2025 at approximately 4:58 p.m. ASM (administrative staff member) #1, the executive director, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, were made aware of the above findings.<br><br>No further information was provided prior to exit.<br><br>2b. Facility staff failed to maintain resident room [ROOM NUMBER] in a clean and sanitary manner.<br><br>On 09/23/2024 at approximately 9:45 a.m., an observation of resident room [ROOM NUMBER] revealed food debris and spill stains next to and under the beds on the A-side and B-side of the room.<br><br>On 09/24/2024 at approximately 9:40 a.m., an observation of resident room [ROOM NUMBER] revealed food debris and spill stains next to and under the beds on the A-side and B-side of the room.<br><br>On 09/24/2025 at approximately 2:35 p.m. an interview was conducted with OSM (other staff member) #3, account manager for environmental services. When asked to describe the procedure housekeepers follow for daily cleaning of resident's room she stated that basic cleaning is done daily. She also stated the housekeeper starts in the resident's room with emptying the resident's trash, wiping down all surfaces, walls, dusting, wiping down the bathroom, dust mopping then damp mopping the bathroom and resident's room. At approximately 2:50 p.m. an observation of resident room [ROOM NUMBER] was conducted with OSM #3. Upon entering the resident room and describing the observations conducted on 09/23/2024 and 09/24/2025 as described above, she agreed with the observations and stated that she was aware of the condition of the room and stated that it was unacceptable and did not present a homelike environment.<br><br>On 9/25/2025 at approximately 4:58 p.m. ASM (administrative staff member) #1, the executive director, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, were made aware of the above findings.<br><br>No further information was provided prior to exit.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2c. Facility staff failed to maintain resident rooms [ROOM NUMBERS] in good repair.<br><br>On 09/23/2024 at approximately 9:45 a.m. an observation of resident room [ROOM NUMBER] was conducted.<br><br>An observation of the wall behind the head-of-the-bed of the A-side revealed gouges in the wall exposing the inside of the plaster board covering an area approximately four foot wide by two feet high. Observation of the wall behind the head-of-the-bed of the A-side revealed gouges in the wall exposing the inside of the plaster board covering an area approximately four foot wide by two feet high.<br><br>On 09/23/2024 at approximately 9:45 a.m., an observation of resident room [ROOM NUMBER] revealed a gouged, unpainted plaster patch on the lower portion of the wall between the resident's dresser and the bathroom door covering an area approximately two feet wide by 18 inches high.<br><br>On 09/24/2024 at approximately 9:40 a.m., an observation of resident room [ROOM NUMBER] was conducted. An observation of the wall behind the head-of-the-bed of the A-side revealed gouges in the wall exposing the inside of the plaster board covering an area approximately four foot wide by two feet high. Observation of the wall behind the head-of-the-bed of the A-side revealed gouges in the wall exposing the inside of the plaster board covering an area approximately four foot wide by two feet high.<br><br>On 09/24/2024 at approximately 9:40 a.m., an observation of resident room [ROOM NUMBER] revealed a gouged , unpainted plaster patch on the lower portion of the wall between the resident's dresser and the bathroom door covering an area approximately two feet wide by 18 inches high.<br><br>On 09/24/2025 at approximately 2:35 p.m. an interview was conducted with OSM #4, plant operator and maintenance director. When asked to describe the procedure for keeping resident rooms in good repair he stated that staff will usually tell him when something needs to be fixed in a resident's room. He also stated that each nurse's has maintenance request log that staff fill in when something in a resident's room in in need of repair. He stated he does walk-throughs checking resident rooms for repairs but that it is inconsistent. At approximately 2:55 p.m. an observation of resident rooms [ROOM NUMBERS] was conducted with OSM #4. He agreed with the findings as stated above and stated the rooms needed repair and it did not present a homelike environment.<br><br>On 9/25/2025 at approximately 4:58 p.m. ASM (administrative staff member) #1, the executive director, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, were made aware of the above findings.<br><br>No further information was provided prior to exit. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495315 | A. Building<br>B. Wing | 09/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Woodstock Valley Health and Rehabilitation | 803 South Main St<br>Woodstock, VA 22664 |

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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure one of 16 residents in the survey sample, Resident #2, was free from mental abuse resulting in psychosocial harm on 3/29/25. The findings include: For Resident #2 (R2) the facility staff failed to ensure the resident was free from mental and verbal abuse resulting in psychosocial harm when the facility staff threatened to have the resident sent out of the facility with a temporary detention order.The resident was admitted to the facility on [DATE], with diagnoses that included but were not limited to: diabetes, obesity, high blood pressure, sleep terrors, insomnia, depressive disorder, anxiety disorder, osteoarthritis, post-traumatic stress disorder, and pain.On the most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 8/3/25, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section E - Behavior, the resident was not coded as having any behaviors during the lookback period.The MDS assessment, a quarterly assessment, with an ARD of 1/17/25, completed prior to 3/29/25, the resident scored a 15 out of 15 on the BIMS score, indicating the resident was not cognitively impaired for making daily decisions. In Section E - Behavior, the resident was coded as having verbal behavioral symptom directed towards others four to six days of the lookback period but not daily.The nurse's note dated 3/29/25 at 3:29 p.m. documented, Resident has been agitated and verbally inappropriate to staff this shift. Resident came up to med (medication) cart crying and stated that she was going through withdrawal, and she felt like she was dying and couldn't do this anymore. DON (director of nursing), NP (nurse practitioner), Police and EMS (emergency medical services) notified. Resident refused to cooperate with all party's (sic) involved.The physician order dated 3/5/25, documented, Fentanyl Transdermal Patch (1) 72 Hours 75 MCG/HR (micrograms per hour); apply 1 patch every 3 days for chronic pain replace after 3 days and remove per schedule. The March 2025 MAR (medication administration record) documented the above order. The MAR documented the medication was administered on 3/17/25. For 3/20/25 it was documented the patch was removed but for the administration it was documented a 9 which indicates, Other/See Nurse Notes. For 3/23/25, there were 9 document for the removal and administration of the Fentanyl. For 3/26/25, there was a 9 documented for the removal and administration of the Fentanyl.The nurse's note dated 3/20/25 at 3:36 p.m. documented in part, Fentanyl.none acaaiable (sic)(applicable), np (nurse practitioner) to write script.The nurse's note dated 3/23/25 at 5:04 p.m. documented in part, Fentanyl . dc/d (discontinued) new order placed.There was no nurse's note dated 3/26/25 related to the Fentanyl.The narcotic sign-off sheet dated 3/4/25, documented the administration of the Fentanyl patch on 3/17/25. The narcotic sheet was dated 3/29/25, documented the administration of the Fentanyl on 3/29/25. There was no record of administration of Fentanyl on a narcotic sheet between 3/17/25 and 3/29/25, a period of 12 days. The Clinical Opioid Withdrawal Score (COWS) dated 3/29/25 at 6:10 p.m., documented the resident scored a 0 on the assessment. A score greater than eight requires treatment in the emergency room.The nurse's note dated 3/29/25 at 7:33 p.m. documented, LATE ENTRY: Resident in NAD/[NAME] (no acute distress/no acute respiratory distress). Sitting in w/c (wheelchair) conversing other residents. Vital signs obtained. 100/64 (blood pressure), 80 (heart rate), 98.1 (temperature), 96% (oxygen saturation rate) RA (room air), 16 (respirations) even and unlabored, 0/10 (no pain on a scale of 0 - 10 ten being the worse pain ever in) pain. Resident assessed for Opiate withdrawal (COWS). Residents (sic) total score = 0. She is cooperative with assessment. Affect congruent.The social services note dated, 3/29/25 at 8:00 p.m. documented, LATE ENTRY: f/u (follow up) with resident after recent incident. Resident says she is fine but not happy. Offered AG (assisted living) grant and let her know it is an option to be in an assisted living vs (versus) nursing home. She stated she 'will think about it.The comprehensive care plan dated, 8/2/24, and revised on 11/6/24, documented in part, Focus: (R2) reports episodes of having night terrors. Interventions: Administer medications per order. Observe for objective and subjective for increase in night terrors and report to MD/NP (medical doctor/nurse practitioner). Psych (psychological) consult as needed. 4/4/25 - Focus: (R2) has the potential for altered psychosocial well-being r/t PTSD. She has voiced c/o night terrors r/t (related to) traumatic hospitalization resulting in coma. She is followed by house psych and (name of community service board - CCB) outside of the facility. She has exercised her right to not allow facility to have visit notes and information from the CCB. Interventions: Counseling as indicated. If conflict arises, remove resident to calm |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>(continued on next page) |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to ensure discharge needs were met for one of 16 residents in the survey sample, Resident #4.The findings include:For Resident #4 (R4), the facility staff failed to evidence 1) that written discharge instructions were given to the resident, 2) that home medications were arranged prior to discharge and 3) that the resident was given provider information that included standardized patient assessment data, and information on quality measures and resource use (where that data is available) to choose a home health provider prior to discharge.On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/29/2024, the resident was assessed as being cognitively intact for making daily decisions.The resident admission demographic information documented R4 being their own responsible party with contact information listed for their spouse under contacts. The demographic information documented the discharge date of 8/12/2024.The progress notes for R4 documented in part, 07/12/2024 11:27 Note Text: Care Plan held in person with spouse and patient. Reviewed by IDT (interdisciplinary team) team. Patient will discharge back home with spouse. Spouse has no questions or concerns. Patient is a full code. 08/02/2024 11:36 Note Text: ABN/NOMNC (Advance Beneficiary Notice of non-coverage/Notice of Medicare non-coverage) issued for OT (occupational therapy). He is min (minimal) assist for ADLs (activities of daily living) and last cover day is 8/5. 08/12/2024 14:58 (2:58 p.m.) Note Text: Rec'd (received) denial notification from [Name of insurance]- patient LCD (last covered day) was 8/9/24. Spoke with spouse- she states she will be picking him up this evening. Referral has been made for therapies/aide/SN (skilled nursing). 08/13/2024 08:51 Note Text: [Name of home health] accepted patient for PT (physical therapy), OT (occupational therapy), SN, Aide. They will contact him/spouse for SOC (start of care). Meds to be sent today to [Name of pharmacy]. 08/13/2024 10:48 Note Text: Called to follow up. Left a VM (voice mail) regarding [Name of home health] accepting to continue therapies and medications faxed to [Name and location of pharmacy].Review of the progress notes failed to evidence a note documenting the discharge from the facility, a review of the discharge instructions or review of the home medications with R4 or their family on 8/12/2024.Review of the clinical record documented a discharge plan and instructions with an effective date of 8/12/2024 electronically signed on 8/13/2024. The Nursing Discharge Summary was observed to be blank. The Social Services Discharge Summary documented, Patient discharging home with wife. [Name of home health] to follow up to continue therapies at the home. Medications to be sent to [Name and location of pharmacy]. Wife to make a follow up appointment with PCP (primary care provider). The discharge plan and instructions failed to evidence review with R4 or their family on 8/12/2024 or a copy provided to the resident at discharge. The discharge instructions included a fax confirmation with a referral sent to the home health agency on 8/12/24 at 2:57 p.m. Attached pre-printed prescriptions hand-signed by the nurse practitioner documented an order date of 8/12/2024.On 9/24/2025 at 3:38 p.m., an interview was conducted with OSM (other staff member) #5, the interim director of rehab who stated that discharge planning was ongoing with social services, the resident and the family for the skilled residents. She stated that after the initial evaluation, it depended on the resident and the family how often they communicated with them, but they did it at least weekly to discuss progress and the potential discharge from services. OSM #5 stated that during morning meetings they discussed discharge plans with social services who involved the family to make sure they were safe at home. She stated that when the resident was discharged from therapy they always referred them to home health, and they gave social services an estimated discharge date but did not wait for the meeting to start the discharge planning. She stated that social services handled all of the referrals for home health, and she thought it was done prior to discharge.On 9/24/2025 at 4:56 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing, who stated that nursing completed a portion of the discharge instructions and at the time of discharge the nurse printed off the instructions, reviewed them with the resident and had them sign it. She stated that they kept a copy of the signed discharge instructions, and she assumed it was scanned in the medical record after discharge. ASM #2 stated that the discharging nurse should make a note in the clinical record documenting that they reviewed the discharge instructions and provided education on the home medications. On 9/25/2025 at 8:49 a.m., an interview was conducted with OSM #1, the director of social services. OSM #1 stated that she recalled having a conversation with R4's spouse during a care plan meeting about the discharge plan. She stated that she had set up home health for R4 on 8/12/2024 and had tried to contact them after discharge but |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to develop a baseline care plan for one of 16 residents in the survey sample, Resident #3. The findings include:For Resident #3 (R3), the facility staff failed to develop a baseline care plan.The nursing admission assessment for R3 dated 1/23/2025 documented the resident admitted with a PICC (peripherally inserted central catheter) access, always being incontinent of bowel and bladder, having multiple wounds present on admission, a colostomy, and taking insulin.Review of the clinical record failed to evidence a baseline care plan developed within 48 hours of R3's admission of 1/23/2025.On 9/24/2025 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that the baseline care plan was developed by the admitting nurse. She stated that the purpose of the care plan was to give them a place to go to see how to take care of the residents. She stated that the admitting nurse would put things in the care plan like diet, ability to move, behaviors, catheters, and colostomy. LPN #2 stated that she was not sure if the PICC line would be on the baseline care plan or not, but it should be a quick overview of what they need to take care of the resident. On 9/25/2025 at approximately 9:25 a.m., ASM (administrative staff member) #1, the administrator, stated that they did not have a baseline care plan for R3 to provide.The facility policy Baseline Care Plan dated 6/1/2025 documented in part, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will: Be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: Initial goals based on admission orders. Physician orders. Dietary orders.On 9/25/2025 at 4:58 p.m., ASM #1, the administrator, was made aware of the concern.No further information was provided prior to exit. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, clinical record review and facility document review, facility staff failed implement the comprehensive care plan for six of 16 current residents in the survey sample, Residents #10 (R10), R11, #7, #2, #3 and #6. The findings include:1. For R10, facility staff failed to provide a smoking apron while smoking a cigarette on the locked Dogwood unit.<br><br>R10 was admitted to the facility with diagnosis that included but not limited to nicotine dependence.<br><br>On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 07/23/2025, R10 scored 9 (nine) out of 15 on the BIMS (brief interview for mental status), indicating the R10 was moderately impaired of cognition for making daily decisions.<br><br>On 09/23/2025 at approximately 10:18 a.m. an observation of R10 was conducted on the locked Dogwood unit. R10 was in a wheelchair, carrying a “Fanny Pak” and observed going outside to the enclosed patio area on the locked Dogwood unit independently. Further observations revealed R10 removing a lighter from the “Fanny Pak”, lighting a cigarette then lighting R11's cigarette. Further observations failed to evidence R10 with a smoking apron while smoking a cigarette.<br><br>At 11:36 a.m., Resident #10 (R10) was observed outside, at 11:37 a.m., R10 was observed taking a cigarette out and lighting it with a lighter that was on his person. R10 proceeded to smoke unsupervised with no staff present in the courtyard area. Further observations failed to evidence a smoking apron for R10.<br><br>The facility's “Smoking Evaluation” dated 04/10/2025 for R10 documented in part, “Comments/Adaptive equipment needed (if applicable): Utilize an apron while smoking.”<br><br>The comprehensive care plan for R10 dated 07/19/2023 documented in part, “Focus. Mr. [NAME] is a smoker. Date Initiated: 07/19/2023.” Under “Interventions” it documented in part, “Observe clothing, use smoking apron and skin for signs of cigarette burns. Date Initiated: 07/19/2023. ”<br><br>On 9/24/25 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that the purpose of the care plan was to make sure they had a generalized location to show how to take care of residents that they were not familiar with. She stated that they implemented the care plan by looking at it and making sure any changes were communicated to the CNAs (certified nursing assistants) as they were noted or communicated to them.<br><br>The facility's policy “Comprehensive Care Plans” documented in part, “It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 9/25/2025 at approximately 4:58 p.m. ASM (administrative staff member) #1, the executive director, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, were made aware of the above findings.<br><br>No further information was provided prior to exit.<br><br>2. For R11, facility staff failed to provide a smoking apron and direct supervision while smoking a cigarette on the locked Dogwood unit.<br><br>R11 was admitted to the facility with diagnosis that included but not limited to dementia (1) and hearing loss.<br><br>On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 08/23/2025, R11 scored 4 (four) out of 15 on the BIMS (brief interview for mental status), indicating the R11 was severely impaired of cognition for making daily decisions.<br><br>On 09/23/2025 at approximately 9:53 a.m. an observation of R11 was conducted on the locked Dogwood unit. R11 was observed in the dayroom sitting in a rocking chair with an unlit cigarette in her right hand up to her mouth. At approximately 10:18 a.m. an observation revealed R11 going outside to the enclosed patio area on the locked Dogwood unit independently followed by R10. Observations also revealed R10 taking a cigarette lighter from his “Fanny Pak”, lighting R10's cigarette while CNA #1 was standing and talking to R10 and R11. Further observations failed to evidence a smoking apron for R11.<br><br>On 9/23/25 at 11:28 a.m. Resident #11 (R11) was observed outside in the courtyard sitting in a chair with a walker and personal belongings in front of her. At 11:36 a.m., R10 was observed outside, at 11:37 a.m., R10 was observed taking a cigarette out and lighting it with a lighter that was on his person. R11 ambulated with her rolling walker over to R10 who proceeded to light a cigarette for her. R11 proceeded to smoke unsupervised with no staff present in the courtyard area. R11 was observed lighting a second partially smoked cigarette with the first cigarette. R11 proceeded to smoke some of the second cigarette and extinguish it into a plastic spoon and store the partially smoked cigarette into the storage pocket of the rolling walker. Further observations failed to evidence a smoking apron for R11.<br><br>The comprehensive care plan for R11 dated 08/20/2024 documented in part, “Focus. (R11) is an unsafe smoker. Date Initiated: 08/20/2024.” Under “Interventions” it documented in part, “She requires a smoking apron while smoking. Date Initiated: 08/20/2024, She requires direct SUPERVISION while smoking. Date Initiated: 08/20/2024.”<br><br>On 9/25/2025 at approximately 4:58 p.m. ASM (administrative staff member) #1, the executive director, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, were made aware of the above findings.<br><br>No further information was provided prior to exit.<br><br>3. For Resident #7 (R7), the facility staff failed to implement the resident's comprehensive care plan for antipsychotic medication administration.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R7's comprehensive care plan dated 4/25/24 documented, (R7) is on antipsychotic therapy r/t (related to) Undifferentiated Schizophrenia. Administer antipsychotic medications as ordered by physician.<br><br>A review of R7's clinical record revealed a physician's order dated 3/14/25 for Ziprasidone (an antipsychotic medication) 60mg (milligrams). One capsule by mouth every morning and at bedtime for schizophrenia.<br><br>A review of R7's MARs (medication administration records) for July 2025 through September 2025 failed to reveal evidence the morning dose of Ziprasidone was administered on 7/21/25, 7/22/25, 7/23/25, 7/24/25, 7/26/25, and 8/11/25, and failed to reveal evidence the bedtime dose of Ziprasidone was administered on 7/21/25, 7/22/25, 7/23/25, 7/24/25, 7/26/25, 7/28/25, 9/15/25, 9/16/25, 9/17/25, and 9/18/25.<br><br>On 9/24/25 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated the purpose of the care plan is to make sure staff have a generalized location of where they are able to go, look, and learn how to take care of residents if they are not familiar with the residents. LPN #2 stated nurses evidence the administration of medications by documenting the medications were administered on the MAR.<br><br>On 9/25/25 at 4:59 p.m., ASM (administrative staff member) #1 (the executive director) was made aware of the above concern.<br><br>No further information was presented prior to exit.<br><br>4a. For Resident #2 (R2), the facility staff failed to implement the care plan for the administration of medications.<br><br>The comprehensive care plan dated, 7/23/24, documented in part, “Focus: (R2) has hypertension. Interventions: Give anti-hypertensive medications as ordered. Focus: (R2) has altered cardiovascular status r/t (relate to) HTN, HLD (high blood pressure and hyperlipidemia). Focus: (R2) has Diabetes Mellitus. Interventions: Diabetes medications as ordered by doctor. Focus: (R2) has constipation. Focus: (R2) is on pain medication therapy r/t chronic arthritis. Interventions: Administer ANALGESIC medications as ordered by physician. Focus: (R2) is on antiplatelet therapy r/t cerebrovascular disease. Interventions: Administer antiplatelet medications as ordered by physician. Focus: (R2) has potential for pain r/t arthritis, right wrist pain/muscle spasms, migraine. Interventions: Administer analgesia as per orders.”<br><br>The physician order dated 7/30/25, documented:<br><br>1. Atorvastatin Calcium Oral Tablet (1) 80 MG (milligrams); Give 80 mg by mouth at bedtime related to hyperlipidemia.<br><br>2. Clopidogrel Bisulfate Oral Tablet (2) 75 MG; Give 75 mg by mouth at bedtime related to Personal history of transient ischemic attach (TIA) and cerebral infarction without residual deficit.<br><br>3. Edarbyclor Oral Tablet (3) 40-25 MG; Give 1 tablet by mouth at bedtime related to essential hypertension (high blood pressure).<br><br>(continued on next page) |

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| | 495315 | A. Building<br>B. Wing | 09/26/2025 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. Miralax Oral Powder (4) 17GM (grams)/scoop; Give 1 scoop by mouth one time a day for constipation.<br><br>5. Gabapentin Oral Capsule (7) 300 MG; Give 2 capsules by mouth every 12 hours for neuropathy related to type 2 diabetes mellitus with other diabetic neuropathy.<br><br>6. Insulin Lispro Injection Solution (9) inject as per sliding scale: if 151-200 = 4 units; 201-250 = 6 units; 251 -300 = 8 units; 301-350 = 10 units; 351-400 = 12 units, over 400 call MD, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with other diabetic neurological complications.<br><br>Review of the Medication Administration Record (MAR) for September 2025 documented the above order. On 9/17/25 and 9/18/25 at the 9:00 p.m. doses of the above medication orders, the MAR was blank.<br><br>Review of the nurse's notes for 9/17/25 and 9/18/25, failed to evidence documentation related to the medications not being administered.<br><br>An interview was conducted with LPN (licensed practical nurse) #1 on 9/24/25 at 11:47 a.m. LPN #1 stated the purpose of the care plan is it is how we are going to care for the resident and it should be followed.<br><br>ASM (administrative staff member) #1, the executive director, and ASM #6, the vice president of operations, were made aware of the above concern on 9/24/25 at 5:32 p.m.<br><br>No further information was obtained prior to exit.<br><br>References:<br><br>1. Atorvastatin is also used to decrease the amount of fatty substances such as low-density lipoprotein (LDL) cholesterol ('bad cholesterol') and triglycerides in the blood and to increase the amount of high-density lipoprotein (HDL) cholesterol ('good cholesterol') in the blood. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a60004.html<br><br>2. Clopidogrel is used alone or with aspirin to prevent serious or life-threatening problems with the heart and blood vessels in people who have had a stroke, heart attack, or severe chest pain. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601040.html<br><br>3. Edarbyclor is used alone or in combination with other medications to treat high blood pressure. This information was obtained from the following website: https://medlineplus.gov/druginfo /meds/a611028.html<br><br>4. Miralax is used to treat occasional constipation. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a603032<br><br>5. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/ a694007.html<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 6. Insulin lispro injection products are also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697021<br><br>4b. For Resident #2 (R2), the facility staff failed to implement the comprehensive care plan for the administration of a wound treatment.<br><br>The comprehensive care plan dated, 8/13/25, documented in part, “Focus: has a surgical wound of the abd (abdomen) from debridement and irrigation of abd tissue r/t (related to) necrotizing fasciitis. Interventions: Administer treatments as ordered.”<br><br>The physician order dated, 8/31/25, documented, “Cleanse ABD (abdominal) wound with wound cleanser, apply hydrofera blue and dry drsg (dressing) every three days at bedtime every 3 days for wound care.”<br><br>The September 2025 Treatment Administration Record (TAR) documented the above order. The TAR documented the treatment was administered on 9/6/25 and 9/9/25. On 9/12/25 a “9” was documented. For 9/15/25, 9/18/25 and 9/21/25, the box where the nurse documents the treatment having been done was blank.<br><br>The nurse's note dated 9/12/25 at 11:09 p.m. documented in part, “Patient wants treatment done tomorrow after she gets a shower.” There was no further documentation on the TAR or nurse's notes that the treatment was done on 9/13/25. Further review of the nurse's notes failed to evidence any documentation for 9/15/25, 9/18/25 or 9/21/25.<br><br>An interview was conducted with LPN (licensed practical nurse) #1 on 9/24/25 at 11:47 a.m. LPN #1 stated the purpose of the care plan is it is how we are going to care for the resident and it should be followed.<br><br>ASM (administrative staff member) #1, the executive director, and ASM #6, the vice president of operations, were made aware of the above concern on 9/24/25 at 5:32 p.m.<br><br>No further information was obtained prior to exit.<br><br>References:<br><br>1. Hydrofera Blue® creates a multifaceted, non-toxic environment for wound healing. Hydrofera Blue's unique capillary action continuously pulls harmful bacteria- laden slough, exudate, and debris away from the wound bed. This information was obtained from the following website: https://hydrofera.com/why-blue/<br><br>5) For Resident #3 (R3), the facility staff failed to A) implement the comprehensive care plan to administer medication as ordered during dates in February and April of 2025 and B) to provide treatments to pressure injuries as ordered during dates in January and February of 2025.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/28/2025, the resident was assessed as receiving medications including insulin, antibiotic, diuretic, opioid, antiplatelet and hypoglycemic medication. Section M documented R3 having three Stage 3 pressure injuries and two Stage 2 pressure injuries that were present on admission.<br><br>A) The comprehensive care plan for R3 documented in part,<br><br>“[Name of R3] has impaired cognitive function and/or impaired thought processes r/t (related to) recent hospitalization for sepsis, metabolic encephalopathy. Date Initiated: 02/03/2025.” Under “Interventions” it documented in part, “… Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 02/03/2025…”<br><br>“[Name of R3] has potential for fluid deficit r/t Diuretic use, Poor intake. Date Initiated: 02/03/2025. ” Under “Interventions” it documented in part, “Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 02/03/2025…”<br><br>“[Name of R3] has Diabetes Mellitus. Date Initiated: 02/03/2025.” Under “Interventions” it documented in part, “…Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Date Initiated: 02/03/2025…”<br><br>“[Name of R3] has anemia r/t iron deficiency. Date Initiated: 02/03/2025.” Under “Interventions” it documented in part, “…Give medications as ordered. Monitor for side effects, effectiveness. Date Initiated: 02/03/2025…”<br><br>Review of the eMAR (electronic medication administration record) for R3 dated 2/1/25-2/28/25 failed to evidence administration of the following medication on the dates listed below:<br><br>Daptomycin-Sodium Chloride Intravenous Solution 500-0.9 MG (milligram)/50ML (milliliter)-% (Daptomycin-Sodium Chloride) Use 500 mg intravenously in the morning related to Sepsis, Unspecified Organism. On 2/9/25 and 2/21/25. The eMAR for 2/9/25 was observed to be blank and 2/21/25 eMAR progress note documented “ordered call to pharmacy.”<br><br>Epoetin Alfa-epbx Injection Solution 40000 UNIT/ML (Epoetin Alfa-epbx) Inject 1 ml subcutaneously one time a day every Fri for Anemia of Chronic disease. On 2/14/25. The eMAR progress note documented “Not available in omni cell, awaiting from pharmacy.<br><br>Gabapentin Oral Capsule 100 MG (Gabapentin) Give 4 capsule by mouth in the morning for Neuropathy related to Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified. Take 2 capsules twice daily. On 2/22/25, 2/23/25 and 2/24/25. The eMAR progress note dated 2/22/25 documented “on order”, 2/23/25 “pharmacy to send” and 2/24/25 “pharmacy contacted.”<br><br>Gabapentin Oral Capsule 100 MG (Gabapentin) Give 8 capsule by mouth at bedtime for neuropathy. On 2/21/25, 2/22/25 and 2/23/25. The eMAR progress note dated 2/21/25 and 2/22/25 documented “on order.” The eMAR progress note dated 2/23/25 documented “pharmacy to send.”<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Neurontin Oral Capsule 400 MG (Gabapentin) Give 2 capsule by mouth every morning and at bedtime for neuropathy. On 2/27/25. The eMAR progress note dated 2/27/25 documented “on order.”<br><br>Insulin Glargine Subcutaneous Solution (Insulin Glargine) Inject 8 unit subcutaneously in the morning related to Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified. On 2/9/25, the eMAR was observed to be blank.<br><br>Review of the eMAR for R3 dated 4/1/25-4/30/25 failed to evidence administration of the following medication on the dates listed below:<br><br>Spironolactone Oral Tablet 25 MG (Spironolactone) Give 1 tablet by mouth in the morning every Mon, Wed, Fri for Heart Failure. (to treat fluid retention) (8) On 4/4/25 and 4/7/25 the eMAR progress notes documented, “ordered.” It failed to evidence notification of the physician of the medication not being administered.<br><br>On 9/24/2025 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that the purpose of the care plan was to make sure they had a generalized location to show how to take care of residents that they were not familiar with. She stated that they implemented the care plan by looking at it and making sure any changes were communicated to the CNAs (certified nursing assistants) as they were noted or communicated to them. LPN #2 stated that medications were evidenced as given by documentation in the eMAR and if medication was not available on the medication cart they checked the Omnicell stock and if not there they called the pharmacy to see when it would be available.<br><br>B) The comprehensive care plan for R3 documented in part, “[Name of R3] has pressure injury to left ischium r/t decreased mobility, occasional bladder incontinence, history of radiation and chemotherapy r/t rectal cancer, poor nutrition, Non-compliance with treatment and regimen. Date Initiated: 02/03/2025.” Under “Interventions” it documented in part, “Administer treatments as ordered and monitor for effectiveness. Date Initiated: 02/03/2025…”<br><br>Review of the eTAR (electronic treatment administration record) for R3 dated 1/1/25-1/31/25 failed to evidence treatments completed on the following dates:<br><br>Clean all wounds on buttocks with wound cleanser, apply skin prep to outer edges of wounds. Soak gauze in Dakin's solution, put gauze into wounds, squeeze out excess liquid, cover with foam dressings every day shift every 3 day(s). On 1/27/25 the eTAR was observed to be blank.<br><br>Review of the eTAR for R3 dated 2/1/25-2/28/25 failed to evidence treatments completed on the following dates:<br><br>Gentamicin Sulfate External Ointment 0.1 % (Gentamicin Sulfate (Topical)) Apply to sacrum, L + R ischium topically one time a day for pseudomonas infection for 2 Weeks. On 2/4/25, 2/6/25, and 2/7/25. The dates were observed to be blank.<br><br>Wound care for left ischium, right ischium, sacrum. Cleanse with wound cleanser, pat dry. Apply gentamicin 0.1% ointment to wound bed, then apply calcium alginate to wound bed. Cover with foam dressing QD (every day) and change PRN (as needed) for saturation/soilage every day shift. On 2/4/25, 2/6/25, 2/7/25, 2/13/25, and 2/17/25 the eTAR was observed to be blank.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Wound care order for left heel Cleanse with wound cleanser, apply calcium alginate, cover with foam dressing QD every day shift for Wound Care. On 2/4/25, 2/6/25, 2/7/25, 2/13/25, and 2/17/25 the eTAR was observed to be blank.<br><br>Wound care order for right heel Cleanse with wound cleanser, pat dry, apply skin prep QD. OFFLOAD with boot or heelz up pillow one time a day. On 2/4/25, 2/6/25, 2/7/25, 2/13/25, and 2/17/25 the eTAR was observed to be blank.<br><br>The clinical record failed to evidence documentation regarding the missed treatments on the dates listed above in January and February of 2025.<br><br>On 9/24/2025 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that the purpose of the care plan was to make sure they had a generalized location to show how to take care of residents that they were not familiar with. She stated that they implemented the care plan by looking at it and making sure any changes were communicated to the CNAs (certified nursing assistants) as they were noted or communicated to them. LPN #2 stated that treatments were evidenced as completed by documentation in the eTAR.<br><br>On 9/25/2025 at 4:58 p.m., ASM (administrative staff member) #1, the administrator, was made aware of the concern.<br><br>No further information was provided prior to exit.<br><br>6) For Resident #6 (R6), the facility staff failed to implement the comprehensive care plan to provide treatments for a pressure injury on multiple dates in July, August and September 2025 and failed to complete weekly assessments that included measurement and description of wound progress.<br><br>On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 8/13/25, the resident was assessed as having one unstageable pressure injury that was not present on admission or reentry.<br><br>The comprehensive care plan for R6 documented in part, “[Name of R6] has unstageable pressure injury to the coccyx r/t (related to) poor mobility, incontinence. Date Initiated: 08/14/2019.” Under “Interventions” it documented in part, “Administer treatments as ordered and monitor for effectiveness. Date Initiated: 05/14/2025. Assess/record/monitor wound healing. Date Initiated: 05/14/2025… Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Date Initiated: 05/14/2025.”<br><br>Review of the clinical record documented skin assessments documenting presence of the wound and continued wound treatments but failed to evidence weekly measurements of the pressure injury including width, length, depth, type of tissue and exudate described.<br><br>Review of the eTAR (electronic treatment record) for R6 dated 7/1/25-7/31/25 failed to evidence treatments completed to the coccyx pressure injury on 7/3/25, 7/21/25, 7/22/25, 7/23/25, 7/24/25 and 7/25/25. The dates were observed to be blank.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the eTAR for R6 dated 8/1/25-8/31/25 failed to evidence treatment completed to the coccyx pressure injury on 8/23/25. The date was observed to be blank.<br><br>Review of the eTAR for R6 dated 9/1/25-9/30/25 failed to evidence treatments completed to the coccyx pressure injury on 9/5/25 and 9/20/25. The dates were observed to be blank.<br><br>The clinical record failed to evidence documentation regarding the missed treatments on the dates listed above in July, August and September of 2025.<br><br>On 9/24/2025 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that the purpose of the care plan was to make sure they had a generalized location to show how to take care of residents that they were not familiar with. She stated that they implemented the care plan by looking at it and making sure any changes were communicated to the CNAs (certified nursing assistants) as they were noted or communicated to them. LPN #2 stated that treatments were evidenced as completed by documentation in the eTAR. She stated that the facility formerly had a wound care nurse practitioner who came in weekly and assessed residents pressure injuries, measuring them and adjusting treatments as needed but they did not come there any longer. She stated that she had been on night shift and was not sure of the current process but if a new wound was reported to her she asked a nurse trained in wounds to measure it and referred it to the physician for treatment.<br><br>On 9/24/2025 at 4:56 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing who stated that the former assistant director of nursing used to keep a log sheet where she tracked pressure injuries and measured them weekly but had stepped down from the position. She stated that there was an assessment that they could complete in the electronic medical record to record their assessments but there had been a lapse due to the assistant director stepping down, and the wound nurse practitioner leaving. She stated that she could say that after the assistant director of nursing stepped down there was a period when there was a gap in tracking and measuring but they had a new doctor who started last week to assist them. ASM #2 stated that R6 was non-compliant with repositioning and tended to lay flat on her back or on the left side.<br><br>On 9/25/2025 at 4:58 p.m., ASM #1, the administrator, was made aware of the concern.<br><br>No further information was provided prior to exit. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice for two of 16 residents in the survey sample, Residents #1, and #3. The findings include:1. For Resident #1 (R1), the facility staff failed to obtain the physician's authorization to transcribe orders for tramadol and oxycodone. Back dated orders were written on 8/19/25 for 8/10/25 and the physician was unaware of this.<br><br>A review of R1's clinical record revealed the following physician's orders:<br><br>5/18/25-tramadol 50mg (milligrams). One tablet by mouth every four hours as needed for pain.<br><br>6/19/25-oxycodone 5mg. One tablet every six hours as needed for pain.<br><br>R1 was transferred to the hospital on 7/29/25. R1 returned to the facility on 8/4/25 and the orders for tramadol and oxycodone were discontinued on that date.<br><br>A review of R1's controlled medication utilization records revealed the resident was administered one tablet of tramadol 50mg on 8/10/25 at 9:15 a.m. and one tablet of oxycodone 5mg on 8/10/25 at 11:30 a.m. A review of R1's August 2025 physician's orders and August 2025 MAR (medication administration record) revealed there were no orders on 8/10/25 for tramadol or oxycodone (until back dated orders were created in the computer system on 8/19/25).<br><br>A physician's order dated 8/10/25 and created on 8/19/25 by RN (registered nurse) #1 documented an order for oxycodone 5mg by mouth as needed for pain. Give a one-time dose. The order documented the medication was ordered by ASM (administrative staff member) #3 (R1's physician). A physician's order dated 8/10/25 and created on 8/19/25 by RN #1 documented an order for tramadol 50mg as needed by mouth times one dose. The order documented the medication was ordered by ASM (administrative staff member) #3 (R1's physician). A nurse's note with an effective date of 8/10/25 and created by RN #1 on 8/19/25 documented, Received order to give resident 50 mg po (by mouth) tramadol x (times) 1 dose, if ineffective give oxycodone 5 mg x 1 dose, VTO (verbal telephone order) (name of ASM #3).<br><br>On 9/23/25 at 11:06 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that on 8/10/25, there were no tramadol or oxycodone orders for R1 in the computer system but there were tramadol and oxycodone medication cards with R1's name in the medication cart. RN #1 stated she incorrectly assumed the medications were prescribed for R1, so she administered the medications. RN #1 stated she did not directly talk to ASM #3 about this matter. RN #1 stated she entered the back dated orders into the computer system because someone from nursing management told her they spoke with ASM #3 who said he approved and to go ahead and enter the orders into the system.<br><br>On 9/23/25 at 12:25 p.m., an interview was conducted with ASM #3. ASM #3 stated he did not remember anyone asking, or him approving orders for R1 to be administered one-time doses of tramadol or oxycodone for when the resident was administered the medications on 8/10/25.<br><br>On 9/24/25 at 4:58 p.m., an interview was conducted with LPN #1 (the staff development coordinator). LPN #1 stated she talked to ASM #3 about R1 but did not remember the conversation or recall information regarding late tramadol or oxycodone orders put into the computer system.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495315 | A. Building<br>B. Wing | 09/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Woodstock Valley Health and Rehabilitation | 803 South Main St<br>Woodstock, VA 22664 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 9/24/25 at 5:22 p.m., an interview was conducted with ASM #2 (the director of nursing). ASM #2 stated she was not involved in R1's late tramadol or oxycodone orders being put into the computer system.<br><br>On 9/25/25 at 4:59 p.m., ASM #1 (the executive director) was made aware of the above concern.<br><br>The facility policy titled, Physician Orders documented, The center will ensure that Physician orders are appropriately and timely documented in the medical record .The ordering physician or physician extender will review and confirm orders.<br><br>No further information was presented prior to exit.<br><br>2) For Resident #3 (R3), the facility staff failed to follow professional standards of practice of medication administration for administration of Carvedilol (to treat heart failure and high blood pressure) (1) and Entresto (to treat heart failure) (2).<br><br>On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/28/2025, the resident was assessed as being cognitively intact for making daily decisions. It documented no behaviors, no refusals of care and diagnoses that included but were not limited to hypertension, diabetes, and heart failure.<br><br>Review of the eMAR (electronic medication administration record) for R3 dated 3/1/25-3/31/25 failed to evidence administration of the following medication on the dates listed below:<br><br>Carvedilol Oral Tablet 12.5 MG (Carvedilol) Give 1 tablet by mouth two times a day for Heart Failure. On 3/30/25 at 5:00 p.m. the eMAR documented a code “7”, the eMAR chart codes documented “7=sleeping.” It failed to evidence additional attempts to administer the medication or notification of the physician of the medication not administered.<br><br>Entresto Oral Tablet 49-51 MG (Sacubitril-Valsartan) Give 1 tablet by mouth two times a day for DMT2 (diabetes mellitus type 2). On 3/30/25 at 5:00 p.m. the eMAR documented a code “7”, the eMAR chart codes documented “7=sleeping.” It failed to evidence additional attempts to administer the medication or notification of the physician of the medication not administered.<br><br>Review of the physician orders documented orders for the medications listed above. The orders failed to evidence guidance to hold the medication if the resident was sleeping.<br><br>On 9/24/2025 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that medications were evidenced as given by documentation in the eMAR. LPN #2 stated that if a resident was sleeping when she came in with their medications she would come back at the end of her med pass to try again. She stated that for medications like Entresto and Coreg she would wake the resident up because they were important unless there was a physician order to hold them when sleeping. LPN #2 stated that the physician should be notified when medications are held.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | According to Fundamentals of Nursing, 8th edition, [NAME] & [NAME], pg. 589 documented in part, .In promoting or maintaining a patient's health, the nurse identifies factors that improve or diminish well-being . Several nursing interventions promote adherence to the medication regimen and foster independence. Teach the patient and family about the benefit of a medication and the knowledge needed to take it correctly and integrate the patient's health beliefs and cultural practices into the treatment plan .Patients need to know how to take medications properly and the risks associated with failing to do so .<br><br>On 9/25/2025 at 4:58 p.m., ASM (administrative staff member) #1, the administrator, was made aware of the concern.<br><br>No further information was provided prior to exit.<br><br>Reference:<br><br>(1) Carvedilol: MedlinePlus Drug Information<br><br>(2) Valsartan and Sacubitril: MedlinePlus Drug Information |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to administer medications and treatment per the physician's orders for three of 16 residents in the survey sample, Residents #3, #2 and #7.The findings include:1) For Resident #3 (R3), the facility staff failed to administer medication as ordered during dates in February and April of 2025.<br><br>On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/28/2025, the resident was assessed as receiving medications including insulin, antibiotic, diuretic, opioid, antiplatelet and hypoglycemic medication.<br><br>Review of the eMAR (electronic medication administration record) for R3 dated 2/1/25-2/28/25 failed to evidence administration of the following medication on the dates listed below:<br><br>Gabapentin Oral Capsule 100 MG (Gabapentin) Give 4 capsule by mouth in the morning for Neuropathy related to Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified. (to treat seizures/nerve pain) (1). Take 2 capsules twice daily. On 2/22/25, 2/23/25 and 2/24/25. The eMAR progress note dated 2/22/25 documented “on order”, 2/23/25 documented “pharmacy to send” and 2/24/25 documented “pharmacy contacted.”<br><br>Gabapentin Oral Capsule 100 MG (Gabapentin) Give 8 capsule by mouth at bedtime for neuropathy. On 2/21/25, 2/22/25 and 2/23/25. The eMAR progress note dated 2/21/25 and 2/22/25 documented “on order.” The eMAR progress note dated 2/23/25 documented “pharmacy to send.”<br><br>Neurontin Oral Capsule 400 MG (Gabapentin) Give 2 capsule by mouth every morning and at bedtime for neuropathy. On 2/27/25., the eMAR progress note documented “on order.”<br><br>Insulin Glargine Subcutaneous Solution (Insulin Glargine) Inject 8 unit subcutaneously in the morning related to Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified. (to treat diabetes) (2). On 2/9/25, the eMAR was observed to be blank.<br><br>Review of the eMAR for R3 dated 4/1/25-4/30/25 failed to evidence administration of the following medication on the dates listed below:<br><br>Spironolactone Oral Tablet 25 MG (Spironolactone) Give 1 tablet by mouth in the morning every Mon, Wed, Fri for Heart Failure. (to treat fluid retention) (3) On 4/4/25 and 4/7/25 the eMAR progress notes documented, “ordered.”<br><br>On 9/24/2025 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that medications were evidenced as given by documentation in the eMAR and if medication was not available on the medication cart they checked the Omnicell stock (in house stocked medication) to see if the medication was in there for them to pull out and administer.<br><br>Review of the facility provided Omnicell inventory list dated 9/23/25, documented Gabapentin 100mg stocked with a par level of 10 capsules, Gabapentin 400mg stocked with a par level of 10 capsules, Lantus Solostar 100 unit/ml stocked with a par level of two vials, and Spironolactone 25mg stocked with a par level of 10 tablets.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility policy “Medication Administration” dated 6/1/2025 documented in part, “Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection… Policy Explanation and Compliance Guidelines: Administer medication as ordered in accordance with manufacturer specifications .”<br><br>On 9/25/2025 at 4:58 p.m., ASM (administrative staff member) #1, the administrator, was made aware of the concern.<br><br>No further information was provided prior to exit.<br><br>Reference:<br><br>(1) Gabapentin: MedlinePlus Drug Information<br><br>(2) Insulin Glargine (rDNA origin) Injection: MedlinePlus Drug Information<br><br>(3) Spironolactone: MedlinePlus Drug Information<br><br>2a. For Resident #2 (R2), the facility staff failed to administer multiple medications on 9/17/25 and 9/18/25.<br><br>An interview was conducted with R2 on 9/23/25 at 10:00 a.m. R2 stated she did not get her medications as ordered.<br><br>The physician order dated 7/30/25, documented:<br><br>1. Atorvastatin Calcium Oral Tablet (1) 80 MG (milligrams); Give 80 mg by mouth at bedtime related to hyperlipidemia.<br><br>2. Clopidogrel Bisulfate Oral Tablet (2) 75 MG; Give 75 mg by mouth at bedtime related to Personal history of transient ischemic attach (TIA) and cerebral infarction without residual deficit.<br><br>3. Edarbyclor Oral Tablet (3) 40-25 MG; Give 1 tablet by mouth at bedtime related to essential hypertension (high blood pressure).<br><br>4. Miralax Oral Powder (4) 17GM (grams)/scoop; Give 1 scoop by mouth one time a day for constipation.<br><br>5. Mirapex Oral Tablet (5) 1 MG; Give 1 mg by mouth at bedtime related to restless legs syndrome.<br><br>6. Montelukast Sodium Oral Tablet (6) 10 MG; Give 10 mg by mouth at bedtime related to chronic obstructive pulmonary disease.<br><br>7. Gabapentin Oral Capsule (7) 300 MG; Give 2 capsules by mouth every 12 hours for neuropathy related to type 2 diabetes mellitus with other diabetic neuropathy.<br><br>8. Magnesium Oxide Oral Tablet (8) 400 MG; Give 400 mg by mouth every 12 hours for supplement.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 9. Insulin Lispro Injection Solution (9) inject as per sliding scale: if 151-200 = 4 units; 201-250 = 6 units; 251 -300 = 8 units; 301-350 = 10 units; 351-400 = 12 units, over 400 call MD, subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with other diabetic neurological complications.<br><br>Review of the Medication Administration Record (MAR) for September 2025 documented the above order. On 9/17/25 and 9/18/25 at the 9:00 p.m. doses of the above medication orders, the MAR was blank.<br><br>Review of the nurse's notes for 9/17/25 and 9/18/25, failed to evidence documentation related to the medications not being administered.<br><br>The comprehensive care plan dated, 7/23/24, documented in part, “Focus: (R2) has hypertension. Interventions: Give anti-hypertensive medications as ordered. Focus: (R2) has altered cardiovascular status r/t (relate to) HTN, HLD (high blood pressure and hyperlipidemia). Focus: (R2) has Diabetes Mellitus. Interventions: Diabetes medications as ordered by doctor. Focus: (R2) has constipation. Focus: (R2) is on pain medication therapy r/t chronic arthritis. Interventions: Administer ANALGESIC medications as ordered by physician. Focus: (R2) is on antiplatelet therapy r/t cerebrovascular disease. Interventions: Administer antiplatelet medications as ordered by physician. Focus: (R2) has potential for pain r/t arthritis, right wrist pain/muscle spasms, migraine. Interventions: Administer analgesia as per orders.”<br><br>An interview was conducted with LPN (licensed practical nurse) #1 on 9/24/25 at 11:47 a.m. LPN #1 stated nurse evidence she's given a medication by checking it off on the MAR. The above MAR was reviewed with LPN #1. She stated it isn't documented as given.<br><br>ASM (administrative staff member) #1, the executive director, and ASM #6, the vice president of operations, were made aware of the above concern on 9/24/25 at 5:32 p.m.<br><br>No further information was obtained prior to exit.<br><br>References:<br><br>1. Atorvastatin is also used to decrease the amount of fatty substances such as low-density lipoprotein (LDL) cholesterol ('bad cholesterol') and triglycerides in the blood and to increase the amount of high-density lipoprotein (HDL) cholesterol ('good cholesterol') in the blood. This information was obtained from the following website: : https://medlineplus.gov/druginfo/meds/a60004.html<br><br>2. Clopidogrel is used alone or with aspirin to prevent serious or life-threatening problems with the heart and blood vessels in people who have had a stroke, heart attack, or severe chest pain. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601040.html<br><br>3. Edarbyclor is used alone or in combination with other medications to treat high blood pressure. This information was obtained from the following website: https://medlineplus.gov/druginfo /meds/a611028.html.<br><br>4. Miralax is used to treat occasional constipation. This information was obtained from the following website: https://medlineplus.gov/druginfo/med s/a603032.html<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 5. Pramipexole (Mirapex) is also used to treat restless legs syndrome. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds /a697029.html<br><br>6. Montelukast is used to prevent wheezing, difficulty breathing, chest tightness, and coughing caused by asthma. This information was obtained from the following website: https://medlineplus.gov/druginfo /meds/a600014.html<br><br>7. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/ a694007.html.<br><br>8. Magnesium oxide also is used as a dietary supplement when the amount of magnesium in the diet is not enough. This information was obtained from the following website: https://medlineplus.gov/druginfo /meds/a601074.html.<br><br>9. Insulin lispro injection products are also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697021<br><br>2b. For Resident #2 (R2), the facility staff failed to administer wound treatments to an abdominal wound between 9/9/25 and 9/23/25.<br><br>An interview was conducted with R2 on 9/23/25 at 10:00 a.m. The resident stated that her current wound dressing is supposed to be every three days. It hasn't been done on many occasions.<br><br>The physician order dated, 8/31/25, documented, “Cleanse ABD (abdominal) wound with wound cleanser, apply hydrofera blue and dry drsg (dressing) every three days at bedtime every 3 days for wound care.”<br><br>The September 2025 Treatment Administration Record (TAR) documented the above order. The TAR documented the treatment was administered on 9/6/25 and 9/9/25. On 9/12/25 a “9” was documented. For 9/15/25, 9/18/25 and 9/21/25, the box where the nurse documents the treatment having been done was blank.<br><br>The nurse's note dated 9/12/25 at 11:09 p.m. documented in part, “Patient wants treatment done tomorrow after she gets a shower.” There was no further documentation on the TAR or nurse's notes that the treatment was done on 9/13/25. Further review of the nurse's notes failed to evidence any documentation for 9/15/25, 9/18/25 or 9/21/25.<br><br>The comprehensive care plan dated, 8/13/25, documented in part, “Focus: has a surgical wound of the abd (abdomen) from debridement and irrigation of abd tissue r/t (related to) necrotizing fasciitis. Interventions: Administer treatments as ordered.”<br><br>An interview was conducted with LPN (licensed practical nurse) #1 on 9/24/25 at 11:47 a.m. LPN #1 stated nurse evidence she's completed a treatment by checking it off on the TAR. The above TAR was reviewed with LPN #1. She stated it isn't documented as completed.<br><br>(continued on next page) |

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| | 495315 | A. Building<br>B. Wing | 09/26/2025 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | ASM (administrative staff member) #1, the executive director, and ASM #6, the vice president of operations, were made aware of the above concern on 9/24/25 at 5:32 p.m.<br><br>No further information was obtained prior to exit.<br><br>References:<br><br>1. Hydrofera Blue® creates a multifaceted, non-toxic environment for wound healing. Hydrofera Blue's unique capillary action continuously pulls harmful bacteria- laden slough, exudate, and debris away from the wound bed. This information was obtained from the following website: https://hydrofera.com/why-blue/<br><br>3. For Resident #7 (R7), the facility staff failed to administer the medication melatonin on multiple dates in July 2025 and September 2025.<br><br>A review of R7's clinical record revealed a physician's order dated 3/5/25 for melatonin 5mg (milligrams). Two tablets by mouth at bedtime for insomnia. A review of R7's July 2025 and September 2025 MARs (medication administration records) failed to reveal evidence that melatonin was administered on 7/21/25, 7/22/25, 7/23/25, 7/24/25, 7/25/25, 7/26/25, 7/28/25, 9/15/25, 9/16/25, 9/17/25, and 9/18/25 (as evidenced by blank spaces on the MARs). A review of the in-house over-the-counter medication supply list revealed melatonin 5mg tablets were available in the facility.<br><br>On 9/24/25 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated nurses evidence the administration of medications by documenting the medications were administered on the MAR.<br><br>On 9/25/25 at 3:51 p.m., another interview was conducted with LPN #2. LPN #2 stated that if a medication is not available in the medication cart, the nurse should obtain the medication from the facility stock of over-the-counter medications or Omnicell (a machine containing various medications) if the medication is available there.<br><br>On 9/25/25 at 4:59 p.m., ASM (administrative staff member) #1 (the executive director) was made aware of the above concern.<br><br>No further information was presented prior to exit. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide care and services to promote healing of a pressure injury for two of 16 residents in the survey sample, Residents #3 and #6.The findings include:1) For Resident #3 (R3), the facility staff failed to provide treatments to pressure injuries (1) as ordered during dates in January and February of 2025. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/28/2025, the resident was assessed as having three Stage 3 pressure injuries and two Stage 2 pressure injuries that were present on admission.Review of the eTAR (electronic treatment administration record) for R3 dated 1/1/25-1/31/25 failed to evidence treatments completed on the following dates:Clean all wounds on buttocks with wound cleanser, apply skin prep to outer edges of wounds. Soak gauze in Dakin's solution, put gauze into wounds, squeeze out excess liquid, cover with foam dressings every day shift every 3 day(s). On 1/27/25 the eTAR was observed to be blank.Review of the eTAR for R3 dated 2/1/25-2/28/25 failed to evidence treatments completed on the following dates:Gentamicin Sulfate External Ointment 0.1 % (Gentamicin Sulfate (Topical)) Apply to sacrum, L + R ischium topically one time a day for pseudomonas infection for 2 Weeks. On 2/4/25, 2/6/25, and 2/7/25. The dates were observed to be blank.Wound care for left ischium, right ischium, sacrum. Cleanse with wound cleanser, pat dry. Apply gentamicin 0.1% ointment to wound bed, then apply calcium alginate to wound bed. Cover with foam dressing QD (every day) and change PRN (as needed) for saturation/soilage every day shift. On 2/4/25, 2/6/25, 2/7/25, 2/13/25, and 2/17/25 the eTAR was observed to be blank.Wound care order for left heel Cleanse with wound cleanser, apply calcium alginate, cover with foam dressing QD every day shift for Wound Care. On 2/4/25, 2/6/25, 2/7/25, 2/13/25, and 2/17/25 the eTAR was observed to be blank.Wound care order for right heel Cleanse with wound cleanser, pat dry, apply skin prep QD. Offload with boot or heelz up pillow one time a day. On 2/4/25, 2/6/25, 2/7/25, 2/13/25, and 2/17/25 the eTAR was observed to be blank. The comprehensive care plan for R3 documented in part, [Name of R3] has pressure injury to left ischium r/t decreased mobility, occasional bladder incontinence, history of radiation and chemotherapy r/t rectal cancer, poor nutrition, Non-compliance with treatment and regimen. Date Initiated: 02/03/2025. The clinical record failed to evidence documentation regarding the missed treatments on the dates listed above in January and February of 2025.On 9/24/2025 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that treatments were evidenced as completed by documentation in the eTAR.On 9/25/2025 at 4:58 p.m., ASM (administrative staff member) #1, the administrator, was made aware of the concern.No further information was provided prior to exit.Reference:(1) A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.2) For Resident #6 (R6), the facility staff failed to provide treatments for a pressure injury on multiple dates in July, August and September 2025 and failed to complete weekly assessments that included measurement and description of wound progress.On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 8/13/25, the resident was assessed as having one unstageable pressure injury that was not present on admission or reentry.A weekly skin integrity review for R6 dated 4/9/2025 documented intact skin.A weekly skin integrity review for R6 dated 4/18/2025 documented in part, .coccyx- open area on coccyx found by CNA (certified nursing assistant) staff member.A wound physician summary for R6 dated 4/22/2025 documented in part, .Patient is seen for evaluation and management of wound(s)/skin. Staff noticed an open area at pt's buttock area and have been placing a dry dressing on the area. Pt has a hx (history) of stage 2 PI (pressure injury) to her left buttock along with previous trauma to the area. Left Buttock: (+) partial thickness ulceration that measures 1.0 x 0.5 x 0.2 cm. Wound base 100% pink/red moist tissue. reopened stage 2 PI Contributing factors to dx: poor mobility, incontinence, previous trauma to area, age, muscle weakness, previous stage 2 PI to left buttock Wound |

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| | 495315 | A. Building<br>B. Wing | 09/26/2025 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide adequate supervision, monitoring, use of safety devices, and fully implement their smoking policy to ensure safety for two of 16 current residents, resident #10 (R10) and R11. This resulted in a determination of Immediate Jeopardy (IJ). After Immediate Jeopardy was removed, the scope and severity were lowered to a level 2, isolated. Also, the facility staff failed to provide interventions for adequate supervision for one of 16 residents in the survey sample, Resident #7. The findings include:1. For R10, the facility staff failed to provide a smoking apron and monitor to ensure a cigarette lighter was not kept on his person.<br><br>R10 was admitted to the facility with diagnosis that included but not limited to nicotine dependence.<br><br>On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 07/23/2025, R10 scored 9 (nine) out of 15 on the BIMS (brief interview for mental status), indicating the R10 was moderately impaired of cognition for making daily decisions.<br><br>On 09/23/2025 at approximately 10:18 a.m. an observation of R10 was conducted on the locked Dogwood unit. R10 was in a wheelchair, carrying a “Fanny Pak” and observed going outside to the enclosed patio area on the locked Dogwood unit independently. Further observations revealed R10 removing a lighter from the “Fanny Pak, lighting a cigarette, then lighting R11's cigarette. Further observations failed to evidence cigarette butt receptacles on the patio area and a smoking apron for R10.<br><br>The facility's “Smoking Evaluation” dated 04/10/2025 for R10 documented in part, “Does resident smoke? Yes. Has fine motor skills needed to securely hold cigarette Yes. Observations: 1. Resident is able to communicate why oxygen must be removed prior to going to the smoking area? Yes. 2. Resident is able to communicate the risks associated with smoking. Yes. 3. Resident does not allow ashes or lit material to fall while smoking, inhaling, or holding smoking item? Yes. 4. Resident does not endanger self or others while smoking, (i.e. burn furniture, wheelchair, clothing, skin, self, or others). Yes. 5. Resident smokes only in designated area? Yes. 6. Resident is able to extinguish cigarette safely when finished smoking. Yes. Resident is determined to be: Safe Smoker. Comments/Adaptive equipment needed (if applicable): Utilize an apron while smoking.”<br><br>The comprehensive care plan for R10 dated 07/19/2023 documented in part, “Focus. Mr. [NAME] is a smoker. Date Initiated: 07/19/2023.” Under “Interventions” it documented in part, “Observe clothing, use smoking apron and skin for signs of cigarette burns. Date Initiated: 07/19/2023; Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Date Initiated: 07/19/2023.”<br><br>On 09/23/2025 at approximately 10:25 a.m. an interview was conducted with R10 in his room. When asked where he obtained the lighter he used to light his and R11's cigarettes, R10 stated the light was in his “Fanny Pak” and that he has it all the time. R10 then opened the “Fanny Pak” and showed the surveyor the cigarette lighter.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 9/23/25 at 3:16 p.m., an interview was conducted with CNA #1 who stated that the smoking at the facility was supervised by staff. She stated that there were designated times, and they were posted at the nurse's station and were the same on both units. She stated that activities normally came over to get the locked unit residents at the smoking times and took the residents over to the other unit for smoke breaks but if they did not come over, the unit CNAs took them out. CNA #1 stated that they kept cigarettes at the desk and the residents came and asked and then went out with them. She stated that everything tobacco related was stored in a drawer behind the nurse's station on the locked unit but it did not have a lock on it. CNA #1 stated that there were only two smokers on their unit currently. CNA #1 stated that R11 was not a smoker but went outside in the courtyard and picked up cigarette butts. CNA #1 stated that R11 would pick them up, not knowing who's they were and smoke them, always asked everyone for cigarettes and lighters. CNA #1 stated that R10 was out in the courtyard this morning with R11 and would provide cigarettes to R11 at times. She stated that R10 would sometimes hide cigarettes, and they were supposed to report them to activities, and they were supposed to confiscate them. CNA #1 stated that she did not give R10 the cigarette he smoked this morning, and she was not sure where R11 got her cigarette from. She stated that they allowed residents to smoke over on the locked unit but did not have any ashtrays to dispose of the cigarette butts, so they threw them on the ground. She stated that they tried to watch R11 to make sure she did not bring the cigarette butts back in the facility, but she probably was. CNA #1 stated that they had a list of residents who required smoking aprons on the other unit. She stated that the residents on the locked unit were allowed to go out to the courtyard as they pleased but were not allowed to smoke whenever they wanted. She stated that they will try to go out to smoke every hour but had to smoke at the designated times with staff supervising them.<br><br>The facility's smoking sign listing smoking times and location documented, “Woodstock Valley Health & (and) Rehab (Rehabilitation). Smoking Times for Rosewood Courtyard ONLY. O600 (6:00 a.m.), 10:00 a.m. , 1:30 p.m., 4:00 p.m., 8:00 p.m.”<br><br>A review of the facility's smoking policy documented in part, “The Center will have safety equipment available in designated smoking areas including smoking blankets, smoking aprons, a fire extinguisher, and non-combustible self-closing ashtrays, the center will establish and post designated smoking areas and times. Further review of the policy failed to evidence the secured storage of smoking implements, supervision and safety of residents who smoke on the locked unit.<br><br>On 9/23/25 at 5:15 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, ASM #10, traveling director of nursing, LPN (licensed practical nurse) #1, staff development coordinator, LPN #2, unit manager, and OSM (other staff member) #9, regional director of human resources and staffing, were made aware of the observations on the Dogwood unit and were notified of immediate jeopardy (IJ) and substandard quality of care.<br><br>The facility presented the following IJ plan which was accepted on 09/23/2025 at 9:26 p.m.<br><br>“Woodstock Valley Health and Rehabilitation 9/23/2025.<br><br>The following plan is being submitted in response to the Immediate Jeopardy citation at F689 for non-compliance with the facility's smoking policy, the lack of supervision, and the lack of smoking safety interventions, all facility residents are likely at risk for serious injury, serious harm, serious impairment or death.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Rooms of Resident #10 and Resident #11 have been searched and they no longer have any smoking materials. The responsible party for both Resident #10 and Resident #11 were notified of the incidents on 9/23/2025.<br><br>The current smoking area on the locked dogwood unit is no longer designated as a smoking area.<br><br>Current residents will have their rooms searched with their permission to identify any smoking materials. If smoking materials are found, they will be removed and placed in a secured storage container maintained on Rosewood unit. If resident refuses to have their rooms searched, the facility will respect their decision and will have increased supervision to observe for any signs of them having smoking materials [i.e. smell of smoke, burns in clothing, etc.]. A locked container of all smoking materials, identified as belonging to which resident, will be maintained in a locked medication room on Rosewood unit. The activity staff or charge nurse for Rosewood unit will have access to the keys of the locked container.<br><br>Current residents will be re-educated on the facility smoking policy. Any resident who desires to smoke will be provided with a written copy of the smoking policy and will be asked to sign the policy. If the resident is unable to sign the policy the resident's responsible party will be contacted and educated on the facility policy. The signed smoking policy by residents or documentation of responsible party education will be documented in the resident's medical record. Residents will only be allowed to smoke in the designated smoking area located in the Rosewood courtyard off the dining room equipped with smoking blankets, smoking aprons, fire extinguisher, and non-combustible self-closing ashtrays at designated smoking times.<br><br>Current residents who desire to smoke will have their charts reviewed to ensure that the smoking assessment is current and accurately reflects any assistance/supervision and/or protective devices for safe smoking. The residents who desire to smoke will have their care plans reviewed to ensure that the care plan accurately reflects the assistance/supervision and safe smoking devices needed by the residents.<br><br>All current staff, including contract staff, will be re-educated on the smoking policy and will be educated on their responsibility of what to do when they observe a resident not following the smoking policy, prior to working their next assigned shift.<br><br>A designated person will be assigned to monitor the doorway leading to the courtyard on the locked Dogwood unit to ensure that if any resident exits into the courtyard they will not smoke. This was initiated 9/23/2025 at approximately 1815 and remains in place until the screamer alarm is installed.<br><br>Monitoring<br><br>§ The Executive Director or designee will make visual observations of the smoking times on Rosewood 2x daily x 2 weeks and then 3x/week x 4 weeks, to ensure that residents are being supervised and using protective devices for safe smoking. If variances are observed, immediate correction will be made and assigned staff for supervision will be counseled in accordance with facility protocol.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | § The Executive Director or designee will make daily observations of the courtyard on the locked Dogwood unit x 2 weeks and then 3x/week x 4 weeks to ensure there are no residents smoking or evidence that someone has been smoking in the non-smoking area.<br><br>§ Findings of the daily observations will be monitored weekly by the RVPO or RDCS weekly x 6 weeks. The Executive Director or designee will re-educate any resident who has been observed not following the smoking policy and discharge notice may be given for repeated non-compliance. Findings of the above audits will be reported to the QAPI Committee for additional oversight.<br><br>Compliance Date: 9/24/2025 @ noon.”<br><br>On 9/24/25, the survey team performed the following actions to verify that the removal plan had been fully implemented:<br><br>*Verified the following parts of the removal plan by paper review, with no concerns noted:<br><br>- Review of the education sign-in sheets for all current facility and contract staff.<br><br>- Reviewed list of current residents who smoked.<br><br>- Reviewed medical records of residents who smoke to verify a signed copy of the facility's smoking policy and current smoking assessment.<br><br>-Reviewed resident's current smoking assessment to verify accurately it reflects any assistance/supervision and/or protective devices for safe smoking.<br><br>-Reviewed the comprehensive care plan of current residents who smoke to verify that the care plan accurately reflects the assistance/supervision and safe smoking devices needed by the residents.<br><br>*Verified by observation, with no concerns noted:<br><br>- Smoking area on the locked Dogwood unit verified was no longer designated as a smoking area.<br><br>- Rosewood courtyard off the dining room was verified to be equipped with smoking blankets, smoking aprons, fire extinguisher, and non-combustible self-closing ashtrays, present at designated smoking times.<br><br>- Residents smoking during a designated smoking time, under staff supervision, and with the use of smoking safety interventions.<br><br>*Verfied Staff Education by staff interviews of Nurses, CNAs, and ancillary staff, demonstrating knowledge compliant with smoking policies and procedures that promoted safety for all residents, with no concerns noted:<br><br>After review of findings with state agency, it was confirmed that the removal plan had been fully implemented by the facility. On 09/24/2025 at 2:00 p.m., ASM #1, the executive director, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, was informed that the removal plan had been verified and the IJ had been abated.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | No further information was provided prior to exit.<br><br>2. For R11, the facility staff failed to provide supervision, a smoking apron and monitor to ensure cigarettes were not kept on her person.<br><br>R11 was admitted to the facility with diagnosis that included but not limited to dementia (1) and hearing loss.<br><br>On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 08/23/2025, R11 scored 4 (four) out of 15 on the BIMS (brief interview for mental status), indicating the R11 was severely impaired of cognition for making daily decisions.<br><br>On 09/23/2025 at approximately 9:53 a.m. an observation of R11 was conducted on the locked unit. R11 was observed in the dayroom sitting in a rocking chair with an unlit cigarette in her right hand up to her mouth. At approximately 9:55 a.m. continued observations of R11 revealed she was holding a plastic cup in her lap. Upon closer observation of the contents of the plastic cup revealed two, unlit, partially smoked cigarettes. At approximately 10:18 a.m. an observation revealed R11 going outside to the enclosed patio area independently followed by R10. Further observations revealed CNA (certified nursing assistant) #1 going out to the patio area after R11 had gone out. Observations also revealed R10 taking a cigarette lighter from his “Fanny Pak”, lighting R10's cigarette while CNA #1 was standing and talking to R10 and R11. Further observations failed to evidence cigarette butt receptacles on the patio area and smoking aprons for R11.<br><br>On 9/23/25 at 11:28 a.m. Resident #11 (R11) was observed outside in the courtyard sitting in a chair with a walker and personal belongings in front of her. R11 took a partially smoked cigarette out of a bag with personal belongings and began peeling off the paper from the cigarette and throwing it onto the sidewalk. At 11:29 a.m., a staff member went outside to speak with the resident but did not take the cigarette. At 11:33 a.m., another staff member was observed to take the cigarette from R11. At 11:36 a.m., Resident #10 (R10) was observed outside, at 11:37 a.m., R10 was observed taking a cigarette out and lighting it with a lighter that was on his person. R11 ambulated with her rolling walker over to R10 who proceeded to light a cigarette for her. Both residents proceeded to smoke unsupervised with no staff present in the courtyard area. R11 was observed lighting a second partially smoked cigarette with the first cigarette and then proceeded to throw the first cigarette butt behind her into a mulched area with fallen dried leaves present. R11 proceeded to smoke some of the second cigarette and extinguish it into a plastic spoon and store the partially smoked cigarette into the storage pocket of the rolling walker with overflowing personal belongings. Further observations failed to evidence cigarette butt receptacles on the patio area and smoking aprons for R10 and R11.<br><br>The comprehensive care plan for R11 dated 08/20/2024 documented in part, “Focus. (R11) is an unsafe smoker. Date Initiated: 08/20/2024.” Under “Interventions” it documented in part, “Her smoking supplies are stored with staff in a lock box. Date Initiated: 08/20/2024, She requires a smoking apron while smoking. Date Initiated: 08/20/2024, She requires direct SUPERVISION while smoking. Date Initiated: 08/20/2024.”<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility's “Smoking Evaluation” dated 06/19/2025 for R11 documented in part, “Does resident smoke? Yes. Observations: 1. Resident is able to communicate why oxygen must be removed prior to going to the smoking area? No. 2. Resident is able to communicate the risks associated with smoking. Yes. 3. Resident does not allow ashes or lit material to fall while smoking, inhaling, or holding smoking item? No. 4. Resident does not endanger self or others while smoking, (ie burn furniture, wheelchair, clothing, skin, self, or others). No. 5. Resident smokes only in designated area? No. 6. Resident is able to extinguish cigarette safely when finished smoking. No. Resident is determined to be: Unsafe Smoker. Comments/Adaptive equipment needed (if applicable): Direct supervision at all times and smoking apron.”<br><br>On 09/23/2025 at approximately 3:45 p.m. an interview was attempted with R10 regarding how she obtained cigarettes. Due to R10's low cognition and hearing difficulty, R10 could not adequately hear and comprehend the questions.<br><br>On 9/23/25 at 3:16 p.m., an interview was conducted with CNA #1 who stated that the smoking at the facility was supervised by staff. She stated that there were designated times, and they were posted at the nurse's station and were the same on both units. She stated that activities normally came over to get the locked unit residents at the smoking times and took the residents over to the other unit for smoke breaks but if they did not come over, the unit CNAs took them out. CNA #1 stated that they kept cigarettes at the desk and the residents came and asked and then went out with them. She stated that everything tobacco related was stored in a drawer behind the nurse's station on the locked unit but it did not have a lock on it. CNA #1 stated that there were only two smokers on their unit currently. CNA #1 stated that R11 was not a smoker but went outside in the courtyard and picked up cigarette butts. CNA #1 stated that R11 would pick them up, not knowing who's they were and smoke them, always asked everyone for cigarettes and lighters. CNA #1 stated that R10 was out in the courtyard this morning with R11 and would provide cigarettes to R11 at times. She stated that R10 would sometimes hide cigarettes, and they were supposed to report them to activities, and they were supposed to confiscate them. CNA #1 stated that she did not give R10 the cigarette he smoked this morning, and she was not sure where R11 got her cigarette from. She stated that they allowed residents to smoke over on the locked unit but did not have any ashtrays to dispose of the cigarette butts, so they threw them on the ground. She stated that they tried to watch R11 to make sure she did not bring the cigarette butts back in the facility, but she probably was. CNA #1 stated that they had a list of residents who required smoking aprons on the other unit. She stated that the residents on the locked unit were allowed to go out to the courtyard as they pleased but were not allowed to smoke whenever they wanted. She stated that they will try to go out to smoke every hour but had to smoke at the designated times with staff supervising them.<br><br>The facility's smoking sign listing smoking times and location documented, “Woodstock Valley Health & (and) Rehab (Rehabilitation). Smoking Times for Rosewood Courtyard ONLY. O600 (6:00 a.m.), 10:00 a.m. , 1:30 p.m., 4:00 p.m., 8:00 p.m.”<br><br>A review of the facility's smoking policy documented in part, “The Center will have safety equipment available in designated smoking areas including smoking blankets, smoking aprons, a fire extinguisher, and non-combustible self-closing ashtrays, the center will establish and post designated smoking areas and times. Further review of the policy failed to evidence the secured storage of smoking implements, supervision and safety of residents who smoke on the locked unit.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 9/23/25 at 5:15 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, ASM #10, traveling director of nursing, LPN (licensed practical nurse) #1, staff development coordinator, LPN #2, unit manager, and OSM (other staff member) #9, regional director of human resources and staffing, were made aware of the observations on the Dogwood unit and were notified of immediate jeopardy (IJ) and substandard quality of care.<br><br>The facility presented the following IJ plan which was accepted on 09/23/2025 at 9:26 p.m.<br><br>“Woodstock Valley Health and Rehabilitation 9/23/2025.<br><br>The following plan is being submitted in response to the Immediate Jeopardy citation at F689 for non-compliance with the facility's smoking policy, the lack of supervision, and the lack of smoking safety interventions, all facility residents are likely at risk for serious injury, serious harm, serious impairment or death.<br><br>Rooms of Resident #10 and Resident #11 have been searched and they no longer have any smoking materials. The responsible party for both Resident #10 and Resident #11 were notified of the incidents on 9/23/2025.<br><br>The current smoking area on the locked dogwood unit is no longer designated as a smoking area.<br><br>Current residents will have their rooms searched with their permission to identify any smoking materials. If smoking materials are found, they will be removed and placed in a secured storage container maintained on Rosewood unit. If resident refuses to have their rooms searched, the facility will respect their decision and will have increased supervision to observe for any signs of them having smoking materials [i.e. smell of smoke, burns in clothing, etc.]. A locked container of all smoking materials, identified as belonging to which resident, will be maintained in a locked medication room on Rosewood unit. The activity staff or charge nurse for Rosewood unit will have access to the keys of the locked container.<br><br>Current residents will be re-educated on the facility smoking policy. Any resident who desires to smoke will be provided with a written copy of the smoking policy and will be asked to sign the policy. If the resident is unable to sign the policy the resident's responsible party will be contacted and educated on the facility policy. The signed smoking policy by residents or documentation of responsible party education will be documented in the resident's medical record. Residents will only be allowed to smoke in the designated smoking area located in the Rosewood courtyard off the dining room equipped with smoking blankets, smoking aprons, fire extinguisher, and non-combustible self-closing ashtrays at designated smoking times.<br><br>Current residents who desire to smoke will have their charts reviewed to ensure that the smoking assessment is current and accurately reflects any assistance/supervision and/or protective devices for safe smoking. The residents who desire to smoke will have their care plans reviewed to ensure that the care plan accurately reflects the assistance/supervision and safe smoking devices needed by the residents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | All current staff, including contract staff, will be re-educated on the smoking policy and will be educated on their responsibility of what to do when they observe a resident not following the smoking policy, prior to working their next assigned shift.<br><br>A designated person will be assigned to monitor the doorway leading to the courtyard on the locked Dogwood unit to ensure that if any resident exits into the courtyard they will not smoke. This was initiated 9/23/2025 at approximately 1815 and remains in place until the screamer alarm is installed.<br><br>Monitoring<br><br>§ The Executive Director or designee will make visual observations of the smoking times on Rosewood 2x daily x 2 weeks and then 3x/week x 4 weeks, to ensure that residents are being supervised and using protective devices for safe smoking. If variances are observed, immediate correction will be made and assigned staff for supervision will be counseled in accordance with facility protocol.<br><br>§ The Executive Director or designee will make daily observations of the courtyard on the locked Dogwood unit x 2 weeks and then 3x/week x 4 weeks to ensure there are no residents smoking or evidence that someone has been smoking in the non-smoking area.<br><br>§ Findings of the daily observations will be monitored weekly by the RVPO or RDCS weekly x 6 weeks. The Executive Director or designee will re-educate any resident who has been observed not following the smoking policy and discharge notice may be given for repeated non-compliance. Findings of the above audits will be reported to the QAPI Committee for additional oversight.<br><br>Compliance Date: 9/24/2025 @ noon.”<br><br>On 09/24/2025 the survey team, through observations, interviews and documentation review, verified the removal plan had been fully implemented by the facility. On 09/24/2025 at 2:00 p.m., ASM #1, the executive director, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, was informed the removal plan had been verified and the IJ had been abated.<br><br>No further information was provided prior to exit.<br><br>References:<br><br>(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.<br><br>3. For Resident #7 (R7), a resident assessed as being at risk of elopement, the facility staff failed to maintain interventions to promote adequate supervision.<br><br>A review of R7's clinical record revealed a nurse's note dated 2/2/25 that documented, [R7's name redacted] found on grounds of facility attempting to go to the store to buy a lighter. Housekeeping manager returned resident to this facility. [R7's name redacted] eloped out of the building and this is an issue because he must have codes to the doors. [R7's name redacted] was a resident on Alzheimer's unit in the past and monitored for elopement risk.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An elopement risk evaluation dated 2/2/25 documented R7 was at risk for elopement. The evaluation further documented that R7 was cognitively impaired, independently mobile, had poor decision-making skills, demonstrated exit seeking behaviors, wandered oblivious to safety needs, had a history of elopement, and had the ability to exit the facility.<br><br>A review of R7's physician's orders revealed an order dated 2/3/25 for a WanderGuard (a bracelet and door controller system used to prevent at-risk residents from exiting the facility) to be applied to the resident's ankle and checked every shift<br><br>R7's comprehensive care plan dated 2/2/25 documented, [R7's name redacted] is an elopement risk r/t [related to] impairment in cognitive functions and awareness: attempted to leave facility. The interventions included:<br><br>2/3/25-Assess for elopement risk.<br><br>2/3/25-Monitor location every 15 minutes (resolved/discontinued on 2/4/25).<br><br>2/4/25-Wanderguard placement every shift (resolved/discontinued on 2/6/25).<br><br>Further review of R7's clinical record failed to reveal any further elopement risk evaluation since 2/2/25, revealed the physician's order for a WanderGuard was discontinued on 2/6/25, and failed to reveal any documentation why the WanderGuard was discontinued or documentation of any further interventions to prevent elopement.<br><br>On 9/23/25 at 2:09 p.m., an observation of R7 was conducted. The resident was observed ambulating with a walker in the hall and was not wearing a WanderGuard. Also, the resident's room was not located on the locked Alzheimer's unit.<br><br>On 9/24/25 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated if a resident is at risk for elopement, the nurse should discuss this with the physician, social services, administrator, and minimum data set coordinator to determine if the resident is suitable for a WanderGuard and update the resident's care plan. LPN #2 stated an additional elopement risk assessment should be done before discontinuing an elopement intervention such as a WanderGuard to make sure the resident truly is no longer at risk for elopement.<br><br>On 9/25/25 at 4:59 p.m., ASM (administrative staff member) #1 (the executive director) was made aware of the above concern.<br><br>The facility policy titled, Elopements and Wandering Residents documented, 4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering<br><br>a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team.<br><br>b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff.<br><br>d. Adequate supervision will be provided to help prevent accidents or elopements.<br><br>e. The IDT (Interdisciplinary Team) will monitor the implementation of interventions, response to interventions, and document accordingly.<br><br>f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff.<br><br>No further information was presented prior to exit. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide respiratory care and services for one of 14 residents in the survey sample, Resident #110. The findings include:For Resident #110 (R110), the facility staff failed to obtain a physician's order for the use of an incentive spirometer (1) and failed to store the incentive spirometer in a sanitary manner. R110's admission minimum data set assessment was not complete. A clinical admission assessment dated [DATE] documented R110 was alert and oriented times four (to person, place, time, and situation). A review of R110's clinical record failed to reveal a physician's order for an incentive spirometer. On 12/1/25 at 1:44 p.m. , R110 was observed sitting up in bed. An incentive spirometer was observed sitting on the resident's nightstand, with the mouthpiece uncovered. R110 stated she used the incentive spirometer, and staff had not provided a cover for the device. On 12/1/25 at 3:51 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated nurses should obtain a physician's order for an incentive spirometer and the order should include how often the resident should use it. LPN #1 stated nurses would not know that a resident is supposed to use an incentive spirometer unless there was an order. LPN #1 stated an incentive spirometer should be stored in a plastic bag for infection control purposes. On 12/2/25 at 3:24 p.m., ASM (Administrative Staff Member) #1 (the [NAME] President of Operations), ASM #2 (the traveling Director of Nursing), and ASM #3 (the acting Director of Nursing) were made aware of the above concern. The facility did not provide a policy regarding an incentive spirometer. No further information was presented prior to exit. Reference:(1) Your health care provider may recommend that you use an incentive spirometer after surgery or when you have a lung illness, such as pneumonia. The spirometer is a device used to help you keep your lungs healthy. Using the incentive spirometer helps you take slow deep breaths. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe, appropriate pain management for a resident who requires such services.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | For Resident #2 (R2), the facility staff failed to administer pain medications per the physician order to manage the resident's pain. On the most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 8/3/25, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. An interview was conducted with R2 on 9/23/25 at 10:00 a.m. R2 stated on 3/29/25, she was going into withdrawal symptoms related to not getting her pain patch (Fentanyl - an opioid used to treat severe pain) (1) as prescribed. She stated she was sick to her stomach, diarrhea and just didn't feel well. She stated her daughter had been in the facility on 3/28/25 and noticed that her pain patch was dated 3/17/25. R2 stated that it has happened again that she didn't get her patch as prescribed. The physician order dated 3/5/25, documented, Fentanyl Transdermal Patch 72 Hours 75 MCG/HR (micrograms per hour); apply 1 patch every 3 days for chronic pain replace after 3 days and remove per schedule. The March 2025 MAR (medication administration record) documented the above order. The MAR documented the medication was administered on 3/17/25. For 3/20/25 it was documented the patch was removed but for the administration it was documented a 9 which indicates, Other/See Nurse Notes. For 3/23/25, there were 9 document for the removal and administration of the Fentanyl. For 3/26/25, there was a 9 documented for the removal and administration of the Fentanyl. The nurse's note dated 3/20/25 at 3:36 p.m. documented in part, Fentanyl.none acaaiable (sic)(available), np (nurse practitioner) to write script. The nurse's note dated 3/23/25 at 5:04 p.m. documented in part, Fentanyl .dc/d (discontinued) new order placed. There was no nurse's note dated 3/26/25 related to the Fentanyl. The narcotic sign-off sheet dated 3/4/25, documented the administration of the Fentanyl patch on 3/17/25. The narcotic sheet was dated 3/29/25, documented the administration of the Fentanyl on 3/29/25. There was no record of administration of Fentanyl on a narcotic sheet between 3/17/25 and 3/29/25, a period of 12 days. The physician order dated, 8/15/25, documented, Fentanyl Transdermal Patch 72-hour 25 MCG/HR; apply 1 patch transdermally every 72 hours for chronic pain for 21 days and remove per schedule. The September 2025 MAR documented the above order. The last documented dose of Fentanyl administration was on 9/2/25. For the scheduled dose for 9/5/25, the box was blank. Review of the nurse's note failed to evidence documentation related to the Fentanyl on 9/5/25. The physician order dated, 9/9/25, documented, Fentanyl Transdermal Patch 72-Hour 25 MCG/HR; apply 1 patch transdermally one time a day every 3 day(s) for pain and remove per schedule. The September 2025 MAR documented the above order. On 9/9/25, a 9 was documented in the box for administration.The nurse's note dated 9/9/25 at 10:15 a.m. documented, Was applied yesterday. Review of the narcotic sing-off sheets dated 8/22/25, documented the Fentanyl was administered on 9/2/25 and 9/12/25. The narcotic sign-off sheet dated 9/8/25, documented the Fentanyl was administered on 9/8/25 and 9/15/25. This indicates the resident received the patch on 9/2/25, no patch was administered on 9/5/25. Fentanyl was administered on 9/8/25, no administration, per the physician order on 9/11/25, and then administered on 9/12/25. The resident missed two doses, one on 9/5/25 and 9/11/25, going six days between doses. The comprehensive care plan dated, 11/6/24, documented in part, Focus: (R2) is on pain medication therapy r/t (related to) chronic arthritis. Interventions: Administer ANALGESIC medication as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT (every shift). On 9/23/25 at 12:25 p.m., an interview was conducted with ASM (administrative staff member) #3 (the medical director). ASM #3 stated symptoms of Fentanyl withdrawal could include tachycardia (an increased heart rate), agitation, itching, and seizures if the patient is on a pretty high dose of the medication.An interview was conducted with LPN (licensed practical nurse) #1 on 9/24/25 at 11:47 a.m. LPN #1 stated nurse evidence she's given a medication by checking it off on the MAR. The above MARs, narcotic sheet and nurse's notes were reviewed with LPN #1. She verified that the resident did not receive her Fentanyl patch for 12 days in March and missed doses of Fentanyl in September per the documentation. The facility policy, Pain Management documented in part, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. ASM (administrative staff member) #1, the executive director, and ASM #6, the vice president of operations, were made aware of the above concern on 9/24/25 at 5:32 p. m. No further information was obtained prior to exit. References:. 1. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601202.html |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on resident interview, staff interview and facility document review, the facility staff failed to maintain sufficient nursing staff to meet the resident's needs for two of two resident units, Dogwood and Rosewood units. The findings include:The facility staff failed to maintain sufficient nursing staff to provide HS (hours of sleep) snacks to residents. The Facility Assessment Tool dated 06/01/2025 documented in part, Staffing plan. Position: Nurse aides - Distribution adjusted based on resident activities and care needs per shift. Total Number Needed or Average or Range: 6-8 (six to eight) CNAs (certified nursing assistants) day shift, 4-6 (four to six) CNAs evening / nights. The facility's As worked schedules for nursing staff on the Dogwood Unit dated 06//2024 through 06/30/2025 documented one CNA (certified nursing assistant) during the 3:00 p.m. to 11:00 p.m. shift on 06/07/2025 with a facility census of 77, and 06/14/2025 with a facility census of 77; one CNA for four hours during the 3:00 p.m. to 11:00 p.m. shift on 06/04/2025 with a facility census of 76, 06/06/2025 with a facility census of 76, 06/08/2025 with a facility census of 78, 06/11/2025 with a facility census of 77, 06/13/2025 with a facility census of 79 and on 06/24/2025 with a facility census of 71. The facility's As worked schedules for nursing staff on the Rosewood Unit dated 06//2024 through 06/30/2025 documented one CNA during the 3:00 p.m. to 11:00 p.m. shift on 06/01/2025 with a facility census of 78 and on 06/08/2025 with a facility census of 78. On 09/24/2025 at approximately 10:40 a.m. an interview was conducted with Resident #2 (R2), resident council president for the Rosewood unit, with a BIMs (Brief Interview for Mental Status) of 15, being cognitively intact for making daily decisions, about snacks being provided to resident during the night shift. She stated that the residents are not offered snacks. On 09/24/2025 at approximately 10:50 a.m. an interview was conducted with R16, resident council president for the Dogwood unit, with a BIMs of 15, being cognitively intact for making daily decisions, about snacks being provided to resident during the night shift. She stated that the residents are not offered snacks. On 09/24/2025 at approximately 2:15 p.m., a telephone interview was conducted with OSM (other staff member) #2, former staffing coordinator. When asked about the number of CNAs needed for the Dogwood and Rosewood units during the 3:00 p.m. to 11:00 p.m. (3-11) shift she stated she would try to get three CNAs but usually had two CNAs for each unit during the 3-11 shift. When asked to describe the procedure she followed if there were not enough staff she stated she would reach out to staff to work another shift or call staff to 0see if they could come in and work. When asked about utilizing agency nursing staff she stated that corporate did not allowed her to use agency staff. On 09/24/2025 at approximately 4:35 p.m. an interview was conducted with CNA (certified nursing assistant) #2 regarding snacks being provided to residents during the night shift. CNA #2 stated that in March and April 2025 she worked on the 7:00 p.m. to 7:00 a.m. shift and that snacks were not consistently provided to the residents because there were not enough staff. On 09/25/2025 at approximately 1:30 p.m. an interview was conducted with OSM #11, district manager for dietary , regarding HS snacks for residents. She stated the HS snacks consisted of sandwiches, cookies, crackers and drinks provided by the dietary department and sent to the nurse's stations at 7:00 p.m. each evening. She further stated that it was the responsibility of the nursing staff to pass on the snacks to the residents. On 09/25/2025 at approximately 3:00 p.m. an interview was conducted with ASM #2 regarding residents receiving HS snacks. She stated that it was hit or miss that the residents received the HS snacks. On 09/25/2025 at approximately 3:15 p.m. an interview was conducted with CNA #7 regarding staffing during the 3:00 p.m. to 11:00 p.m. shift. She stated that there are times when she is the only CNA working on a unit for two to three hours. On 09/25/2025 at approximately 3:20 p.m. an interview was conducted with OSM #8, staffing coordinator for sister facility. After reviewing the As Worked schedule for the dates listed above, she agreed that the facility was short staffed on the 3-11 shift for the dates listed above. The facility's policy Nursing Services and sufficient Staff documented in part, Policy: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment. Policy Explanation and Compliance Guidelines: 3. The facility is required to provide licensed nursing staff 24 hours a day (except when waived), along with other nursing personnel, including but not limited to nurse aides. 5. Providing care includes, but is not limited to, assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. On 9/25/2025 at approximately 4:58 p.m. ASM (administrative staff member) #1, the |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on staff interview, and facility document review, the facility staff failed to meet RN (registered nurse) requirements for 16 of 31 days reviewed. The findings include:1. The facility staff failed to provide RN coverage for eight consecutive hours a day on 8/25/25, 8/30/25, 8/31/25, 9/13/25, and 9/14/25. A review of nursing schedules revealed there was no RN coverage for eight consecutive hours on 8/25/25, 8/30/25, 8/31/25, 9/13/25, and 9/14/25. On 9/25/25 at 1:45 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated there had not been eight consecutive hours of RN coverage in the facility and there was only one other RN besides her working at the facility. On 9/25/25 at 4:59 p.m., ASM (administrative staff member) #1 (the executive director) was made aware of the above concern. The facility policy titled, Nursing Services-Registered Nurse (RN) documented, The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week. No further information was presented prior to exit. 2. The facility staff failed to ensure the Director of Nursing did not serve as a charge nurse on 8/25/25, 8/27/25, 8/29/25, 9/2/25, 9/8/25, 9/9/25, 9/10/25, 9/11/25, 9/12/25, 9/15/25, 9/19/25, and 9/20/25. A review of the nursing schedules revealed the Director of Nursing served as a charge nurse on 8/25/25, 8/27/25, 8/29/25, 9/2/25, 9/8/25, 9/9/25, 9/10/25, 9/11/25, 9/12/25, 9/15/25, 9/19/25, and 9/20/25. A review of nurse staffing postings revealed the resident census on all of those dates was greater than 60 residents. On 9/25/25 at 1:45 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated she was told she was not supposed to work as a nurse on the floor unless there was a crisis, but if we don't have any other choice then we don't have a choice. On 9/25/25 at 4:59 p.m., ASM (administrative staff member) #1 (the executive director) was made aware of the above concern.The facility policy titled, Nursing Services-Registered Nurse (RN) documented, The Director of Nursing may serve as a charge nurse only when the facility has average daily occupancy of 60 or fewer residents. No further information was presented prior to exit. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495315 | A. Building<br>B. Wing | 09/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Woodstock Valley Health and Rehabilitation | 803 South Main St<br>Woodstock, VA 22664 |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observe each nurse aide's job performance and give regular training.<br><br>Based on staff interview, and facility document review, the facility staff failed to complete an annual performance review for four of five CNA (certified nursing assistant) reviews. The findings include:For CNA #3, CNA #4, CNA #5, and CNA #6, the facility staff failed to complete an annual performance review. CNA #3 was hired on 8/22/23. CNA #3's most recent performance review was completed on 8/27/24.CNA #4 was hired on 6/13/23. CNA #4's most recent performance review was completed on 7/23/24.CNA #5 was hired on 7/20/21. CNA #5's most recent performance review was completed on 7/22/24.CNA #6 was hired on 2/15/23. CNA #6's most recent performance review was completed on 7/31/24. On 9/25/25 at 1:45 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated she did not know who was responsible for ensuring the completion of CNA performance reviews because she had only been the director of nursing since April 2025 and had never been a director of nursing before then. ASM #2 stated she assumed CNA performance reviews should be completed every year based on the CNA's hire date. On 9/25/25 at 4:59 p.m., ASM (administrative staff member) #1 (the executive director) was made aware of the above concern. The facility policy titled, Nurse Aide Training Program documented, 2.b. It is the responsibility of the employee to attend/complete mandatory in-service trainings to maintain employment status with the facility. A review of the employee's attendance/completion records shall be performed at least annually, such as at time of performance review. No further information was presented prior to exit. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on staff interview and facility document review, the facility staff failed to meet nurse staffing information requirements for 31 of 31 days reviewed. The findings include:The facility staff failed to ensure the total number and the actual hours worked by registered nurses, licensed practical nurses, and certified nurse aides directly responsible for resident care per shift was documented on the nurse staffing information postings from 8/25/25 through 9/24/25, and failed to ensure accurate nurse staffing information was posted on 9/23/25. A review of nurse staffing information postings from 8/25/25 through 9/24/25 failed to reveal the total number and the actual hours worked by registered nurses, licensed practical nurses, and certified nurse aides (the postings only documented the total number and the actual hours worked by licensed staff and unlicensed staff). On 9/23/25 at 4:05 p.m., an observation of the posted nurse staffing information was conducted. The posting was dated 9/19/25. At this time, ASM (administrative staff member) #1 (the executive director) stated the staffing coordinator resigned the previous day. On 9/25/25 at 10:45 a.m., an interview was conducted with OSM (other staff member) #8 (the staffing coordinator from a related facility). OSM #8 stated she used to manually complete the nurse staffing information postings but now the postings are generated from the online scheduling system and only document the total number and the actual hours worked by licensed staff and unlicensed staff. In regard to the posting of nurse staffing information, OSM #8 stated the information should be posted each morning, every day. On 9/25/25 at 4:59 p.m., ASM #1 was made aware of the above concern. The facility policy titled, Nurse Staffing Information Posting documented, The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information:d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses ii. Licensed Practical Nurses/Licensed Vocational Nurses iii. Certified Nurse Aides. No further information was presented prior to exit. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on facility staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure medications were available for administration for two of 16 residents in the survey sample, Residents #3 and #7.The findings include:1) For Resident #3 (R3), the facility staff failed to ensure medications were available for administration during dates in February and March of 2025.<br><br>Review of the eMAR (electronic medication administration record) for R3 dated 2/1/25-2/28/25 failed to evidence administration of the following medication on the dates listed below:<br><br>Daptomycin-Sodium Chloride Intravenous Solution 500-0.9 MG (milligram)/50ML (milliliter)-% (Daptomycin-Sodium Chloride) Use 500 mg intravenously in the morning related to Sepsis, Unspecified Organism. On 2/9/25 and 2/21/25. (antibiotic to treat infection) (1). The eMAR for 2/9/25 was observed to be blank and 2/21/25 eMAR progress note documented “ordered call to pharmacy.”<br><br>Epoetin Alfa-epbx Injection Solution 40000 UNIT/ML (Epoetin Alfa-epbx) Inject 1 ml subcutaneously one time a day every Fri for Anemia of Chronic disease. (to treat anemia) (2) On 2/14/25. The eMAR progress note documented “Not available in omni cell, awaiting from pharmacy.”<br><br>Pregabalin Oral Capsule 25 MG (Pregabalin) Give 25 mg by mouth every morning and at bedtime related to pain in unspecified joint. (to treat pain) (3) Not administered on the 6:00 a.m. doses on 2/1-2/4/25, 2/6/25, 2/7/25, and 2/20/25 and the 9:00 p.m. doses on 2/1, 2/3, 2/5-2/9/25. The eMAR progress notes on 2/1/25, 2/4/25, 2/6/25, 2/7/25, 2/9/25 documented, “on order”, 2/2/25- “ordered”, 2/3/25- “script needs to be wrote”, 2/8/25- “not available at this time” and 2/20/25- “new order wrote, has not arrived.”<br><br>Review of the eMAR for R3 dated 3/1/25-3/31/25 failed to evidence administration of the following medication on the dates listed below:<br><br>Pregabalin Oral Capsule 300 MG (Pregabalin) Give 1 capsule by mouth every morning and at bedtime for neuropathy. On 3/8/25 at 9:00 a.m. The eMAR progress note documented, “on order.” On 3/20/25 at 9:00 p.m., the eMAR progress note documented, “ordered.”<br><br>On 9/24/2025 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that medications were evidenced as given by documentation in the eMAR. She stated that if a medication was not available on the medication cart they checked the Omnicell (in house medication) stock and if not there they called the pharmacy to see when it would be available. She stated that they were supposed to notify the physician when a medication was not given to let them know when the medication was going to be delivered and follow their instructions.<br><br>The facility policy “Medication Administration” dated 6/1/2025 documented in part, “Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection… Policy Explanation and Compliance Guidelines: Administer medication as ordered in accordance with manufacturer specifications .”<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 9/25/2025 at 4:58 p.m., ASM (administrative staff member) #1, the administrator, was made aware of the concern.<br><br>No further information was provided prior to exit.<br><br>Reference:<br><br>(1) Daptomycin Injection: MedlinePlus Drug Information<br><br>(2) Epoetin Alfa, Injection: MedlinePlus Drug Information<br><br>(3) Pregabalin: MedlinePlus Drug Information<br><br>2. For Resident #7 (R7), the facility staff failed to ensure the medications Ziprasidone and Flomax were available for administration on multiple dates July 2025 through September 2025.<br><br>A review of R7's clinical record revealed the following physician's orders:<br><br>3/14/25-Ziprasidone 60mg (milligrams). One capsule by mouth every morning and at bedtime for schizophrenia.<br><br>5/6/25-Flomax 0.4mg. One capsule by mouth once a day for enlargement of the prostate gland.<br><br>A review of R7's MARs (medication administration records) for July 2025 through September 2025 failed to reveal evidence the morning dose of Ziprasidone was administered on 7/21/25, 7/22/25, 7/23/25, 7/24/25, 7/26/25, and 8/11/25, failed to reveal evidence the bedtime dose of Ziprasidone was administered on 7/21/25, 7/22/25, 7/23/25, 7/24/25, 7/26/25, 7/28/25, 9/15/25, 9/16/25, 9/17/25, and 9/18/25, and failed to reveal evidence the daily dose of Flomax was administered on 7/21/25, 7/22/25, 7/23/25, 7/24/25, 7/26/25, 7/27/25, and 8/11/25.<br><br>On 9/24/25 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated nurses evidence the administration of medications by documenting the medications were administered on the MAR.<br><br>On 9/25/25 at 3:51 p.m., another interview was conducted with LPN #2. LPN #2 stated that if a medication is not available in the medication cart, the nurse should obtain the medication from the Omnicell (a machine containing various medications) if the medication is available there or contact the pharmacy if the medication is not available in the Omnicell.<br><br>A review of the Omnicell list revealed Ziprasidone and Flomax were not available in the Omnicell.<br><br>On 9/25/25 at 4:59 p.m., ASM (administrative staff member) #1 (the executive director) was made aware of the above concern.<br><br>No further information was presented prior to exit. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident’s drug regimen must be free from unnecessary drugs.<br><br>Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a resident was free from unnecessary medications for one of 16 residents in the survey sample, Resident #1. The findings include:For Resident #1 (R1), the facility staff failed to obtain and/or ensure a physician's order was in place prior to administering tramadol and oxycodone to the resident on 8/10/25. A review of R1's clinical record revealed the following physician's orders:5/18/25-tramadol 50mg (milligrams). One tablet by mouth every four hours as needed for pain.6/19/25-oxycodone 5mg. One tablet every six hours as needed for pain. R1 was transferred to the hospital on 7/29/25. R1 returned to the facility on 8/4/25 and the orders for tramadol and oxycodone were discontinued on that date. A review of R1's controlled medication utilization records revealed the resident was administered one tablet of tramadol 50mg on 8/10/25 at 9:15 a.m. and one tablet of oxycodone 5mg on 8/10/25 at 11:30 a.m. A review of R1's August 2025 physician's orders and August 2025 MAR (medication administration record) revealed there were no orders on 8/10/25 for tramadol or oxycodone (until back dated orders were created in the computer system on 8/19/25). On 9/23/25 at 11:06 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that on 8/10/25, there were no tramadol or oxycodone orders for R1 in the computer system but there were tramadol and oxycodone medication cards with R1's name in the medication cart. RN #1 stated she incorrectly assumed the medications were prescribed for R1, so she administered the medications. RN #1 stated she made a mistake and should have verified active orders before administering the tramadol and oxycodone to R1. On 9/25/25 at 4:59 p.m., ASM (administrative staff member) #1 (the executive director) was made aware of the above concern. The facility policy titled, Medication Administration documented, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician . 11. Review MAR to identify medication to be administered. No further information was presented prior to exit. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>Based on observation, staff interview and facility document review, facility staff failed to provide residents with the correct amount of food according to the facility's menu in one of one facility kitchens. The findings include:On 09/22/2025 at approximately 2:00 p.m. an observation in the facility's kitchen revealed OSM (other staff member) #10, acting dietary manager plating Caesar salad into bowls using a beige/ off-white handle scoop. Further observations revealed OSM #10 placing one scoop of salad into each bowl. At approximately 4:24 p.m. an observation of the facility's kitchen tray line revealed the cook plating food for the resident's dinner. Observations of the serving utensils being used by the cook to plate the food revealed he was using a grey handle scoop for serving lasagna, and a red handle scoop for sliced carrots. Continued observations revealed the cook placed one scoop of lasagna, carrots on the resident's dinner plates and one bowl of Caesar salad on each meal tray. The facility's menu for dinner on 09/22/2025 documented in part, Monday. Entree. Lasagna w/ (with) meat sauce 1 (one) square. Caesar Salad 1 Cup. Sliced Carrots 1/2 (half) Cup.The facility's Production Count dated Monday-9/22/2025 documented in part, Lasagna w/MeatSauce 8 Oz (eight ounces), Caesar Salad 1 Cup, Sliced Carrots 1/2 Cup. The kitchen's Disher Size reference sheet documented in part, SCOOP NO. (number) MENU OZ VOLUME#4 8 Oz 1 Cup#8 4 Oz 1/2 Cup#10 3 Oz 3/8 (three-eighth) Cup#16 2Oz 1/4 (quarter) Cup On 09/25/2025 at approximately 1:10 p.m. an interview was conducted with OSM #11, district manager for dietary. When asked about the serving sizes of the grey, red and beige/ off-white handle scoops, OSM #11 showed the surveyor the scoops and stated the that the grey handle scoop holds four ounces, the red handle scoop holds two ounces and the beige/ off-white handle scoop holds three ounces. After informed of the observation of the serving utensils/scoops being used for food portions as stated above for the resident's dinner on 09/22/2025 OSM #11 stated the cook should have referenced the Production Sheet and check for the correct serving utensil/scoop to serve the correct portions of food. When asked if residents received the correct amount of food for dinner on 09/22/2025 she stated no. On 9/25/2025 at approximately 4:58 p.m. ASM (administrative staff member) #1, the executive director, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation and staff interview, it was determined that the facility staff failed to serve palatable food on one of two facility units, Rosewood Unit. The findings include:On 09/22/2025 at approximately 5:45 p. m., a test tray consisting of lasagna with meat sauce, sliced carrots, green beans and mash potatoes were placed on a food cart in the facility's kitchen and sent to the Rosewood Unit of the facility. The cart was followed by the surveyor, OSM (other staff member) #11, district manager for dietary. At approximately 6:05 p.m., the last dinner tray was served to a resident on the Rosewood Unit and OSM #11 was asked to remove cover from the test plate then proceeded to take the temperatures of the food. Two surveyors observed OSM #11 obtaining the food temperatures of the test tray. The lasagna with meat sauce was 127-degrees F (Fahrenheit), the green beans were 117-degrees F, sliced carrots were 113-degrees F and the potatoes were 112-degrees F. The test tray was sampled by two surveyors, OSM #11 for appropriate holding temperatures and palatable taste. When asked to describe the taste of the food OSM #11 stated the food could have been warmer. After tasting all the food on the test tray OSM #11 was asked if the food was palatable. She stated the food was not palatable and should have been 130-degree F. On 9/25/2025 at approximately 4:58 p.m. ASM (administrative staff member) #1, the executive director, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on resident interview, staff interview and facility document review, facility staff failed to provide HS (hours of sleep) snacks on two of two resident units, Dogwood and Rosewood units. The findings include:The facility's Meal Delivery Schedule documented in part, Breakfast (7:30 a.m.)-8:00 (a.m.)). Rosewood (unit) 8:00. Dinner 4:30 (p.m.)-5:15 (p.m.). Rosewood 5:15. According to the Meal Delivery Schedule there are 14 hours and 15 minutes between the last full evening meal and the first full meal of the next day. On 09/24/2025 at approximately 10:40 a.m. an interview was conducted with Resident #2 (R2), resident council president for the Rosewood unit, about snacks being provided to resident during the night shift. She stated that the residents are not offered snacks and that the resident council had never agreed to allow up to 16 hours to elapse between a substantial evening meal and breakfast the following day. On 09/24/2025 at approximately 10:50 a.m. an interview was conducted with R16, resident council president for the Dogwood unit, about snacks being provided to resident during the night shift. She stated that the residents are not offered snacks and that the resident council had never agreed to allow up to 16 hours to elapse between a substantial evening meal and breakfast the following day On 09/24/2025 at approximately 4:35 p.m. an interview was conducted with CNA (certified nursing assistant) #2 regarding snacks being provided to residents during the night shift. CNA #2 stated that in March and April 2025 she worked on the 7:00 p.m. to 7:00 a.m. shift and that snacks were not consistently provided to the residents because there were not enough staff. On 09/25/2025 at approximately 1:30 p.m. an interview was conducted with OSM #11, district manager for dietary , regarding HS snacks for residents. She stated the HS snacks consisted of sandwiches, cookies, crackers and drinks provided by the dietary department and sent to the nurse's stations at 7:00 p.m. each evening. She further stated that it was the responsibility of the nursing staff to pass on the snacks to the residents. OSM #11 also stated that she received pictures form OSM #12, the facility's dietary account manager, showing the HS snacks from previous evenings were not passed on to residents and she had an email from OSM #12 regarding concerns of the snack not being passed on to the residents. The email dated 08/14/2025 at 9:07 a.m. from OSM #12 to OSM #11 documented in part, .So the snacks are being given out. The CNAS (certified nursing assistants) and residents are still coming to get milk because it is not being given out. I did send (Name of Administrative staff Member #1) a text message of pictures to show her. In the stand up she told me she received them and told me she would address it but said nothing at the stand up meeting. But we are doing our part for once and they are not doing theirs. On 09/25/2025 an attempt to interview OSM #12 was unsuccessful due to her being out on leave. On 09/25/2025 at approximately 2:22 p.m. an interview was conducted with ASM #1, executive director regarding HS snacks. She stated that she did recall the messages from OSM #12 and purchased two new snack carts for each unit in August (2025). She also stated that she informed the nursing managers, LPN (licensed practical nurse) #1 and ASM #2 regarding residents not receiving the HS snacks. ASM #1 stated the nurse managers were to educate the nurses and CNAs who work on the 3:00 p.m.-11:00 p.m. shift about passing HS snacks to residents. On 09/25/2025 at approximately 3:00 p.m. an interview was conducted with ASM #2 regarding residents receiving HS snacks. She stated that it was hit or miss that the residents received the HS snacks. She further stated that she did not recall the conversation with ASM #1. On 09/25/2025 at approximately 4:20 p.m. an interview was conducted with LPN #1. She stated she did not recall the conversation with ASM #1 regarding the HS snacks. She further stated that the facility's was not bringing the snacks to the unit. On 9/25/2025 at approximately 4:58 p.m. ASM (administrative staff member) #1, the executive director, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. |

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| | 495315 | A. Building<br>B. Wing | 09/26/2025 |

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| Woodstock Valley Health and Rehabilitation | 803 South Main St<br>Woodstock, VA 22664 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations and staff interviews, the facility staff failed to serve food in a sanitary manner in one of one facility kitchens. The findings include:On 09/22/2025 at approximately 5:30 p.m. an observation in the facility kitchen revealed OSM (other staff member) #10, acting dietary manager and OSM #11 , district manager for dietary, hand drying 20 resident meal trays, placing them on the tray line. Continuing observation revealed kitchen staff at the tray line, sliding the meal trays down the tray line, placing resident's meals on the tray and placing the tray in the food carts to be taken to the unit floors. On 09/25/2025 at approximately 1:30 p.m. an interview was conducted with OSM #11. When informed of the observation as stated above OSM #11 stated that the meal trays should have been air dried to prevent contamination. On 9/25/2025 at approximately 4:58 p.m. ASM (administrative staff member) #1, the executive director, ASM #6, vice president of operations, and ASM #9, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0836<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.<br><br>Based on staff interview, and clinical record review, the facility staff failed to provide services in compliance with State code for one of 16 residents in the survey sample, Resident #1. The findings include:For Resident #1 (R1), the facility staff failed to obtain a physician's order for tramadol and oxycodone prior to administering the medications on 8/10/25. The Virginia Administrative Code 12VAC5-371-300 (E). Pharmaceutical services. documents, Excluding cannabidiol oil and THC-A oil, no drug or medication shall be administered to any resident without a valid verbal order or a written, dated and signed order from a physician, dentist, podiatrist, nurse practitioner, or physician assistant, licensed in Virginia. A review of R1's clinical record revealed the following physician's orders:5/18/25-tramadol 50mg (milligrams). One tablet by mouth every four hours as needed for pain.6/19/25-oxycodone 5mg. One tablet every six hours as needed for pain. R1 was transferred to the hospital on 7/29/25. R1 returned to the facility on 8/4/25 and the orders for tramadol and oxycodone were discontinued on that date. A review of R1's controlled medication utilization records revealed the resident was administered one tablet of tramadol 50mg on 8/10/25 at 9:15 a.m. and one tablet of oxycodone 5mg on 8/10/25 at 11:30 a.m. A review of R1's August 2025 physician's orders and August 2025 MAR (medication administration record) revealed there were no orders on 8/10/25 for tramadol or oxycodone (until back dated orders were created in the computer system on 8/19/25). A physician's order dated 8/10/25 and created on 8/19/25 by RN (registered nurse) #1 documented an order for oxycodone 5mg by mouth as needed for pain. Give a one-time dose. The order documented the medication was ordered by ASM (administrative staff member) #3 (R1's physician). A physician's order dated 8/10/25 and created on 8/19/25 by RN #1 documented an order for tramadol 50mg as needed by mouth times one dose. The order documented the medication was ordered by ASM (administrative staff member) #3 (R1's physician). A nurse's note with an effective date of 8/10/25 and created by RN #1 on 8/19/25 documented, Received order to give resident 50 mg po (by mouth) tramadol x (times) 1 dose, if ineffective give oxycodone 5 mg x 1 dose, VTO (verbal telephone order) (name of ASM #3). On 9/23/25 at 11:06 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that on 8/10/25, there were no tramadol or oxycodone orders for R1 in the computer system but there were tramadol and oxycodone medication cards with R1's name in the medication cart. RN #1 stated she incorrectly assumed the medications were prescribed for R1, so she administered the medications. RN #1 stated she did not directly talk to ASM #3 about this matter. RN #1 stated she entered the back dated orders into the computer system because someone from nursing management told her they spoke with ASM #3 who said he approved and to go ahead and enter the orders into the system. On 9/23/25 at 12:25 p.m., an interview was conducted with ASM #3. ASM #3 stated he did not remember anyone asking, or him approving orders for R1 to be administered one-time doses of tramadol or oxycodone for when the resident was administered the medications on 8/10/25. On 9/24/25 at 3:52 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated nurses definitely should obtain a physician's order prior to administering medications to a resident. On 9/24/25 at 4:58 p.m., an interview was conducted with LPN #1 (the staff development coordinator). LPN #1 stated she talked to ASM #3 about R1 but did not remember the conversation or recall information regarding late tramadol or oxycodone orders put into the computer system. On 9/24/25 at 5:22 p.m., an interview was conducted with ASM #2 (the director of nursing). ASM #2 stated she was not involved in R1's late tramadol or oxycodone orders being put into the computer system. On 9/25/25 at 4:59 p.m., ASM #1 (the executive director) was made aware of the above concern. No further information was presented prior to exit. |

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| F 0840<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.<br><br>Based on staff interview, and facility document review, the facility staff failed to provide evidence of an updated contract with an outside provider for one of eight contracts reviewed, potentially affecting seven residents who received respiratory equipment services. The findings include:The facility staff failed to provide an updated contract for respiratory equipment. A review of facility contracts with outside service providers revealed there was no current contractual agreement with the respiratory equipment provider. The contract was between the outside provider and the name of the previous owner of the facility, a company no longer in existence. On 9/25/25 at 1:54 p.m., an interview was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1 stated that when the new company began ownership of the facility (June 2025), she had to reach out to all vendors, write up new contracts, send the contracts to the new company's legal team for review, send the contracts back to the vendors for changes, then send the contracts back to the new company's legal team. ASM #1 stated the new company bought approximately 48 or 49 facilities and this has been a slow process. On 9/25/25 at 4:59 p.m., ASM #1 was made aware of the above concern. No further information was presented prior to exit. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to maintain a complete and accurate medical record for three of 16 residents in the survey sample, Residents #3, #2, and #1.The findings include:1) For Resident #3 (R3), the facility staff failed to maintain a complete and accurate medical record.<br><br>The resident admission demographics for R3 documented a discharge date of 4/8/2025.<br><br>The resident census information documented a stop billing date of 4/8/2025.<br><br>Review of the clinical record documented a fall risk evaluation, Braden scale for predicting pressure sore risk and elopement risk evaluation for R3 completed and dated 4/30/2025.<br><br>On 9/25/2025 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #1 who stated that assessments should be documented for the date that they are done and the assessments for R3 dated 4/30/2025 probably should have been late entries because the resident no longer resided at the facility at that time. She stated that the medical record was not accurate because R3 was not in the building on 4/30/2025.<br><br>The facility policy “Documentation in Medical Record” dated 6/1/2025 documented in part, “Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation… Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred… When documentation occurs after the fact, outside acceptable time limits, the entry shall be clearly indicated as “late entry”…”<br><br>On 9/25/2025 at 4:58 p.m., ASM #1, the administrator, was made aware of the concern.<br><br>No further information was provided prior to exit.<br><br>2. For Resident #2, the facility staff failed to document correctly the administration of Fentanyl.<br><br>The physician order dated 3/5/25, documented, “Fentanyl Transdermal Patch 72 Hours 75 MCG/HR (micrograms per hour); apply 1 patch every 3 days for chronic pain replace after 3 days and remove per schedule.”<br><br>The March 2025 MAR (medication administration record) documented the above order. For 3/20/25 it was documented the patch was removed but for the administration it was documented a “9” which indicates, “Other/See Nurse Notes.”<br><br>The nurse's note dated 3/20/25 at 3:36 p.m. documented in part, “Fentanyl…none acaaiable (sic)(available), np (nurse practitioner) to write script.”<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The narcotic sign-off sheet dated 3/4/25, documented the administration of the Fentanyl patch on 3/17/25. The narcotic sheet was dated 3/29/25, documented the administration of the Fentanyl on 3/29/25. There was no record of administration of Fentanyl on a narcotic sheet between 3/17/25 and 3/29/25, a period of 12 days.<br><br>An interview was conducted with LPN (licensed practical nurse) #1, on 9/24/25 at 11:47 a.m. LPN #1 stated a nurse evidence that she's given a medication by checking it off on the MAR. The above MAR was reviewed with LPN #1. LPN #1 stated it is an error in documentation as the nurse signed it off and didn't give it as it wasn't in the building according to the narcotic sign off sheets.<br><br>ASM (administrative staff member) #1, the executive director, and ASM #6, the vice president of operations, were made aware of the above concern on 9/24/25 at 5:32 p.m.<br><br>No further information was obtained prior to exit.<br><br>References:<br><br>1.This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601202.html.<br><br>3. For Resident #1 (R1), the facility staff failed to document complete and accurate information regarding the resident's change in condition and interventions that were implemented on 8/10/25.<br><br>A review of R1's clinical record revealed a change in condition form dated 8/10/25 that documented R1 was non-responsive, staff called 911, and the resident was transferred to the hospital. A review of R1's nurses' notes dated 8/10/25 failed to document information regarding the resident's change in condition or interventions that were implemented.<br><br>On 9/23/25 at 11:06 a.m., an interview was conducted with RN (registered nurse) #1 (the nurse who sent R1 to the hospital). RN #1 stated that on 8/10/25, R1 became unresponsive. RN #1 stated she had administered narcotic medication to R1 earlier that day so when the resident became unresponsive, she administered two doses of Narcan (medication used to reduce or reverse the effects of opioids) which were not effective. RN #1 stated another nurse attempted to obtain R1's vital signs. RN #1 stated R1 looked like she wasn't breathing, and the resident's oxygen saturation level did not register, so RN #1 administered oxygen via a non-rebreather mask and began chest compressions until EMS (emergency medication services) arrived. RN #1 stated she should have documented this information in R1's clinical record.<br><br>On 9/25/25 at 4:59 p.m., ASM (administrative staff member) #1 (the executive director) was made aware of the above concern.<br><br>No further information was presented prior to exit. |

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| F 0843<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care.<br><br>Based on staff interview, and facility document review, the facility staff failed to provide evidence of an updated hospital transfer agreement for one of one agreement reviewed, potentially affecting all residents, a census of 86. The findings include:The facility staff failed to provide an updated hospital transfer agreement. A review of the hospital transfer agreement revealed there was no current contractual agreement with the hospital. The agreement was between the hospital and the name of the previous owner of the facility, a company no longer in existence. On 9/25/25 at 1:54 p.m., an interview was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1 stated that when the new company began ownership of the facility (June 2025), she had to reach out to all vendors, write up new contracts, send the contracts to the new company's legal team for review, send the contracts back to the vendors for changes, then send the contracts back to the new company's legal team. ASM #1 stated the new company bought approximately 48 or 49 facilities and this has been a slow process. On 9/25/25 at 4:59 p.m., ASM #1 was made aware of the above concern. No further information was presented prior to exit. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>Based on staff interview, and facility document review, the facility staff failed to ensure the required QAPI (Quality Assurance and Performance Improvement) committee members attended for three of three quarterly meeting reviews, (October 2024 through December 2024, January 2025 through March 2025, and April 2025 through June 2025). The findings include:The facility staff failed to ensure an Infection Preventionist attended QAPI meetings from October 2024 through June 2025. A review of QAPI meeting sign-in sheets for October 2024 through June 2025 failed to reveal the signature of an Infection Preventionist. On 9/25/25 at 1:54 p.m., an interview was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1 stated an infection preventionist is supposed to attend the QAPI meetings and she could not show an infection preventionist attended the QAPI meetings from October 2025 through June 2025. On 9/25/25 at 4:59 p.m., ASM #1 was made aware of the above concern. 1. The facility policy titled, Quality Assurance and Performance Improvement (QAPI) documented, The QAA Committee shall be interdisciplinary and shall:a. Consist at a minimum of: i. The Infection Preventionist.b. Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary. No further information was presented prior to exit. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to implement infection control practices for one of 14 residents in the survey sample, Resident #104. The findings include:For Resident #104 (R104), the facility staff failed to implement enhanced barrier precautions (1) during wound care. A review of R104's clinical record revealed a wound care physician note dated 11/28/25 that documented R104 presented with a stage four pressure injury (2) on the sacrum. A physician's order dated 12/1/25 documented, Cleanse wound with wound cleanser. Pat dry. Apply medihoney and foam to wound bed QD (every day) one time a day for Wound care. Further review of R104's clinical record failed to reveal a physician's order for enhanced barrier precautions. On 12/2/25 at 11:24 a.m., LPN (Licensed Practical Nurse) #5 was observed performing wound care on R104's sacral wound. LPN #5 did not wear a gown during wound care. A Centers for Disease Control sign on R104's room door documented, ENHANCED BARRIER PRECAUTIONS. EVERYONE MUST Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contract Resident Care Activities .Wound Care: any skin opening requiring a dressing. On 12/2/25 at 11:48 a.m., an interview was conducted with LPN #5. LPN #5 stated the sign on the door documented to wear a gown during wound care and she did not. On 12/2/25 at 3:24 p.m., ASM (Administrative Staff Member) #1 (the [NAME] President of Operations), ASM #2 (the traveling Director of Nursing), and ASM #3 (the acting Director of Nursing) were made aware of the above concern. The facility policy titled, Enhanced Barrier Precautions documented, 2.b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers) . 3. Implementation of Enhanced Barrier Precautions: b. PPE (Personal Protective Equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities .4. High-contact resident care activities include: h. Wound care: any skin opening requiring a dressing . No further information was presented prior to exit. References:(1) Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). This information was obtained from the website: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html (2) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar (dead skin tissue) may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. |