STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynn Care Center	1000 Shenandoah Avenue Front Royal, VA 22630

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to protect the residents' right to be free from physical abuse by other residents for 11 of 52 residents in the survey sample, Residents #127, #94, #126, #128, #25, #13, #41, #68, and #58, resulting in the identification of immediate jeopardy; and for Residents #48 and #35. The findings include:1. For Resident #127 (R127), the facility staff failed to protect the resident's right to be free from physical abuse by Resident #99 on 2/1/25.A review of the facility's final synopsis of events dated 2/6/25 revealed, in part: On Saturday, February 1, 2025, it was alleged that [R99] became agitated, combative and struck [R127] in her left eye on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both residents, they wander throughout the unit and [R99] can become agitated and combative at times, especially when residents are in her personal space. When interviewing both residents involved, neither resident was able to recall the event.A review of R127's clinical record revealed the following progress notes: 2/1/25 Resident was part of an altercation with [R99]. [R99] was swinging both arms and hit [R127] in the face from behind with closed hands unprovoked. [R127] was sitting at dining room table waiting on lunch. CNAs (certified nursing assistants) separated the residents immediately and notified the nurse.2/3/25 Support visit held with resident. Resident was involved in an unprovoked altercation with [R99] where she was struck in the face. Resident denies any pain at the time. Resident denies recall of the altercation. When asked if resident felt safe, she stated yes.A review of R127's comprehensive care plan dated 1/28/25 failed to reveal any information related to this incident of abuse.2. For Resident #94 (R94), the facility staff failed to protect the resident's right to be free from physical abuse by Resident #99 on 2/15/25.A review of the facility's final synopsis of events dated 2/20/25 revealed, in part: On Saturday, February 15, 2025, it was alleged that [R99] became combative and struck [R94] on the right side of her face on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both residents, they wander throughout the unit and [R99] can become agitated and combative at times, especially when residents are in her personal space. When interviewing both residents involved, neither resident was able to recall the event.A review of R94's clinical record revealed the following progress note dated 2/17/25: Support visit held with resident r/t (related to) altercation with [R99]. Resident unable to recall the event. Resident stated she felt safe and happy.A review of R94's comprehensive care plan dated 1/16/25 revealed no information related to this incident of abuse.3. For Resident #126 (R126), the facility staff failed to protect the resident's right to be free from physical abuse by Resident #99 (R99) on 3/25/25.A review of the facility's final synopsis of events dated 3/27/25 revealed, in part: On Tuesday, March 25, 2025, it was alleged that [R99] became combative and struck [R126] on the right side of her face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	both residents, they wander throughout the unit and [R99] can become aggressive, without provocation. When interviewing both residents involved, neither resident was able to recall the incident.A review of R126's clinical record revealed the following progress note dated 3/25/25: This nurse was coming out of nurse station and saw [R99] struck (sic) [R126] with a fabric bed pad on the right side of her face. Separated [R99] immediately from situation. No injuries observed. No S/S (signs or symptoms) of distress or discomfort.A review of R126's comprehensive care plan dated 1/16/25 revealed no information related to this incident of abuse.4. For Resident #128 (R128), the facility staff failed to protect the resident's right to be from physical abuse from Resident #99 (R99) twice on 4/18/25 and on 4/20/25.A review of the final facility synopsis of events dated 4/24/25 revealed, in part: On Friday April 18, 2025, it was alleged that [R99] became combative and struck [R128] in the face on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both [R99] and [R128], they both wander throughout the unit; [R99] can become protective of the staff when other residents become agitated or aggressive towards them and [R128] is very anxious and can become easily agitated and aggressive with staff at times, especially when she feels as though others are in her personal space. When interviewing both residents involved, neither resident was able to recall the incident.A review of R128's clinical record revealed the following progress note dated 4/18/25 at 6:30 p.m.: Was told by another resident and CNA (certified nursing assistant) that this resident got in [R99's] face and was yelling and allegedly [R99] struck resident in the nose. There was a small red spot at time of incident on the [NAME] of [R128]'s nose. No other injuries observed.A review of the final facility synopsis of events dated 4/24/25 revealed, in part: On Friday April 18. 2025, it was alleged that [R99] became combative and struck [R128] in the face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both [R99] and [R128], they both wander throughout the unit. [R99] can become agitated and aggressive when someone is in her personal space and [R128] is very anxious and can be impulsive at times grabbing items that do not belong to her. When interviewing both residents involved, neither resident was able to recall the incident.A review of R128's clinical record revealed the following progress note dated 4/18/25 at 12:47 p.m.: Nursing observations, evaluation and recommendations are: Resident got in another resident's face and gets into their food. [R99] got upset and allegedly struck [R128]'s face. No injuries to the face.A review of the facility's final synopsis of events dated 4/25/25 revealed, in part: On Sunday April 20, 2025, it was alleged that [R99] became combative and struck [R128] in the mouth on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both [R99] and [R128], they both wander throughout the unit; [R99] can become protective of the staff when other residents become anxious, aggressive or physical towards them, and [R128] is very anxious and will grab on to staff at times for comfort, especially when she feels overwhelmed. When interviewing both residents involved, neither resident was able to recall the incident.A review of R128's clinical record revealed the following progress note dated 4/21/25 at 12:28 a.m.: Reported to this writer resident was punched by [R99] in the upper lip. CNA (certified nursing assistant) stated she was escorting [R128] from room [ROOM NUMBER]. [R128] grabbed CNA's upper arm. [R99] was outside room [ROOM NUMBER] when she grabbed CNA's other arm, told [R128] to let go of her. [R99] then punched [R128]in the upper lip. Both residents were separated.A review of R128's comprehensive care plan dated 2/17/25 revealed no information related to these incidents of abuse.5. For Resident #25 [R25], the facility staff failed to protect the resident's right to be free from physical abuse from Resident #99 (R99) on 5/17/25.A review of the facility's final synopsis of events dated 5/23/25 revealed, in part: On Saturday May 17, 2025, it was alleged that [R99] became combative and struck (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	writer went to intervene, resident went to swing at writer. [R99] hit resident on shoulder.Was able to redirect [R99] to their room. Resident remained agitated and aggressive toward staff. 8/21/25 2:06 p.m. Support visit held. Resident has no recall of negative encounter with another resident.A review of R41's comprehensive care plan dated 2/2/25 revealed no information related to the incident of abuse.8. For Resident #68 (R68), the facility staff failed to protect the resident's right to be free from physical abuse from Resident #99 (R99) on 10/24/25.A review of the facility's final synopsis of events dated 10/31/25 revealed, in part: On Friday, October 24, 2025, it was alleged that [R99] became combative and struck [R68]on the right side of her face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both residents that [R99] wanders throughout the unit and can become agitated when another resident is in her space. When interviewing both residents involved, [R68] was able to recall the incident.A review of R68's clinical record revealed the following progress notes: 10/24/25 9:45 p.m. Resident states [R99] was aggressive towards her. No injuries noted at this time and Resident denies pain or discomfort. 10/25/25 6:50 a.m. This writer spoke with [R68] in reference to her complaint of [R99] being aggressive on 10/24/25. Resident stated she was 'whacked' across the right side of her face. 10/27/25 Resident presented as anxious throughout [social services] visit; however, she attributed it to adjusting to new environment due to recent admission. She did not express feeling unsafe in her environment.A review of R68's comprehensive care plan dated 10/23/25 revealed no information related to the incident of abuse.9.a. For Resident #58 (R58), the facility staff failed to protect the resident's right to be free from physical abuse from Resident #99 (R99) on 8/16/25.A review of the facility's final synopsis of events dated 8/22/25 revealed, in part: On Saturday, August 16, 2025, it was alleged that [R99] became agitated and aggressively pulled [R58]'s hair in the dining area of the Memory Care Unit. Throughout the investigation, it was reported by staff that frequently care for both [R99] and [R58] that they both wander throughout the unit and [R99] can become agitated at times, especially when residents are in her personal space. When interviewing both residents involved, none was able to recall the event.A review of R58's progress notes revealed, in part: 8/16/25 Resident was at dining room table when [R99] grabbed her hair at back of head, shook her head. CNA (certified nursing assistant) intervened and redirected [R99]. Resident removed from dining room and vital signs taken. No apparent injuries noted.8/18/25 Support visit held. Resident has no recall of negative encounter with another resident.On 1/8/26 at 11:29 a.m., LPN (licensed practical nurse) #1, a unit manager, was interviewed. She stated usually there is a staff member in the memory care unit dining room. She explained that a hospitality aide sits among the residents and monitors them in the morning. She stated if residents become involved in a physical altercation, the staff separates, redirects them, and assesses them for injury. She stated that if a resident is hit in the face or head, the likelihood of a serious injury would depend on the situation. She explained that if a resident is punched with a fist, then there is a good likelihood of a serious injury. She stated there is also a likelihood of serious injury such as bleeding if the resident who is hit is on a blood thinning medication. She stated that any resident could experience bruising or a laceration if they are hit hard enough. She added that even residents with cognitive impairment like those who live on the memory care unit can be traumatized by a resident to resident altercation. She stated residents on the memory care unit are especially vulnerable to serious injury because of their cognitive status, and because they are sometimes not able to communicate their symptoms. On 1/12/26 at 2:36 p.m., OSM (other staff member) #9, the director of social services, was interviewed. She stated her [NAME] is to focus on the residents' needs after a resident to resident altercations. She stated she wants to make sure that the residents still feel (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for four of 52 residents in the survey sample, Residents #94, #128, #25, and #13.The findings include:1. For Resident #94 (R94), the facility staff failed to revise the resident's care plan after she was abused by Resident #99 (R99).A review of the facility's final synopsis of events dated 2/20/25 revealed, in part: On Saturday, February 15, 2025, it was alleged that [R99] became combative and struck [R94] on the right side of her face on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both residents, they wander throughout the unit and [R99] can become agitated and combative at times, especially when residents are in her personal space. When interviewing both residents involved, neither resident was able to recall the event.A review of R94's clinical record revealed the following progress note dated 2/17/25: Support visit held with resident r/t (related to) altercation with [R99]. Resident unable to recall the event. Resident stated she felt safe and happy.A review of R94's comprehensive care plan dated 1/16/25 revealed no information related to this incident of abuse.On 1/12/26 at 2:36 p.m., OSM (other staff member) #9, the director of social services, was interviewed. She stated she is responsible for following up on a resident's psychosocial needs following any resident to resident altercation. She stated the abused resident's care plan should be updated following any such incident.On 1/12/26 at 3:24 p.m., RN (registered nurse) #3 was interviewed. She stated that a resident's care plan is maintained to make sure all care team members are on the same page and are providing appropriate care to the resident. She stated the resident's care plan should be updated for any victim of abuse. She explained that unit managers ordinarily update the care plans.On 1/12/26 at 3:43 p.m., LPN (licensed practical nurse) #7, a unit manager, was interviewed. She stated a resident's care plan should be updated after an incident of abuse by another resident because such an event could trigger a trauma response. She stated floor nurses do not typically update care plans, and that this task is usually accomplished by unit managers.A review of the facility policy, Care Planning - Comprehensive Person-Centered, revealed, in part: The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans.When there has been a significant change in the resident's condition.When goals, needs, and preferences change.On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns.No additional information was provided prior to exit.2. For Resident #128 (R128), the facility staff failed to revise the resident's comprehensive care plan after she was abused by Resident #99 (R99).A review of the final facility synopsis of events dated 4/24/25 revealed, in part: On Friday April 18, 2025, it was alleged that [R99] became combative and struck [R128] in the face on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both [R99] and [R128], they both wander throughout the unit; [R99] can become protective of the staff when other residents become agitated or aggressive towards them and [R128] is very anxious and can become easily agitated and aggressive with staff at times, especially when she feels as though others are in her personal space. When interviewing both residents involved, neither resident was able to recall the incident.A review of R128's clinical record revealed the following progress note dated 4/18/25 at 6:30 p.m.: Was told by another resident and CNA (certified nursing assistant) that this resident got in [R99's] face and was yelling and allegedly [R99] struck resident in the nose. There was a small red spot at time of incident on the [NAME] of [R128]'s nose. No other injuries observed.A review of the (continued on next page)

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Lynn Care Center	1000 Shenandoah Avenue Front Royal, VA 22630

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	final facility synopsis of events dated 4/24/25 revealed, in part: On Friday April 18. 2025, it was alleged that [R99] became combative and struck [R128] in the face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both [R99] and [R128], they both wander throughout the unit. [R99] can become agitated and aggressive when someone is in her personal space and [R128] is very anxious and can be impulsive at times grabbing items that do not belong to her. When interviewing both residents involved, neither resident was able to recall the incident.A review of R128's clinical record revealed the following progress note dated 4/18/25 at 12:47 p.m.: Nursing observations, evaluation and recommendations are: Resident got in another resident's face and gets into their food. [R99] got upset and allegedly struck [R128]'s face. No injuries to the face.A review of the facility's final synopsis of events dated 4/25/25 revealed, in part: On Sunday April 20, 2025, it was alleged that [R99] became combative and struck [R128] in the mouth on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both [R99] and [R128], they both wander throughout the unit; [R99] can become protective of the staff when other residents become anxious, aggressive or physical towards them, and [R128] is very anxious and will grab on to staff at times for comfort, especially when she feels overwhelmed. When interviewing both residents involved, neither resident was able to recall the incident.A review of R128's clinical record revealed the following progress note dated 4/21/25 at 12:28 a.m.: Reported to this writer resident was punched by [R99] in the upper lip. CNA (certified nursing assistant) stated she was escorting [R128] from room [ROOM NUMBER]. [R128] grabbed CNA's upper arm. [R99] was outside room [ROOM NUMBER] when she grabbed CNA's other arm, told [R128] to let go of her. [R99] then punched [R128]in the upper lip. Both residents were separated.A review of R128's comprehensive care plan dated 2/17/25 revealed no information related to these incidents of abuse.On 1/12/26 at 2:36 p.m., OSM (other staff member) #9, the director of social services, was interviewed. She stated she is responsible for following up on a resident's psychosocial needs following any resident to resident altercation. She stated the abused resident's care plan should be updated following any such incident.On 1/12/26 at 3:24 p.m., RN (registered nurse) #3 was interviewed. She stated that a resident's care plan is maintained to make sure all care team members are on the same page and are providing appropriate care to the resident. She stated the resident's care plan should be updated for any victim of abuse. She explained that unit managers ordinarily update the care plans.On 1/12/26 at 3:43 p.m., LPN (licensed practical nurse) #7, a unit manager, was interviewed. She stated a resident's care plan should be updated after an incident of abuse by another resident because such an event could trigger a trauma response. She stated floor nurses do not typically update care plans, and that this task is usually accomplished by unit managers.On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns.No additional information was provided prior to exit.3. For Resident #25 [R25], the facility staff failed to revise the resident's comprehensive care plan after she was abused by Resident #99 (R99). A review of the facility's final synopsis of events dated 5/23/25 revealed, in part: On Saturday May 17, 2025, it was alleged that [R99] became combative and struck [R25] on the right side of her face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both residents, that [R99] wanders throughout the unit and can become aggressive immediately after care as she does not like anyone in her personal space. When interviewing both residents involved, neither resident was able to recall the incident.A review of R25's clinical record revealed the following progress notes: 5/17/25 [R99] was combative and swung her hand at glove dispenser that gave her a skin tear on left wrist. After resident was out of the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bathroom she went to [R25] and hit the other resident on the right side of her face. The two were separated, assessed, and treated as per protocol. 5/19/25 This writer provided follow up visit r/t (related to) negative encounter with another resident. She was unable to recall incident. She did not express any concern or fear of safety to this writer. She presented calm with no s/s (signs or symptoms) of distress.A review of R25 comprehensive care plan dated 3/5/25 revealed no information related to this incident of abuse.On 1/12/26 at 2:36 p.m., OSM (other staff member) #9, the director of social services, was interviewed. She stated she is responsible for following up on a resident's psychosocial needs following any resident to resident altercation. She stated the abused resident's care plan should be updated following any such incident.On 1/12/26 at 3:24 p.m., RN (registered nurse) #3 was interviewed. She stated that a resident's care plan is maintained to make sure all care team members are on the same page and are providing appropriate care to the resident. She stated the resident's care plan should be updated for any victim of abuse. She explained that unit managers ordinarily update the care plans.On 1/12/26 at 3:43 p.m., LPN (licensed practical nurse) #7, a unit manager, was interviewed. She stated a resident's care plan should be updated after an incident of abuse by another resident because such an event could trigger a trauma response. She stated floor nurses do not typically update care plans, and that this task is usually accomplished by unit managers.On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns.No additional information was provided prior to exit.4. For Resident #13 (R13), the facility staff failed to revise the resident's comprehensive care plan after she was abused by Resident #99 (R99). A review of the facility's final synopsis of events dated 6/24/25 revealed, in part: On Wednesday, June 18, 2025, it was alleged that [R99] became combative and aggressive and struct [R13] on the right side of her face with a comb in the memory care unit. Throughout the investigation, staff who frequently cared for [R99] and [R13] reported that they wander throughout the unit. Staff also reported that [R99] can become agitated at times, especially when residents are in her personal space. When interviewing both residents involved, neither resident was able to recall the incident.A review of R13's clinical record revealed the following progress notes: 6/18/25 8:16 a.m. The resident was sitting in her wheelchair by the nurse's computer table when another resident approached her and hit her on the face with a comb. Nurse assessed the face, no injuries noted. 6/18/25 12:17 p.m. Support visit held. Resident has no recall of negative encounter with another resident. Resident cont. (continued) to ask questions back to this writer and stated she did feel safe in facility.A review of the facility's final synopsis of events dated 11/7/25 revealed, in part: On Sunday, November 2, 2025, it was alleged that [R99] became combative and struck [R13] in the middle of her face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both residents that [R99] can become agitated when another resident touches her or is in her space. When interviewing both residents involved, neither was able to recall the incident.A review of R13's clinical record revealed the following progress notes: 11/2/25 8:00 p.m. This nurse was notified by CNA (certified nursing assistant) that resident was hit in the face with a padded box by [R99] after this resident gently touched [R99] on the arm. This nurse assessed resident. No injuries noted. 11/4/25 4:19 p.m. Bruising to upper lip noted after incident occurred. 11/5/25 1:58 p.m. Resident met with this writer but did not provide any remembrance to questions regarding her recall of a negative encounter with another resident or her comfort level among others in the facility.A review of R13's comprehensive care plan dated 12/17/24 revealed no information related to the incidents of abuse.On 1/12/26 at 2:36 p.m., OSM (other staff member) #9, the director of social services, was interviewed. She stated she is (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsible for following up on a resident's psychosocial needs following any resident to resident altercation. She stated the abused resident's care plan should be updated following any such incident.On 1/12/26 at 3:24 p.m., RN (registered nurse) #3 was interviewed. She stated that a resident's care plan is maintained to make sure all care team members are on the same page and are providing appropriate care to the resident. She stated the resident's care plan should be updated for any victim of abuse. She explained that unit managers ordinarily update the care plans.On 1/12/26 at 3:43 p.m., LPN (licensed practical nurse) #7, a unit manager, was interviewed. She stated a resident's care plan should be updated after an incident of abuse by another resident because such an event could trigger a trauma response. She stated floor nurses do not typically update care plans, and that this task is usually accomplished by unit managers.On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns.No additional information was provided prior to exit.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide care, services, and adequate supervision for resident safety for two of 52 residents in the survey sample, Resident #99, resulting in the identification of immediate jeopardy and for Resident #40, resulting in harm. The findings include:1. For Resident #99 (R99), on twelve occasions in 2025, the resident physically assaulted other residents on the memory care unit, despite being known to have had previous aggressive behaviors. The lack of adequate supervision of R99 resulted in injury to two victims, Residents #127 and #128. On 2/1/2025, R99 struck Resident #127 in the left eye resulting in redness to the eye. On 4/18/2025, R99 struck Resident #128 in the face resulting in bruising on the bridge of the nose. On the significant change minimum data set (MDS) with an assessment reference date (ARD) of 12/8/2025, R99 was coded as being severely impaired for making daily decisions with diagnoses that included but were not limited to non-Alzheimer's dementia and depression. The assessment documented no functional limitation in range of motion for upper or lower extremities and the resident not using a wheelchair or walker. It further documented that R99 required substantial/maximal assistance for transfers and partial/moderate assistance for walking 10/50/150 feet. The MDS assessment documented behaviors of rejection of care occurring daily that had worsened since the previous assessment. On 1/6/2026 at 9:19 AM, R99 was observed sitting in a recliner in the common area of the memory care unit eating breakfast. On 1/7/2026 at 5:05 PM, R99 was observed sitting in a recliner in the common area of the memory care unit. R99 was observed to be drowsy but easily aroused when approached by staff. R99's dinner tray was delivered by staff and placed on a tray at the side of the recliner however R99 did not eat until a staff member sat with them and assisted them to eat. On 1/8/2026 at 7:49 AM, R99 was observed in bed. From 8:21a.m. to 8:25 a.m., R99 was observed standing and walking independently without support while straightening the sheet and blanket on the bed in their room. The resident was observed kneeling on the bed, crawling on the bed and sitting down on the bed. At 8:29 a.m. R99 left the room with a certified nursing assistant (CNA) arm-in-arm from the room to a recliner in the dining area. After arriving in the dining area, the activities assistant held resident's hand while the aide placed a changing pad in the recliner. Further observation revealed the resident initiated the hand holding while waiting to sit in the recliner. On 1/8/2026 at 11:45 AM, R99 was observed in a recliner in the common area of the memory care unit. R99 was observed getting out of the recliner and standing up beside the chair. At that time, licensed practical nurse (LPN) #1 came over to R99 and assisted them to ambulate down the hallway to their room into the bathroom. A review of R99's clinical record revealed facility documentation regarding aggressive behaviors dating back to 12/30/2024. Interventions for 1:1 supervision until back to baseline were documented on 12/31/2024, 2/1/2025, 2/15/2025 and 3/25/2025, as well as increased supervision as tolerated on 4/18/2025. A review of the facility synopsis of events documented R99 striking Resident #127 in the left eye (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	resulting in redness to the eye on 2/1/2025 and R99 striking Resident #128 in the face on 4/18/2025 resulting in bruising on the bridge of the nose. Review of additional events documented R99 involved in the following resident to resident altercations with no injuries observed. On 12/30/2024, R99 struck Resident #58 on the left side of the face, on 2/15/2025, R99 struck Resident #94 on the right side of the face and on 3/25/2025, R99 struck Resident #126 with a cloth pad on the right side of the face. On 4/18/2025, R99 struck Resident #128 on the right side of the face, on 4/20/2025, R99 struck R128 in the mouth and on 5/17/2025, R99 struck Resident #25 in the face. On 6/18/2025, R99 struck Resident #13 on the right side of the face with a comb, and on 8/16/2025, R99 aggressively pulled Resident #58's hair. On 8/20/2025, R99 struck Resident #41 on the arm, on 10/25/2025, R99 struck Resident #68 on the right side of the face and on 11/3/2025, R99 struck Resident #13 in the face. The events documented them happening on the memory care unit with other cognitively impaired residents. Review of the final investigation summaries for the events documented statements that included, Throughout the investigation it was reported by staff that frequently care for both residents, that [R99] wanders throughout the unit and can become protective over staff when another resident is in their space . , [R99] can become protective of the staff when other residents become anxious, aggressive or physical towards . and [R99] can become aggressive, without provocation . The comprehensive care plan, initiated 12/23/2024 and updated 11/3/2025, documented in part, BEHAVIORS: [Name of R99] has behaviors of kicking, grabbing, being combative and scratching staff during care. Other behaviors include: refusing medications and throwing them on the floor, throwing objects at staff or onto the floor, wandering into other residents rooms and rummaging through their belongings. Striking other residents with a closed fist; combative/ physical with staff; kicking and spitting at staff; being confrontational with staff and other resident and not easily being redirected; throwing medication; shaking other residents; attempting to strike other residents, some being successful attempts; Throwing drinks at staff; Crying at times with no known cause; Becoming verbally abusive to other residents; Urinating in inappropriate areas; Striking other residents with objects 11/2/25. Change in Condition evaluations for R99 documented in part, - 2/1/2025 15:00 (3:00 PM) Behavioral symptoms, Resident hit another resident . Resident was fine just a few minutes before, and then out of nowhere she began sticking [sic] another resident. It was unprovoked . needs one on one watching when like this . - 4/18/2025 12:47 (12:47 PM) Behavioral symptoms . This resident allegedly struck resident [Room number of other resident] after her food was touched at lunch time. This resident was separated and redirected. No injuries observed at the time of this incident . - 4/18/2025 16:30 (4:30 PM) Behavioral symptoms . Dinner time this resident was approached by the resident in [Room number of other resident] in the dining room while aides were assisting other residents with their dinner. This resident allegedly struck resident in the nose. At the time it weas [sic] a little red . Separated and redirected until back to baseline . - 4/20/2025 19:43 (7:43 PM) Behavioral symptoms . This resident was observed striking the resident in [Room number of other resident] in the face in the hallway. No injuries observed . - 6/18/2025 07:45 (AM) Behavioral symptoms . Resident approached another resident that was sitting in her wheelchair and hit her on the face with a comb. Resident re-directed . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- 8/16/2025 23:54 (11:54 PM) Other change in condition: Physical aggression initiated . resident grabbed hair of [Room number of other resident] and shook head. No injuries to that resident. This resident was redirected to her room. Resident's daughter came in to sit w/resident . - 8/20/2025 22:59 (11:59 PM) Other change in condition: resident became physically aggressive . resident was walking towards [Room number of other resident] and [Room number] started yelling at resident. This writer stepped in between and [Room number of other resident] swung at this writer and resident swung at [Room number of other resident] making contact with [Room number of other resident] L (left) shoulder. [Room number of other resident] swung at resident and made contact w/resident's L shoulder. Was able to redirect resident to her room. [Room number of other resident] followed and threw pack of wipes at resident and this writer but missed. Tried redirecting [Room number of other resident] back to living room . - 10/24/2025 21:30 (9:30 PM) Other change in condition: Another Resident states [R99] was going through her drawers and aggressive tour [sic] her when she asked her to stop . - 11/2/2025 20:56 (8:56 PM) Other change in condition: resident to resident altercation . resident hit another resident [Room number of other resident] in the face with a padded sewing box after [Room number of other resident] reached out and gently touched resident, both residents assessed, no injuries noted, all parties notified . Psychiatry progress notes for R99 documented in part, - 2/10/2025 . The patient was asked to be seen by the psych team the patient reportedly has been aggressive towards other residents in the facility therefore the medications are adjusted . Patient is encouraged to participate in activities on the unit . - 3/10/2025 .reportedly the patient has been still having episodes of irritability and agitation and appears to be hyperactive and labile . -3/21/2025 .reported by staff that the patient continues to have episodes of mood swings and irritability therefore the medications are adjusted . - 5/30/2025 .behavioral disturbances including combativeness and crying spells . history of violent behavior towards others . Nurses and CNA's reports that the incidents of combativeness are reported to occur daily, often triggered by perceived threats to her possessions or food . While the overall frequency of combative episodes has decreased, the patient remains capable of violent outbursts . - 6/6/2025 . The nurse reported that the patient is always agitated and has a history of physical altercations, including unprovoked attempts to hit others. Her behavior can be triggered by perceived threats or playful actions from others. She has been known to approach and try to fight individuals in these situations . - 6/20/2025 . The patient's aggressive episodes appear to be triggered by agitation and anxiety. Nurse reports that when the patient is pissed off, she becomes combative when approached and potentially kicking others. These incidents are not isolated, with staff noting that such behavior occurs every time the patient is agitated. Patient continue to pace around appearing anxious .Treatment plan: Agitation and Aggressive Behavior, This appears to be a recurrent issue, as staff report that the patient becomes agitated and potentially violent when pissed off. Continue to monitor and redirect (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	patient as needed . - 7/11/2025 . presents with increasing aggression. She has always been exhibiting violent behavior, including hitting, smacking and throwing coffee. Last night, she threw hot coffee on a nurse and broke a CNA's necklace . The severity of her actions is significant, as evidenced by the hot coffee incident and the breaking of a CNA's necklace. These behaviors are impacting the safety of the healthcare staff and potentially other patients on the unit . Treatment Plan: Aggressive Behavior, Plan: Exercise caution for safety when interacting with the patient. Monitor patient closely for further aggressive outbursts . - 8/19/2025 . incidents of aggression towards another resident. The patient reportedly exhibited aggressive behavior over the weekend, which involved grabbing another resident's hair while the other resident was in a wheelchair . This nurse described her behavior as unpredictable, especially towards new people . - 9/23/2025 . Patient throw [sic] water at another resident, which appears to be related to her dislike of having her personal space invaded, though she herself tends to be touchy and likes to touch others . - 10/28/2025 . On Friday night, [R99] was observed going through a new resident [Name of other resident] drawers, and when [Name of other resident] asked her to stop, [R99] turned and punched her. [Name of other resident] was able to recall and recount this incident multiple times over several hours and again today, though no staff witnessed the actual event. [R99]'s aggressive behaviors toward staff have been worsening, including hitting, spitting, and kicking. While she has always exhibited these behaviors, they are becoming more frequent and severe. She is more easily triggered and angered, with episodes of including crying spells. Specifically, she becomes triggered when she sees other peers and the husband of one of the residents and attempts to go after him for no apparent reason. Treatment adherence has been problematic, as [R99] frequently refuses to take her medications . - 11/18/2025 .She has had two physical altercations with other people over the past couple of weeks with the most recent incident occurring the weekend before last (not this past weekend) . On 1/8/2026 at approximately 9:10 AM, an interview was conducted with other staff member (OSM) #1, activities assistant, regarding R99's ambulation status and behaviors. OSM #1 stated that she worked on the memory care unit every day, was familiar with R99 and frequently provided one-to-one interaction with them. She stated that R99 could walk independently but required someone to walk next to them due to the risk of falling. OSM #1 stated that R99 had attempted to hit another resident when their wheelchair came close to them, but they did not hit R99. OSM #1 stated she could not recall when the incident occurred, but she had intervened by grabbing R99's hand. On 1/8/2026 at approximately 9:20 AM, an interview was conducted with CNA #1 who stated that R99 could walk by herself but required supervision to prevent falls. She stated that the type of supervision R99 required when walking was for staff to walk with them. CNA #1 stated that R99 had behaviors of hitting in the past but not recently. On 1/8/2026 at approximately 9:25 AM, an interview was conducted with CNA #2 who stated that she had worked with R99 for approximately a month. She stated that R99 could walk by themselves but required someone to hold their hand to prevent falls and that she had not witnessed any aggressive behaviors. (continued on next page)

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Lynn Care Center	1000 Shenandoah Avenue Front Royal, VA 22630

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/8/2026 at approximately 9:33 AM, an interview was conducted with LPN #1 who stated that R99 required stand-by assistance when ambulating to prevent falls. She stated that R99 no longer wandered on the unit but would wander in their room around their bed by themselves. LPN #1 stated that since a recent fall, R99 had not been aggressive towards other residents. At 11:30 AM, LPN #1 stated that staff supervision of residents on the memory care unit was by staff who stayed in the common area and rounded on residents in their rooms a minimum of every two hours. She stated that they tried to prevent any altercations but if anything happened they immediately separated the residents. LPN #1 stated that if a resident was hit in the face or head there were risks because it was a more sensitive area. She stated that if a resident was on a blood thinner that increased the risk of bleeding, bruising, brain bleeding, or mental status changes. LPN #1 stated that the residents on the memory care unit were more vulnerable due to their cognitive status and they were less likely to report any altercations but more at risk due to behaviors. On 1/8/2026 at approximately 11:54 AM, an interview was conducted with LPN #6 who stated that on the memory care unit they supervised the residents by having staff in the common area to monitor the residents at the tables and in the recliners and she parked the medication cart facing them when passing medications to watch them. She stated that the CNAs rounded on the residents in the rooms every couple of hours or more as needed. LPN #6 stated that if they had residents with aggressive behaviors they tried not to escalate the behaviors to an altercation and tried to redirect them and watch a little more closely. She stated that if a resident received a hit to the head by a fist there could be a likelihood of injury, but it depended on the situation. LPN #1 stated that residents on blood thinners or with bleeding disorders would be at risk from being hit in the face or head because it could cause bruising, bleeding, a laceration or trauma. She stated that in her previous employment any resident hit in the head would be sent out for evaluation if they were on blood thinners due to the risk, but she was not sure of the practice at the facility. LPN #6 stated that they used activities and music and tried to create a calming space for the residents on the memory care unit because they were more vulnerable due to their cognitive status and they could not advocate for themselves. On 1/12/2026 at 3:24 PM, an interview was conducted with registered nurse (RN)#3 who stated that if one resident struck another, it was abuse. She stated that residents are not being adequately supervised if they are repeatedly abusing other residents and in these cases, the facility staff should be looking more closely at these residents and providing closer supervision. The facility's deficient practice placed all residents on the memory care unit at risk of being abused by R99. This resulted in a determination of Immediate Jeopardy (IJ), cited at level four pattern beginning on 2/1/2025. On 1/8/2025 at 1:44 PM, administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were informed of these concerns and that the facility was in immediate jeopardy (IJ). On 1/8/2025 at 6:04 PM, the facility's IJ Removal Plan was accepted by the SA (state agency) supervisor. Facility Removal Plan Plan of corrective action for those residents found to be affected by deficient practices:Resident #99 was placed on 1 on 1 supervision until the resident discharge or significant change in condition limits the resident's physical ability to come in contact with another resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Corrective Actions taken for residents with potential to be affected by deficient practice: All residents of the facility have the potential to be affected by this deficient practice. An audit will be conducted on Point of Care behavior documentation for the current month to ensure that residents identified with aggressive behaviors have interventions and care plans in place to provide adequate supervision. Systemic changes put into place to ensure the deficient practice does not reoccur: All staff of the facility/agency will be reeducated on the HVHC Safety and Supervision of Residents Policy. All staff will have education starting on 1/8/26, any staff not present on 1/8/26 will be required to receive mandatory education prior to the start of their next shift. No staff member will be allowed to return to work after 1/8/26 until this mandatory education has been completed. New hire orientation will include this training as part of the new hire process and all agency staff will be required to complete this education prior to starting work in the facility. The facility alleges removal of the Immediate Jeopardy on 1/8/2026 at 8:00 p.m. On 1/9/2026 at 9:00 a.m., the survey team began verification of the facility's removal plan. This verification process included observation of the resident on 1:1 supervision, staff interviews on all elements of the removal plan, and review of the facility's credible evidence. The survey team was able to verify that the facility completed the removal plan on 1/8/2026 at 8:00 p.m. After immediate jeopardy was removed, the scope and severity was lowered to a level three isolated. A review of the facility policy, Safety and Supervision of Residents documented in part, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed. This determination is based on the individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident . The care team will target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices . Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly and consistently; b. Evaluating the effectiveness of interventions; c. Modifying or replacing interventions as needed; and d. Evaluating the effectiveness of new or revised interventions. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment . No additional information was provided prior to exit. 2. For Resident #40 (R40), the facility staff failed to provide adequate supervision for the prevention of a fall resulting in hospitalization for a right hip fracture and a brain bleed. R40 was admitted to the facility with a diagnosis that included but not limited to muscle weakness, difficulty walking and dementia (1). On the most recent comprehensive MDS (minimum data set), a 5 (five)-Day assessment with an ARD (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	(assessment reference date) of 06/29/2025, R40 scored 2 (two) out of 15 on the BIMS (brief interview for mental status), indicating R40 was severely impaired of cognition for making daily decisions. GG0170 Mobility coded R40 as requiring Substantial/maximal assistance –)helper does more than half the effort. The helper lifts or holds trunk or limbs and provides more than half the effort) for Sit to stand: the ability to come to a standing position from sitting in a chair, wheelchair or on the side of the bed. Under Toilet transfer: The ability to get on and off a toilet or commode R40 was coded 88. Not attempted due to medical condition or safety concerns. The comprehensive care plan for R40 dated 04/24/2025 it documented in part, Focus. Risk For Falls: the resident is at risk for falls related to: functional impairments, impaired physical mobility. Date Initiated: 04/24/2025. Revision on 05/12/2025. Under Interventions it documented in part, Educate staff on importance of not leaving resident alone in room. Date Initiated: 06/06/2025. The Occupational Therapy (OT) Discharge Summary for R40 dated 07/09/2025 documented in part, STG (short term goal) #1.0 Discontinue on 07/03/2025. Patient will increase standing balance during ADLs (activities of daily living) to Fair spontaneously righting self when needed in order to reduce the risk for falls and in order to facilitate upright posture. Discharge (07/03/25) Fair-(Min(A) (minimal assistance) or UE (upper extremity) support to stand w/o (without) LOB (loss of balance) & (and) to reach ipsilaterally (2); unable to weight shift). The Physical Therapy (PT) Evaluation & Plan of Treatment for R40 dated 07/23/2025 documented in part, STG #2.0 – New Goal. Patient will safely perform functional transfers with MOD(A) (moderate assistance) and 50% (fifty percent) Verbal Cues and 50% Tactile (touch0 Cues for proper sequencing w/o LOB and with reduced risk for falls in order to facilitate increased participation with functional daily activities and facilitate increased (I) (independence) with functional mobility throughout facility. (Target 8/5/2025). Baseline (7/23/2025). Transfers Max(A) (maximum assistance). The facility's Fall Risk Assessment for R40 dated 05/27/2025 and 06/05/2025 documented in part, A score of 10 or above deems residents at risk. The fall risk assessment dated [DATE] documented AT RISK and a fall risk score of 19.0 and the fall risk assessment dated [DATE] documented AT RISK and a fall risk score of 11.0. The facility's nursing note for R40 dated 7/29/2025 documented, 23:38 (11:38 p.m.) Note Text: resident on bathroom floor laying on R (right) side. Nursing supervisor called to come and assist this writer. Resident c/o (complain of) R hip pain, R elbow pain. v/s (vital signs) obtained bp (blood pressure) -147/76 147 over 76), p (pulse)-74, temp (temperature)-96.8, r (respiration)-22, O2 (oxygen saturation)-84%. 3 rd (third-eye; physician on-call service) was contacted with no response, (Name of Physician) was contacted and left a detailed message of the incident. Per assessment of the resident [sic] was determined to call 911 to send resident to hospital for further evaluation. Skin assessment performed and has contusion (bruise) to R elbow, contusion to R side of head, healingbruise [sic] to L (left) hand. And bilateral (both sides) lower leg edema (swelling). Resident was transferred via (by) ambulance to ER (emergency room) with correct paperwork to include face sheet, med (medication) list, DNR (Do Not Resuscitate). Did contact ER to let them know of the incident and resident would be on the way. Rsident [sic] RP (responsible party) (Name of RP) was contacted. The facility's nursing note for R40 dated 7/29/2025 documented in part, 23:51 (11:51 p.m.) Situation: The Change In Condition/s reported on this CIC (change in condition) Evaluation are/were: Falls. Nursing observations, evaluation, and recommendations are: resident on bathroom floor c/o R hip pain and R elbow pain. vs obtained and documented. resident then stated to c/o needing to throw up and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	was determined to send resident to ER. The facility's nursing note for R40 dated 7/29/2025 documented, 02:23 (2:23 a.m.) Note Text: received phone call from ER and resident has a R hip fracture and a brain bleed. ER trying to get a hold of RP. Advised ER I would try to call as well. Left message with granddaughter (Name of Granddaughter) and son (Name of Son) to call ER as soon as possible. ER is wanting to transfer resident to (Name of Hospital). The ED (emergency department) report from (Name of Hospital) for R40 dated 07/30/2025 documented in part, Final Impression. 1. Fall, initial encounter. 2. Closed fracture of right hip, initial encounter. 3. Intercranial hemorrhage (brain bleed). On 01/06/2026 at approximately 1:10 p.m. an interview was conducted with OSM (other staff member) #3, occupational therapist, regarding R40's sitting and standing balance. She stated R40 received occupational therapy for ADLs (activities of daily living). She stated that R40 had poor standing balance and required supervision due to the fact that R40 was impulsive when she wanted to stand. On 01/06/2026 at approximately 1:36 p.m. an interview was conducted with OSM (other staff member) #4, physical therapist, regarding R40's sitting and standing balance. She stated R40 had poor standing balance and required maximum assistance (support when standing) and R40's transfers also required maximum assistance. On 01/07/2025 at approximately 10:02 a.m. a telephone interview was conducted with CNA #5 regarding the fall and injury R40 sustained on 07/29/2025. She stated that she was familiar with R40 and that R40 had difficulty with standing balance and required someone to be within reach of her. CNA #5 stated she was familiar with R40's fall precautions and the only time R40 could be alone was [NAME] she was in bed or in a wheelchair. She also stated R40 was at risk for falls when transferring and standing up. She stated she was working on the night shift on the Shenandoah Gardens unit on 07/29/2025 and assisted R40 to and on the toilet in R40's room when R40's roommate entered the room and tried to enter the bathroom while R40 was occupying the toilet. She stated that she physically redirected the roommate to another resident room to use the bathroom. When asked to elaborate her actions regarding R40 being on the toilet and redirecting R40's roommate she stated that she closed the bathroom door while R40 was sitting on the toilet so she could open the resident room entrance door and physically escorted R40's roommate out of the room to another resident room next to R40's room. CNA #5 stated that she left R40 for only a brief period of time and when she went back to R40 she found R40 on the bathroom floor. On 01/07/2025 at approximately 12:04 p.m. an interview was conducted with LPN (licensed practical nurse) #8. She stated that at the time of R40's fall, 07/29/2025, she was working during the night shift as the night shift supervisor and was on another unit when the incident occurred. She stated she received a call from LPN #2 who was on the Shenandoah Gardens unit informing her that a resident had fallen and was on the floor in their bathroom and was requesting assistance. She further stated that when she arrived on the Shenandoah Gardens unit she witnessed LPN #2 assessing R40 and assisted in cleaning R40 of feces and transferring the resident to her bed. She stated R40 complained of right hip pain. She stated that the on-call physician service was called but did not get a response from the medical director, so the director of nursing (DON) was called and informed her of the incident and situation. She stated that the DON told them not to wait for a call back from the medical director and call 911 to R40 sent to the hospital. LPN #8 stated she spoke with CNA #5 to determine what had happened. She stated CNA #5 told her that she took R40 to the bathroom and assisted R40 onto the (continued on next page)

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