STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495319	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Boulevard Post Acute	9229 Arlington Blvd Fairfax, VA 22031

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	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, clinical record review, and facility documentation review, the facility staff failed to provide supervision for one resident, Resident #96 (R96), to prevent a fall resulting in harm, and failed to provide a safe bed environment for one resident, Resident #100 (R100) of twenty-nine residents in the sample. The findings included1. The facility staff failed to provide adequate supervision and assistance during incontinence care of Resident #96 (R96), which resulted in R96 sustaining a fall that required immediate medical attention at the hospital and resulted in sutures, which constituted harm. Resident #96 was admitted to the facility on [DATE], with diagnoses of, but not limited to, metabolic encephalopathy, cognitive communication disorder, hemiplegia (affecting the left nondominant side) and urinary tract infection. R96 was discharged to an acute care facility on 11/29/2024 and did not return. Resident #96's, most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 08/02/24, was an admission Assessment. The MDS coded Resident #96 with a BIMS (Brief Interview for Mental Status) score of 9 out of 15 possible points, indicating the moderate cognitive impairment. Resident #96 was unable to complete the interview. The Functional Abilities Assessment coded R96 as requiring substantial/maximal assistance for rolling left and right, and as not attempted due to medical condition or safety for sitting to lying, lying to sitting, sitting to standing, chair transfer and walking. On 04/07/26, at approximately 10:00 a.m., and multiple times during the four days of survey, Residents were observed in their hospital beds, in the low position, some with grab bars or partial rails. No issues observed with supervision, or turning and repositioning during or after incontinent care. A closed clinical record review of Resident #96's chart revealed the following: On 09/26/24, a Bedrail assessment was completed by OT (occupational therapy): Pt [patient] verbalizes understanding of risks and benefits of installation of U-bar bed rails. Pt would benefit from U-bar on L [left] side of bed to increase independence with turning/positioning while in bed and transfers to/from bed. Discussed with nursing regarding results of assessment and visual inspection of bed, noting that mattress overhangs from bed frame on R [right] side of bed. On 09/30/24, a Fall Risk Assessment read in part, Fall Risk: History of falls (past 3 months): 1-2 falls in past 3 months. Level of consciousness / mental status: Alert (oriented x 3) OR comatose. Resident is chairbound / incontinent. Systolic blood pressure: No noted drop between lying and standing. Vision (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	status: Adequate (with or without glasses). Predisposing disease: None present. Resident had a change in condition in the last 14 days. Recent hospitalization history in last 30 days: Yes. Notes: Resident Gait / balance: Balance problem while walking. Medication: Takes 1-2 of these medications (or medication classes) currently and / or within last 7 days. Fall Risk Score: 11.0 [sic]. On 09/30/24 a Fall Note entry read, Around 06:00 am, This Writer was given the morning medications upon entering I observed the Assigned CNA [certified nursing assistant] was changing the Resident brief the Resident was turn to her right side at the moment Resident ask if she had bowel movement in the second the Resident fell from the bed to the floor she Hurt[sic] her Head to the dresser , Resident noted with bleeding to the head , Immediately this writer assessed the resident including ROM [range of motion], PAIN, Vital signs , This writer call 911 they arrived at facility at around 06:15 am and Resident was transferred to [hospital name redacted] Hospital by Ambulance with all required Medications list , face sheet, MD (medical doctor) and RP (Responsible Party) contacted by phone notified about the fall , Unit Manager aware [sic]. On 09/30/24, a Post Fall Progress Note read: Resident is alert and oriented to self and situation with some confusion, continues neuro checks after returning from the ER [emergency room], Pupils reactive to light, lung sounds clear bilaterally on auscultation, capillary refill less than three seconds, abdomen soft, non-distended, bowel sounds active in all four quadrants. Resident had a left side weakness, bruising to the left eye, skin tear to forehead has two sutures, scant bleeding observed intermittently. pressure dressing applied. No complaint of pain or discomfort. skin warm to touch, urine color yellow with clear consistency. ADLs provided, medications administered [sic]. On 10/01/24 a Post Fall Progress Note entry read, Resident is S/P [status post] Fall day 1/3, alert and oriented verbally responsive noted in bed with both eyes close ,easily arouse to environmental stimuli ,HOB [head of bed] elevated to prevent aspiration, no complaint of pain or discomfort noted , Temp-97.8, no acute respiration distress noted at this time ,BP [blood pressure] taken within normal limit, abdomen is soft, non-distended, non-tender to touch , Resident is incontinent of bowel and bladder, required one person assist for transfer, safety precaution maintained bed in lower position call light within reach[sic]. R96's care plan was reviewed and revealed the care plan was initiated on 07/26/24. No guidance regarding supervision, turning, repositioning or incontinent care was on the initial Care Plan. The care plan was updated 09/30/24 on to include Incontinent Care and Turning and Repositioning will be provided by 2 Staff. On 04/8/26, at 11:10 a.m., an interview was conducted with CNA (Certified Nursing Assistant) CNA #1. When asked if she remembered R96 she stated that she did not. When asked to explain what is expected for a resident that with cognitive impairments, and or functional impairments and is agitated but requires incontinent care? She stated she would wait to see if the resident settled down, or if she could assist to calm the resident first. Then I would get someone to assist with the incontinent care for safety. When asked, would you attempt to move the resident? CNA#1 said, not at that time. On 04/8/26, at 2:20 p.m., an interview was conducted with the Director of Nursing (DON), and the Regional Director of Operations. We discussed R96 and the documentation of the fall on 09/30/24. When asked if she remembered R96 or the alleged fall. The DON stated that most of the staff were new, and that she was not here then. When asked what is expected during turning and repositioning of dependent Residents, during turning, repositioning and incontinent care. The DON stated she would (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	expect the staff to assess the resident for needs functional status first, take care of the resident according to the physician orders and care plan. When asked, based on the clinical record documentation reviewed, what would she have expected? The DON stated R96's care plan did not provide care parameters regarding turning positioning and incontinent care prior to the actual fall on 09/30/24. The care plan was updated on 09/30/24, to include Incontinent Care and Turning and Repositioning will be provided by 2 Staff. On 04/09/26, an interview was conducted with CNA #6, who stated that she was working with R96 on the morning of the fall 09/30/24. She stated that R96 had multiple episodes of diarrhea and some vomiting during the night. Also stated that in the past, R96, spouse had directed the staff to clean R96 quickly, because she gets more agitated when she is soiled. CNA #1 said she knew this to be true as she was very familiar with working R96. She went on to say that R96 was very agitated on the morning of 09/30/24, it was the end of shift and the other CNA was busy, so she asked Licensed Practical Nurse (LPN) #1 to assist her with incontinent care for R96, because we never attempt to turn, reposition, provide incontinent care or get R96 up by ourselves with one person because she is a fighter, a large woman, a tall woman. She went on the say the LPN#1 had R96 on her [the resident's] right side while CNA#1 was standing on the other side of the bed, behind the resident, changing the pull sheet and pad. When R96 pushed LPN#1 and yelled leave me alone CNA#1 stated that was when R96, fell off the bed striking her head on the nightstand as she fell. CNA #1 stated that the nurse immediately called for help. The physician and Resident Representative were notified. This finding was reviewed with the administrator and DON during a meeting on 4/8/26 at 5:35 p.m. and again on 04/09/26 at 11:15 a.m. with no further information presented prior to the end of the survey. 2. Facility staff failed to provide a safe bed environment for Resident #100. Resident #100 was observed in bed with a mesh barrier/rail installed along the middle portion of the bedside with no indication for use or prior assessment for safety. Resident #100 (R100) was admitted to the facility with diagnoses that included humerus fracture, vertigo, major depression disorder and cognitive communication deficit. An admission assessment dated [DATE] assessed R100 as alert and oriented to person, place and time. On 4/6/26 at 3:21 p.m., R100's bed was observed. The bed had 1/4 length grab rails installed on both sides near the head of the bed. Installed on the left side of the bed (standing at foot of bed), inside the grab rail, was a mesh barrier/rail covering the middle section of the bed. The barrier had a small diameter metal frame covered with a stretchy, mesh fabric. The mesh barrier was approximately 25 inches tall and covered the entire middle portion of the bedside. On 4/6/26 at 5:08 p.m., R100 was observed in bed with the mesh barrier/rail in the raised position. R100 was interviewed at this time about the mesh barrier. R100 stated she used the mesh rail at her home to keep her from rolling/falling out of bed. R100 stated she had experienced falls from the bed at home and that her family member insisted that she use the rail while in the nursing facility. R100 denied any falls or accidents since her admission to the nursing facility. R100's clinical record documented a nursing note dated 3/28/26 stating, .Resident arrived to the unit via stretcher .Sling in place on left arm. Per family, resident is a high fall risk and they are requesting bed rails for tonight. Supervisor was notified. Family plans to bring bed rails from home this evening; request approved by supervisor . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R100's clinical record documented an admission assessment and baseline care plan for use of bed rails dated 3/28/26. This assessment documented the resident was appropriate for use of 1/4 length right and left grab rails. A consent was signed by R100's family member on 3/30/26 for 1/4 length grab/bed rails. R100's clinical record documented a physician's order dated 3/31/26 for side rails/grab bars for bed mobility. There was no assessment, physician's order or plan of care for use of the mesh covered barrier/rail provided by the family and observed in use on 4/6/26. On 4/7/26 at 3:43 p.m., the registered nurse unit manager (RN #3) was interviewed about the mesh barrier/rail on R100's bed. RN #3 stated the family brought and installed the mesh barrier/rail to R100's bed and that she had previously told the resident and family member that the mesh barrier was not allowed. RN #3 stated she provided the family member education about bed rails. RN #3 stated she thought the family member just brought it (mesh barrier/rail) anyway. RN #3 stated the mesh barrier/rail was not installed by facility staff and that the family member had installed the device. RN #3 stated the mesh barrier/rails should not be in use on the resident's bed. RN #3 stated staff had not reported to her that the mesh barrier/rail was currently in use. On 4/7/26 at 4:46 p.m., the director of nursing (DON) was interviewed about the mesh barrier/rail observed on R100's bed. The DON stated she thought the family had been told that the mesh barrier/rail was not allowed. The facility's policy/side rail consent form (signed 3/30/26) documented the facility's policy as, The Resident has the right to be free from use of side rails when imposed for purposes of discipline or convenience, and not required to treat the Resident's medical symptoms/need . The consent form documented benefits of side rail use include provision of assistance for turning/positioning, transfers, stabilization while sitting on the side of the bed and to keep resident independently in control of mattress position. The consent form documented risks of side rails included entrapment, injuries such as skin tears/abrasion/bruises, psychological risks including humiliation, fear of abandonment, depression, agitation, catastrophic reactions for residents with dementia, panic, acting out behaviors and disorientation. This finding was reviewed with the administrator and DON during a meeting on 4/8/26 at 5:35 p.m. with no further information presented prior to the end of the survey.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility document review and clinical record review, facility staff failed to follow physician orders for four of twenty-nine residents in the survey sample (Residents #11, #38, #41, and #72) and failed to provide care for a skin tear in a manner to promote healing for one of twenty-nine residents in the survey sample (Resident #11).The findings included:1. Resident #11 did not have care provided for a skin tear at the frequency ordered by the physician. Staff failed to provide a dressing change for the skin tear in a manner to promote healing. Resident #11 (R11) was admitted to the facility with diagnoses that included atrial fibrillation, depression, end stage renal disease with hemodialysis, anemia, osteoarthritis, respiratory failure, polyneuropathy, hypertension and congestive heart failure. The minimum data set (MDS) dated [DATE] assessed R11 as cognitively intact. a.) Resident #11 did not have care provided for a skin tear on 4/4/26 as ordered by the physician. On 4/6/26 at 2:54 p.m., R11 was observed in her room. A dressing was observed on R11's right lower leg with date of 4/2 written on the dressing. R11 was interviewed at this time about the dressing. R11 stated she hit her leg against the wheelchair when getting out of bed and got a skin tear on the right lower leg. R11's clinical record documented a nursing note dated 3/27/26 stating the resident was observed in the bathroom with skin tear noted on the right shin with the resident reporting that she bumped her leg against the wheelchair. This note documented a physician's order dated 3/27/26 to cleanse the right shin skin tear with wound cleanser, pat dry, apply Xeroform and cover with dry dressing each Tuesday, Thursday and Saturday. R11's treatment administration record (TAR) documented dressing changes were scheduled as ordered with the most recent dressing change listed as 4/4/26. On 4/6/26 at 3:15 p.m., accompanied by licensed practical nurse (LPN #4), registered nurse (RN #2) and with R11's permission, the dressing on the resident's right lower leg was observed, dated 4/2. LPN #4 was interviewed at this time about the date on the dressing and the orders requiring a dressing change on 4/4/26. LPN #4 stated that the dressing should have been changed on Saturday 4/4/26. LPN #4 stated she was not sure why the dressing was not changed on 4/4/26 as ordered. On 4/6/26 at 3:38 p.m., accompanied by LPN #4 and with the resident's permission, a dressing change was observed to the right lower leg skin tear. The skin tear was irregular shaped with scabbed skin noted along the edges of the wound. Red tinted drainage was noted on the removed dressing with the Xeroform dressing slightly stuck to the wound. The skin surrounding the wound was pink/red with purplish tone. On 4/7/26 at 3:33 p.m., the unit manager (RN #3) caring for R11 was interviewed about the wound care not completed on 4/4/26 as ordered. RN #3 stated the wound care should have been provided on 4/4/26 as ordered/scheduled and that the nurse should not have documented the wound care was done if not completed. On 4/7/26 at 4:31 p.m., the director of nursing (DON) was interviewed about the missed wound care on 4/4/26. The DON stated that nurses were expected to follow physician orders and if not followed, the provider should have been notified and an explanation provided. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11's clinical record documented a physician assessment of the skin tear on 4/8/26. Current treatment with Xeroform was continued with referral to the wound consultant for ongoing monitoring/treatment. The facility's policy titled Physician Orders (revised January 2025) documented, .Licensed nurses will obtain, document and provide care and services in accordance with orders received from the physician . This finding was reviewed with the administrator and DON during a meeting on 4/7/26 at 5:15 p.m. with no further information presented prior to the end of the survey. b.) Facility staff failed to provide care for R11's skin tear in a manner to promote healing. On 4/6/26 at 3:38 p.m., with R11's permission, licensed practical nurse (LPN #4) was observed performing wound care/dressing change to the resident's right lower leg skin tear with the following observed. LPN #4 used hand sanitizer, put on a gown and clean gloves then entered the resident's room carrying wound care supplies. LPN #4 touched the room light switch to turn on the overhead light then rearranged/moved R11's personal items from the overbed table. Without sanitizing the table or providing a clean barrier, LPN #4 placed the dressing change supplies that included gauze pads, cover dressing and wound cleanser on the overbed table. With the resident on the bed, LPN #4 placed a clean barrier under the right lower leg. LPN #4 then moved the trash can near to bedside, touching the edges of the trash can with her gloved hand. With no hand hygiene or gloves changed, LPN #4 opened the gauze packages, placing the clean gauze pads on top of the gauze packaging. LPN #4 then removed the soiled dressing from R11's leg. LPN #4 sprayed the wound with cleanser several times as the soiled Xeroform dressing was adhered to the wound. With the same gloves on since entering the room, LPN #4 loosened then removed and discarded the soiled Xeroform gauze from the skin tear. Without hand hygiene or gloves changed, LPN #4 then cleansed the wound using wound cleanser spray and clean gauze, wiping and discarding several times over the wound and surrounding skin. LPN #4 then removed gloves and without hand hygiene, put on clean gloves prior to placing the new Xeroform gauze on the skin tear and covering the wound with a dry dressing. LPN #4 then removed the barrier from under the leg, discarded used items, removed gloves and used hand sanitizer. The skin tear was irregular shaped with scabbed skin noted along the edges of the wound. Red tinted drainage was noted on the removed dressing and the skin surrounding the wound was pink/red with purplish tone. On 4/6/26 at 3:50 p.m., LPN #4 was interviewed about the observed dressing change without a clean surface for supplies and lack of hand hygiene/glove changes between contact with dirty/clean items. LPN #4 stated she should have cleaned the overbed table prior to placing clean supplies. Regarding hand hygiene and glove changes, LPN #4 stated she used hand sanitizer prior to entering the room. LPN #4 stated she changed gloves during care and used alcohol wipes on her hands between the glove change. On 4/7/26 at 3:33 p.m., the registered nurse unit manager (RN #3) caring for R11 was interviewed about the observed wound care. RN #3 stated if room items were touched such as the light switch and trash can, the nurse should have performed hand hygiene and put on clean gloves prior to touching the wound. RN #3 stated nurses were expected to follow infection control practices for all wound care. On 4/7/26 at 4:01 p.m., the infection preventionist was interviewed about the observed wound care for R11's skin tear. The infection preventionist stated that nurses were expected to follow infection (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	protocols during wound care. The infection preventionist stated hand hygiene was supposed to be done between glove changes, after handling soiled/dirty items and prior to cleaning the wound. On 4/7/26 at 4:31 p.m., the director of nursing (DON) was interviewed about the observed wound care for R11's skin tear. The DON stated, The basics were not followed. The DON stated that care should have been provided adhering to infection control protocols for wound care. The facility's policy titled Wound Treatment (reviewed July 2024) documented, .The purpose of this procedure is to provide guidelines for the care of wounds to promote healing . This policy documented steps for wound care included, .Assemble the equipment and supplies as needed .Disinfect overbed table .Perform hand hygiene .Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table .Prepare supplies on the clean field using clean technique .mark dressing label or tape with date, time, and initials .prepare a plastic bag or wastebasket for discarded materials .Position resident .Place disposable cloth next to resident (under the wound) to serve as a barrier .Perform hand hygiene and put on clean gloves .Remove soiled dressing and discard into designated container .Remove gloves and perform hand hygiene .Put on clean gloves .Evaluate the appearance of the wound and surrounding skin .Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke .Apply treatment as ordered .Apply dressing as ordered .Reposition the resident if necessary .Discard disposable items into appropriate receptacle. Remove gloves and discard .Perform hand hygiene .Disinfect reusable supplies as indicated (i.e., outsides of containers that were touched by unclean hands, scissor blades, etc.) Return supplies to treatment cart . This finding was reviewed with the administrator and DON during a meeting on 4/7/26 at 5:15 p.m. with no further information presented prior to the end of the survey. 2. Resident #41 did not have weekly weights obtained as ordered by the physician and per the plan of care. Resident #41 (R41) was admitted to the facility with diagnoses that included cerebrovascular accident (stroke), vascular Parkinson's, dementia, aphasia, dysphagia with use of gastrostomy, protein-calorie malnutrition, vertebra compression fracture, seizures and spondylosis. The minimum data set (MDS) dated [DATE] assessed R41 with short and long-term memory problems and moderately impaired cognitive skills. R41's clinical record documented a physician's order dated 2/24/26 for weekly weights each Tuesday. R41's plan of care (initiated 2/25/26) documented the resident was at risk of malnutrition and altered hydration due to dysphagia. Interventions to maintain proper nutrition/hydration included, Obtain weights at ordered intervals. R41's clinical record documented a weight was obtained on 3/31/26 but no other weights were documented in the clinical record. R1's medication administration record documented weights were scheduled but not obtained on 3/3/26, 3/10/26, 3/16/26, 3/24/26 and 4/7/26. Codes were entered on these dates by nursing indicating the ordered weights were not obtained. Nursing notes documented no explanation of why the weights were not done as ordered. On 4/8/26 at 12:11 p.m., the registered nurse unit manager (RN #3) caring for R41 was interviewed about the ordered weight monitoring. RN #3 stated the weights were obtained but not entered into the electronic health record. RN #3 stated the weights were provided to the registered dietitian (RD) and that the RD was responsible for adding the weights to the clinical record. When asked for the weights, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #3 stated again the weights had been provided to the RD. On 4/8/26 at 1:17 p.m., the facility's RD (other staff #3) was interviewed about the ordered weight monitoring for R41. The RD had a sticky note with no resident name and weights listed dated 3/10/26 and 3/24/26. The RD stated R41 had a weight in the record upon admission from the hospital but no admission weight was obtained at the facility. The RD stated it was protocol to obtain an initial weight upon admission and weights were ordered weekly for monitoring. The RD stated that R41 was difficult to weigh because she required a mechanical lift. The RD stated she had asked about the weights and did not know why the weights were not obtained as ordered. The facility's policy titled Physician Orders (revised January 2025) documented, .Licensed nurses will obtain, document and provide care and services in accordance with orders received from the physician .The provision of care and services in accordance with the physician orders will be documented in accordance with professional standards of practice . This finding was reviewed with the administrator and director of nursing during a meeting on 4/8/26 at 5:35 p.m. with no further information presented prior to the end of the survey. 3. Resident 38 (R38) did not have compression stocking applied as ordered. R38 diagnoses included Dementia, atrial fabulation, anxiety, and depression. The most recent MDS (minimum data set) was a quarterly assessment dated [DATE] and indicated R38 was cognitively intact. Review of R38's active physician orders documented Compression stockings every day and evening shift for hypotension. Apply in the mornings, remove in the evenings. On 4/7/2026 at 2:30 p.m. R38 was observed in the dining area without compression stockings in place. On 4/8/2026 at 11:46 a.m. R38 was again observed in the dining area without compression stockings. At this time license practical nurse (LPN #5, assigned to R38 on 4/7/26 and 4/8/26) was interviewed. LPN #5 observed R38 without compression stockings and said they are supposed to be applied in morning and said they were not applied because R38 toe is hurting. It was expressed to LPN #5 that R38 had not had stockings applied on 4/7/26 and 4/8/26 and the treatment administration record (TAR) had documented they were applied on 4/7/26 and had yet to be documented on 4/8/26. LPN #5 did not give a reason for the documentation of applying compression hose for 4/7/26. LPN #5 was asked to accompany the surveyor to see if there were any compression stockings in R38's room. After looking through drawers and a closet, an unopened pair of compression stockings were found in the bottom of one of the dresser drawers. Further review of R38's clinical record did not evidence that R38 was or had been complaining of toes hurting or physician being notified that R38 was unable to wear compression hose due to toes hurting. On 4/8/26 at 5:20 p.m. the administrator and director of nursing (DON) was notified of the above finding. On 4/9/26 at 10:30 a.m. the DON verbalized that the TAR indicated R38 had refused compression (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stockings on 4/8/26. It was expressed to the DON that the documentation on 4/8/26 was done after bringing it to the attention of LPN #5 and attempting to apply the compression hose. No other information was provided prior to exiting the facility on 4/9/26. 4. For R72, the facility staff failed to ensure that a physician order for daily weights was implemented. On 4/8/26 at 6:00 pm, a clinical record review was conducted. During the clinical record review, it was identified that a physician order existed for daily weights for R72. There was no documented evidence that daily weights had been initiated or consistently obtained as ordered. On 4/9/26 at 9:00 am, an interview was conducted with the director of nursing, (DON). During the interview the DON stated that physician order was expected to be entered and followed as written. The DON reviewed the electronic record for R72 and acknowledged that the order for daily weights had not been followed. At the time of the interview, the DON indicated that daily weights for R72 would begin that day. The facility's policy titled Physician Orders (revised January 2025) documented, .Licensed nurses will obtain, document and provide care and services in accordance with orders received from the physician .The provision of care and services in accordance with the physician orders will be documented in accordance with professional standards of practice . The administrator, director of nursing, and regional director of operations was informed of the above findings. There was no new information provided prior to exit conference.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility documentation review, the facility staff failed to store and label food in accordance with professional standards for food safety in the main kitchen and on one of three units, (Cardinal) unit. The findings included:In the main kitchen the facility staff failed to discard items beyond the use by date in the dry storage and refrigerated storage areas and the items were available for use. In the main kitchen the facility staff failed to wear hair restraints while in food preparation areas, failed to perform hand hygiene to prevent contamination of food, and failed to maintain food holding temperatures. On 04/06/2026 at 3:10 p.m. an initial tour of the main kitchen was conducted with the Executive Chief. Prior to observation of dry goods and refrigerators, executive chef was asked what the expectation of opened items (dry goods and refrigerated items) regarding labeling them. The executive chef replied that all open items should have an open date and use by date when the product is opened. The kitchen tour was then conducted with the executive chef. The dry storage room yielded the following open products with used by dates of 4/5/26: a half a bag of open rice and a half of a bag of dry cereal. In walk-in refrigerator, covered containers of used Texas Barbeque sauce, ricotta, chipotle cream and garlic aioli that were all dated to be used by 4/4/2026. The reach-in refrigerator contained two large silver trays, one tray had eleven 1-pound packets of deli sliced turkey. The other tray contained seventeen 1-pound packets of deli sliced ham. All packages of deli meat had a use by date of 4/5/26. The executive chef removed all items of concern and verbalized due to the use by date the items should not have been in the refrigerator and will be discarded. On 04/07/26 at 11:33 AM a follow-up visit to the kitchen was conducted. Upon entering the kitchen staff could be heard speaking in loud voices, they're here they're here. It was noted that the staff were putting on hair and beard nets. While reviewing food temperatures on the tray line with the executive chef, a cold turkey salad croissant had a temperature of 46.8 degrees. The croissant was then plated and placed on the food cart to be served. At this time the executive chef was asked what holding temperature should cold turkey salad be. The executive chef verbalized the turkey salad should be held at 41 degrees or less. It was then pointed out that staff had just plated the turkey salad and placed it on the cart to be served. The executive chef removed the tray from the cart and then removed all croissants from the tray line. During food service prep a dietary staff member (OS #2) was observed wearing gloves while using a meat slicer. It was noted that OS #2 left the meat slicer three different times to pick up other inanimate objects (a can of spray and other utensils) from different areas of the kitchen and touching face and nose without removing gloves or washing hands and returning to slice the meat. OS #2 was asked if she could explain why she did not change her gloves after touching different items, she responded, I don't speak English very well, let me get someone. The executive chef walked over and was asked to explain the procedure for staff changing their gloves after touching other surfaces. The executive chef said gloves should be changed and hands need to be washed. 2. In the Cardinal unit nourishment room, the facility staff failed to label and date items, failed to remove products that were damaged, and failed to remove items that were beyond the use by date.On 04/07/2026 at 3:32 PM. prior to observation of the resident's nourishment room, registered nurse (RN #4) was interviewed regarding refrigerator storage and labeling. RN #4 said that the food in the refrigerator is labeled with the expiration date. The nourishment room on the Cardinal unit was then observed. The refrigerator had a sign on the door that read All residents food items in the refrigerator must be dated mm/dd/yyyy, all items will be discarded after 3 days, and staff items must be stored in break room.Contents of the refrigerator revealed individual packets of butter inside of a container with an expiration date 3/20/26, an opened bottle of Electrolyte solution was not labeled. RN #4 verbalized unawareness of who the electrolyte solution belonged to.The freezer contained an unopened container of freezer burnt ice cream. Certified nursing assistant (CNA #4) quickly took the ice cream and discarded it into a trashcan, verbalizing the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident is no longer at the facility. Two opened bottles of frozen fruit juice were not labeled or dated. RN #4 acknowledged the findings and discarded the items. The Facilities policies were reviewed for the above concerns and noted the following:A facility policy titled Food handling, hair restraints, and personal was obtained and read in part, all employees involved in food preparation or service must wear an effective hair restraint (hairnet, cap, or visor). [NAME] restraints must be worn by any employee with facial hair longer than 1/4 inch. Employees must not touch hair, face or body while handling food. If contact occurs, proper handwashing is required before resuming food handling. A facility policy titled F&B FIFO (First in, First Out) was obtained and read in part, for labeling and tracking to clearly label all items with date received and expiration date. A facility policy titled Food storage Policy was obtained and read in part, perishable foods must be monitored for expiration and disposed of promptly when expired. A facility policy titled Food Receiving and Storage was obtained and read in part, food and snacks kept on the nursing units food items to be kept at or below 41 degrees Fahrenheit are placed in the refrigerator located at the nurse's station and labeled with a use by date. On 4/7/26 at 5:15 p.m. the above finding was presented to the administrator and director of nursing (DON).No other information was provided prior to exiting the facility on 4/9/26.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. Based on observation, resident interviews, staff interviews, and review of facility documentation, the facility failed to ensure that notices of resident rights were posted in accessible areas for all residents residing on three of three units. Findings included:The facility failed to ensure that resident rights was posted in accessible locations within the facility for residents, families, and visitors.On 4/6/26 at 2:00 pm, a tour of the facility's three nursing units and lobby areas was conducted. During the tour, no postings of resident rights were observed in any of these areas.On 4/7/26 at 10:30 am, a resident council meeting was held with six residents present (Resident #11, Resident #25, Resident #43, Resident #54, Resident #74, and Resident #84). During the meeting, Resident #25, Resident #74, and Resident #84 stated they had never seen any postings of resident rights in the facility.On 4/7/2026 at 4:15 pm, an interview was conducted with the director of nursing, (DON). The DON stated the resident rights should be posted in the lobby and at the nurses stations. The DON walked around the nurses station and dining room, and was not able to find the postings. The DON said, I will check with someone and let you know what I find out. On 4/7/26 at 4:30 pm, a second tour of the nursing units and lobby areas was conducted. During the tour, no postings of resident rights were observed on the nursing units or in the lobby areas. On 4/7/26 at approximately 5:15 pm, an end of day meeting was conducted with the administrator, director of nursing and the regional director of operations. They were informed of the above concerns and no new information was provided. On 4/8/26 at 8:00 am, the administrator was interviewed and said, that the resident rights poster had been put up, and was in place now. The administrator said, the resident rights notices were taken down during construction of the units, and we never placed them back. On 4/8/26 at 2:00 pm, a review of the facility documentation was conducted. The policy titled, Resident Rights, read in part, .j. be informed about his or her rights and responsibilities. On 4/8/26 at approximately 5:15 pm, end of day meeting conducted and no new information was provided prior exit conference.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has the right to receive notices in a format and a language he or she understands. Based on observation, resident interviews, staff interviews, and review of facility documentation, the facility failed to ensure that required notices and contact information for the state survey agency and other entities such as adult protective services and the ombudsman, were posted in accessible areas for all residents on three of three units.The findings included:The facility failed to ensure that contact information for state agencies and other entities was posted in accessible locations within the facility for residents, families, and visitors.On 4/6/26 at 2:00 pm, a tour of the facility's three nursing units and lobby areas was conducted. During the tour, required notices and contact information for state agencies and other entities were not observed posted within the facility.On 4/7/26 at 10:30 am, a resident council meeting was held with six residents present (Resident #11, Resident #25, Resident #43, Resident #54, Resident #74, and Resident #84). During the meeting, Resident #25, Resident #74, and Resident #84 stated they had never seen any required notices posted in the facility with contact information for state agencies or any other entities.On 4/7/26 at 4:15 pm, an interview was conducted with the director of nursing, (DON). The DON stated the required notices with the contact information for state agencies and other entities should be posted in the lobby and at the nurses stations. The DON walked around the nurses station on one unit and dining room area, and was not able to find the postings. The DON said, I will check with someone and let you know what I find out. On 4/7/26 at 4:30 pm, a second tour of the nursing units and lobby areas was conducted. During this tour, no postings with required notice of state agencies and other entities information were observed on the nursing units or in the lobby areas. On 4/7/26 at approximately 5:15 pm, an end of day meeting was conducted with the administrator, director of nursing and the regional director of operations. They were informed of the above concerns and no new information was provided. On 4/8/26 at 8:00 am, the administrator was interviewed and said, that the required notices with the state agencies contact information had been put up, and were in place now. The administrator said, the required notices were taken down during construction of the units, and we never placed them back. On 4/8/26 at 2:00 pm, a review of the facility documentation was conducted. The policy titled, Resident Rights, read in part, .u. voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal. x. communicate with outside agencies (e.g. local, state, or federal officials, state and federal surveyors, state long term care ombudsman, protection or advocacy organization, etc.) regarding any matter. On 4/8/26 at approximately 5:15 pm, end of day meeting conducted and no new information was provided prior exit conference.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, staff interviews, and review of facility documentation, the facility staff failed to ensure that privacy was provided during activities of daily living (ADL) care for one resident, Resident #18 (R18) in a survey sample of 29 residents. Findings included:During ADL care, the facility staff failed to ensure privacy for R18, resulting in the resident's buttocks being exposed and visible from the hallway. On 4/6/26 at 4:55 pm, an observation was made of R18 receiving ADL care without privacy being provided. The privacy curtain was not pulled, and R18's buttocks was exposed and visible from the hallway. On 4/6/26 at 5:04 pm, an interview was conducted with the certified nursing assistant (CNA#5), who was providing ADL care to R18. The privacy curtain was not pulled, and R18's buttocks were exposed and visible from the hallway. CNA#5 said, we should have pulled the privacy thing at the door to provide more privacy. CNA#5 then demonstrated how the curtain should be pulled around the resident during care and apologized for not providing privacy. On 4/6/26 at 5:25 pm, an interview was conducted with the director of nursing (DON). The DON stated that the expectation was for staff to provide comfort and privacy for residents during care. On 4/7/26 at 2:00 pm, a review of facility documentation was conducted. The policy titled. Resident Rights, read in part, .t. privacy and confidentiality. The policy for ADL's was requested and was never provided by the facility. On 4/7/26 at approximately 5:15 pm an end of day meeting was held with the administrator, director of nursing, and regional director of operations. The above concerns were discussed and no new information was provided prior to exit conference.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and facility document review, the facility failed to maintain a clean room environment for one of three units (Dogwood Unit).The finding include:On 04/06/2026 at 1:35 PM an initial tour of the Dogwood Unit was conducted and the following was observed. room [ROOM NUMBER] had a heavy amount of dirt and debris accumulated on the floor. A bug was observed on the floor of room [ROOM NUMBER]. room [ROOM NUMBER] had a heavy amount of dirt and debris on the floor, including medical waste and food items. room [ROOM NUMBER] had dirt and debris on the floor. room [ROOM NUMBER] had dirt and debris on the floor of the bathroom. room [ROOM NUMBER] had a heavy amount of dirt, debris, including food items and medical waste on the floor. On 04/08/2026 at 10:20 AM, resident #28 (R#28) was interviewed regarding housekeeping services. R#28 stated housekeeping comes once a week, sometimes more depending on their staffing. Regarding the cleaning process, R#28 stated that housekeeping leaves debris on the floor and if something spills, the resident must clean it up and added They [staff] could do a better job. The minimum data set (MDS) dated [DATE] assessed R28 as cognitively intact, with a Brief Interview of Mental Status (BIMs) score of 15 out of 15. When the Environmental Services Director (Other Staff, OS #4) was interviewed on 04/08/2026 at 11:35 AM regarding cleaning of resident rooms and common areas. OS #4 stated that housekeepers start their shift at 8:00 AM and there is one housekeeper assigned to each unit. The housekeepers are to clean the shower room first, then have occupied rooms cleaned by 12:00 PM so they can clean the rooms of discharging residents. OS #4 stated that cleaning of resident rooms includes sweeping, mopping, dusting, cleaning high touch areas, and a complete cleaning of the bathroom. OS #4 advised that no additional housekeeper cleaning of resident rooms occurs after the initial cleaning and that other unit staff are responsible for lite cleaning. On 04/08/2026 at 12:30 PM OS #4 provided the housekeeping policy which included a cleaning check list by area. The checklist for daily cleaning of resident rooms was: 1. Empty trash and replace liner, 2. Disinfect high-touch surfaces (bed rails, overbed table, call bell, light switches, 3. Clean and disinfect bathroom (toilet, sink, grab bars, shower), 4. Dust horizontal surfaces, 5. Sweep and mop floor, 6. Replenish supplies (toilet paper, soap). On 04/08/26 at 5:35 PM, the above findings were reviewed with the Administrator, RDO (Regional Director of Operations), and DON (Director of Nursing). No additional information was provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility documentation, clinical record review the facility staff failed to develop and implement a comprehensive care plan for two residents, Resident #96 (R96), and Resident #R41 (R41) in a survey sample of twenty-nine residents. The findings included:1. The facility failed to develop and implement a comprehensive care plan for R96 to include care problems, goals and or interventions related to adequate care or safety during turning, repositioning, or incontinent care. Resident #96 was admitted to the facility on [DATE], with diagnoses of, but not limited to, metabolic encephalopathy, cognitive communication disorder, hemiplegia (affecting the left nondominant side) and urinary tract infection. R96 was discharged to an acute care facility on 11/29/2024 and did not return. On 04/8/26, at 2:20 p.m., an interview was conducted with the Director of Nursing (DON), and the Regional Director of Operations. We discussed R96 and the documentation of the fall on 09/30/24. When asked if she remembered R96 or the alleged fall. The DON stated that most of the staff were new, and that she was not here then. When asked what is expected during turning and repositioning of dependent Residents, during turning, repositioning and incontinent care. The DON stated she would expect the staff to assess the resident for needs functional status first, take care of the resident according to the physician orders and care plan. When asked, based on the clinical record documentation reviewed, what would she have expected? The DON stated R96's care plan did not provide care parameters regarding turning positioning and incontinent care prior to the actual fall on 09/30/24. The care plan was updated on 09/30/24, to include Incontinent Care and Turning and Repositioning will be provided by 2 Staff. A closed clinical record review documented that R96's plan of care was initiated on 07/24/24, but did not address, and had no problems, goals and/or interventions regarding care or safety during turning, repositioning, or incontinent care. R96's care plan was not updated until 09/30/24, after the fall, to include Incontinent Care and Turning and Repositioning will be provided by 2 Staff. This finding was reviewed with the administrator and DON during the end of day meeting on 4/9/26. No additional information was provided prior to the end of the survey. 2. Resident #41 had no care plan developed regarding care of a feeding tube insertion site. Resident #41 (R41) was admitted to the facility with diagnoses that included cerebrovascular accident (stroke), vascular Parkinson's, dementia, aphasia, dysphagia with use of gastrostomy, protein-calorie malnutrition, vertebra compression fracture, seizures and spondylosis. The minimum data set (MDS) dated [DATE] assessed R41 with short and long-term memory problems and moderately impaired cognitive skills. R41's clinical record documented a physician's order for nothing by mouth with nutritional formula and hydration provided via gastrostomy (feeding tube). R41's plan of care (initiated 2/25/26) documented (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident was at risk of malnutrition and altered hydration and that nutrition and supplements were provided through a feeding tube as ordered. There were no physician's orders regarding care of the tube insertion site. R41's plan of care (initiated 2/25/26) included no problems, goals and/or interventions regarding care of the feeding tube insertion site. On 4/7/26 at 3:48 p.m., the registered nurse unit manager (RN #3) caring for R41 was interviewed about a plan of care for the feeding tube insertion site. RN #3 stated there should have been a care plan developed regarding care of the tube insertion site. On 4/7/26 at 3:51 p.m., accompanied by RN #3, R41's feeding tube insertion site was observed. The insertion site was covered with clean, dry split gauze. The skin surrounding the insertion site was clean, dry and without signs of irritation or complication. On 4/7/26 at 4:44 p.m., the director of nursing (DON) was interviewed about a plan of care regarding care of R41's feeding tube site. The DON stated that care of the feeding tube site should have been included in the care plan. On 4/7/26 at 10:31 a.m., the MDS coordinator (RN #1) responsible for care plan development, was interviewed about R41. The MDS coordinator stated that care of the tube insertion site was a standard of practice for residents with a feeding tube and should have been included as part of the comprehensive care plan. This finding was reviewed with the administrator and DON during a meeting on 4/7/26 at 5:15 p.m. with no further information presented prior to the end of the survey.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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 follow professional standards of care for wound assessment and care documentation for one of twenty-nine residents in the survey sample (Resident #11).The findings include:Resident #11 had no initial or ongoing assessments documented for monitoring of a skin tear. Nursing failed to document in the clinical record an observed dressing change/treatment and status of the wound at the time of the dressing change.Resident #11 (R11) was admitted to the facility with diagnoses that included atrial fibrillation, depression, end stage renal disease with hemodialysis, anemia, osteoarthritis, respiratory failure, polyneuropathy, hypertension and congestive heart failure. The minimum data set (MDS) dated [DATE] assessed R11 as cognitively intact.Review of R11's clinical record revealed a nursing note, a skin assessment form and a change of condition form dated 3/27/26 that documented the resident had acquired a skin tear on the right lower leg. The forms/notes documented the resident was assessed with no pain but listed no descriptive assessment of the skin tear including size, appearance, skin color or status of bleeding/drainage. Ongoing skin assessments documented on 3/31/26, 4/5/26 and 4/7/26 listed the resident had a skin tear on the right lower leg but included no description of the skin tear's status such as size, appearance, surrounding skin color or presence of drainage/exudate.On 4/6/26 at 3:38 p.m., with R11's permission, licensed practical nurse (LPN #4) was observed performing wound care and a dressing change to the resident's right lower leg skin tear. Wound cleansing and dressings were provided as ordered. The skin tear was irregular shaped with scabbed skin noted along the edges of the wound. Red tinted drainage was noted on the removed dressing with the Xeroform stuck to the wound. The skin surrounding the wound was pink/red with purplish tone. A review of R11's clinical record on 4/7/26 revealed the dressing change and treatment observed on 4/6/26 was not documented in the clinical record. The clinical record included no assessment or mention of the status of R11's skin tear at the time of the dressing change on 4/6/26.On 4/7/26 at 3:33 p.m., the registered nurse unit manager (RN #3) caring for R11 was interviewed about assessment of the skin tear. RN #3 stated the nurse that found the skin tear should have assessed the wound and documented the appearance, size and condition. On 4/7/26 at 4:31 p.m., the director of nursing (DON) was interviewed about the lack of descriptive assessments of the wound's status. The DON stated that when the skin tear was found, an assessment should have been documented that included description, color, size and any bleeding/drainage noted. The DON stated ongoing monitoring of the wound should have included at least a weekly assessment of the skin tear, with the status and appearance of the wound noted.On 4/8/26 at 2:36 p.m., the DON stated she talked with LPN #4 about the dressing change/treatment on 4/6/26 not documented. The DON stated LPN #4 reported that she did not record the dressing change because it was not the scheduled day for the treatment and there was no space designated on the treatment administration record. The DON stated that documenting a dressing change was not about checking a box and there should have been a note of the wound care in the clinical record that included the status of the wound.The facility's policy titled Physician Orders (revised January 2025) documented, .The provision of care and services in accordance with the physician orders will be documented in accordance with professional standards of practice .The facility's policy titled Wound Treatment (reviewed April 2024) documented, .The purpose of this procedure is to provide guidelines for the care of wounds to promote healing .Evaluate the appearance of the wound and surrounding skin .The following information should be recorded in the resident's medical record .Appearance of the wound as observed during the treatment .Any change in the resident's condition .The facility's policy titled Charting and Documentation (revised July 2017) documented, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .The (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following information is to be documented in the resident medical a record .Treatments or services performed .Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate .The Lippincott Manual of Nursing Practice 11th edition on page 15 documents that common departures from standards of care include, .Failure to monitor or observe a patient's clinical status adequately .Failure to monitor or observe a change in a patient's clinical status .Failure to make prompt, accurate entries in a patient's medical record . This reference documents on page 15, .A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events . (1) This finding was reviewed with the administrator and DON during a meeting on 4/7/26 at 5:15 p.m. with no further information provided prior to the end of the survey.(1) [NAME], [NAME] M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/[NAME] & [NAME], 2019.

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	495319	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Boulevard Post Acute	9229 Arlington Blvd Fairfax, VA 22031

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and clinical record review, the facility staff failed to implement interventions for pressure ulcer care for two of twenty-nine residents, Resident #22 and Resident #72 The Findings Include:1. Resident 22's (R22) air mattress and wound vac (a negative-pressure wound therapy device) were not set according to the physician orders. R22 diagnoses include chronic stage four pressure ulcer right buttock, macular degeneration, malignant neoplasm, and anemia. The most recent MDS (minimum data set) was an admission assessment dated [DATE] and indicated R22 was moderately cognitively intact. Review of active physician orders indicated R22 was ordered a wound vac to be set continuously at 125 mm of negative pressure and R22's air mattress was ordered to be set by body weight at 118.9. On 4/7/2026 at 4:15 p.m. R22's air mattress and wound vac settings were noted to be set at 350 pounds on the air mattress and 116 negative pressure on the wound vac. On 4/7/26 at 4:26 p.m. registered nurse (RN #4, assigned to R22) was interviewed. RN #4 went to R22's room and noted the settings of the bed and wound vac then reviewed the orders with the surveyor. RN #4 verbalized that the settings were not correct and would take care of the concern. On 4/7/26 at 5:15 p.m. the above information was provided to the administrator and director of nursing (DON). On 4/8/26 at 4:20 p.m. The DON verbalized that the setting on the wound vac and the bed had been corrected. No other information was presented prior to exit conference. 2. For Resident #72 (R72) the facility staff failed to ensure that an alternating pressure mattress to promote wound healing was implemented for 18 days. On 4/8/26 at 11:00 am, a clinical record review was conducted. During clinical record review, it was identified that a physician order dated 3/20/26, indicated R72 was to have an alternating pressure mattress to promote wound healing for R72. According to R72's care plan it indicated alternating pressure mattress at all times as an intervention. There was no evidence that the alternating pressure mattress had been put in place as ordered. Review of the treatment medical record revealed that nursing staff had documented signatures indicating the alternating pressure mattress was in place; however, observation and interview confirmed that the mattress had not been implemented at the time those entries were made. On 4/08/2026 at 12:09 pm, an interview was conducted with licensed practical nurse, LPN#2. LPN#2 stated that signing off on the treatment record indicates that the treatment was completed. LPN#2 further stated that when signing off on an assistive device, it indicates the device is present and being used. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/08/2026 at 12:40 pm and interview was conducted with the assistant director of nursing (ADON). The ADON went to R72's room to observe the resident's bed and confirmed that the resident did not have an alternating pressure mattress in place. She stated the mattresses are available in-house and that when one is ordered, staff is expected to notify maintenance, who then delivers the mattress to the resident's room. The ADON addressed the documentation on the treatment record indicating the mattress was in place and stated that staff signing off on the mattress when it was not in place, and stated it reflected a need for staff education. The facility's policy titled Physician Orders (revised January 2025) documented, .Licensed nurses will obtain, document and provide care and services in accordance with orders received from the physician .The provision of care and services in accordance with the physician orders will be documented in accordance with professional standards of practice . The above concerns were presented to the director of nursing, administrator, and the regional director of operations. No new information was shared prior to exit conference.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on resident interview, staff interview, clinical record review, and facility documentation the facility failed to provide necessary treatment and care for catheter management for one resident (Resident #72, R72) out of a survey sample of 29 residents. The findings included:The staff failed to ensure foley catheter care and treatment was performed appropriately to allow the flow of urine.On 4/06/2026 at 2:38 pm, interview was conducted with R72. R72 said, I kept telling the staff that I could feel myself peeing, but my bag was empty all day. No way urine could come out of my bag, a week ago today was when this happened. I had some pain and then was tested with a urinary tract infection and started on antibiotic and my urologist changed it when I saw him. R72 stated that the staff did not address concerns related to his catheter until his wife intervened. The resident reported that staff assessed his bladder and evaluated him for pain only after his wife requested assistance. R72 further stated that when his daughter arrived, it was discovered that the catheter tubing was capped off. Once the tubing was corrected and cap removed, urine began to flow, and approximately 600 cc of urine was obtained.On 4/08/2026 11:40 am, an interview was conducted with the director of nursing (DON). The DON stated that 300 cc of urine was obtained in the morning prior to the urinary drainage bag being capped in order to switch from and overnight bag to a leg bag. The DON reported that the catheter bag was capped at approximately 7:00 am and remained capped until approximately 6:30 pm. The DON stated that a bladder scan had been conducted and obtained 200 cc of residual urine. The DON further stated that a urology appointment had been scheduled prior to this occurrence and no new physician orders were received following the appointment the day after this incident with foley being capped off.Review of the nursing documentation revealed that the first shift nurse documented that the foley catheter was patent and draining yellow colored urine, but no urine output was recorded, after the initial 300 cc at 7:00 am, during the shift. The DON acknowledged this documentation and indicated concern about it.The DON confirmed that the catheter should have been assessed by first shift staff, and lack of urine output should have been identified and reported. The DON was unable to locate documentation of a bladder scan in the medical record. Although it was initially stated that a bladder scan showed 200 cc of residual urine, further review revealed there was no physician order for a bladder scan and no documented evidence that the procedure was completed.On 4/8/26 at 2:00 pm, during the clinical record review, it was identified that on the day of the incident involving the foley catheter, the resident reported a pain level of one. There was no nursing documentation describing the incident, assessment findings, or interventions related to the catheter by the nurse assigned to the shift, and no documentation completed by the nurse who removed the cap from the catheter tubing.Further review revealed no evidence that the incident was assessed, monitored, or communicated in the medical record. The resident did not require additional pain medication and demonstrated no decline in functional or therapy status and continued participating in therapy as previously.On 4/8/36 at 3:00 pm, a review of facility documentation was conducted. The policy titled, Catheter Care, Urinary, read in part, .Maintaining unobstructed urine flow 1. check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. 2. Unless specifically ordered, do not apply a clap to the catheter. Documentation The following information should be recorded in the resident's medical record: 1. the date and time that catheter care was given, 2. the name and title of the individual giving the catheter care. 3. All assessment data obtained when giving catheter care.No new information was obtained prior to exit conference.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and facility documentation review the facility staff failed to ensure that medications were properly labeled, dated, and stored in accordance with manufacturer instructions and facility policy for controlled and multi-dose medications on one of three nursing units (Dogwood unit). The findings included:The staff failed to ensure medications were labeled and dated properly, and that controlled substance were double-locked on the Dogwood unit.During observation and medication storage review, it was identified that on the Dogwood unit, a tuberculin multi-dose vial had been opened but was not properly labeled with the date it was opened. Proper dating is required to ensure safe use and prevent use beyond the recommended discard timeframe. The door to the area where the medication were located was unlocked. It was observed that lorazepam vials were not secured in a double-locked storage area as required for controlled substances. The door to the area where the medication were located was unlocked.During staff interview with a registered nurse, which was the unit manager for the Dogwood unit, it was confirmed that proper labeling and secure storage procedures were not consistently followed. She said, I am not sure why the main door was not locked.During the facility documentation review, the policy titled, Medication Storage, read in part, 2. the storage area will be kept locked when not in use. 9. m All medications will be kept in the original containers and will be properly labeled and identified.The above concerns were discussed with the administrator, director of nursing, and the regional director of operations. No new information was obtained prior to exit conference.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, staff interview, clinical record review, and facility documentation review the facility staff failed to arrange for dental services for denture replacement affecting one resident, Resident #86 (R86) in a survey sample of 29 residents. The findings included:For Reisdent #86 (R86), whose dentures were lost while a resident of the facility, the facility staff failed to arrange a dental appointment for denture replacement.On 4/7/26 at 9:30 am, an interview was conducted with R86. During the interview, R86 stated that his lower dentures were lost within a week of admission to the facility. The resident reported that his dentures had been placed in a cup while he was waiting for his wife to bring in denture cleaning tablets. The resident stated that when the tablets were brought to the facility, both the cup and dentures were missing. He reported the lost dentures to staff and was informed they would attempt to locate the dentures; however, the dentures had not been found.Observations of the resident confirmed that he was missing his lower dentures during the interview.A clinical record review was conducted that revealed R86 was admitted to the facility on [DATE]. According to the resident's admission inventory sheet dated 3/17/26, it documented that he had a full set of lower dentures.On 4/7/26 at 3:56 pm, an interview was conducted with the director of nursing (DON). During interview, the DON stated she was not aware of the missing dentures and indicated that no grievance had been filed regarding the issue. The DON confirmed the resident was admitted with lower dentures and that they were listed on the property inventory.On 4/7/26 at 3:58 pm, an interview was conducted with the regional director of clinical services (RDCS). The RDCS conducted interviews with the resident and staff regarding the missing dentures. She stated the resident had reported he had a sore in his mouth and was not wearing his dentures for a few days and had placed them in a white cup. She further stated the issue was discussed during a care plan/discharge meeting and that staff were notified of the missing dentures.On 4/8/26 at 8:15 am, the regional director of operations confirmed the dentures had not been located and stated the facility planned to replace the dentures and would provide the policy for lost items. She said, that in the admission agreement she believed it was stated the facility is not responsible for lost items, but we like to do the right thing in some situations.On 4/8/26 at 10:53 am, the administrator stated that the facility would assist in obtaining a replacement set of dentures for the resident; however, this issue was not addressed until it was brought to their attention by the surveyor.The facility documentation was reviewed. The policy titled, Investigating incidents of Theft and/or Misappropriation of Resident Property, read in part, .inventorying resident belongings upon admission. When an incident of theft and/or misappropriation of Resident property is reported, the administrator appoints a staff member to investigate the incident. The facility policy titled, Lost and Found, read in part, .resident or family complaints of missing items must be reported to the director of nursing services. Reports of misappropriation or mistreatment of resident property are immediately investigated. The administrator, director of nursing, and the regional director of operations was informed of the above concerns. No additional information was obtained prior to exit conference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews, clinical record review, and facility documentation review, it was determined that the facility failed to maintain an accurate and complete clinical record for three residents, Resident #4 (R4), Resident #11 (R11), and Resident #72 (R72) out of a survey sample of 29 residents. The findings included: The facility staff failed to ensure accurate and complete documentation was in R72's medical record. On 4/06/2026 at 2:38 pm, interview was conducted with R72. R72 said, I kept telling the staff that I could feel myself peeing, but my bag was empty all day. No way urine could come out of my bag, a week ago today was when this happened. I had some pain and then was tested with a urinary tract infection and started on antibiotic and my urologist changed it when I saw him. R72 stated that the staff did not address concerns related to his catheter until his wife intervened. The resident reported that staff assessed his bladder and evaluated him for pain only after his wife requested assistance. R72 further stated that when his daughter arrived, it was discovered that the catheter tubing was capped off. Once the tubing was corrected and cap removed, urine began to flow, and approximately 600 cc of urine was obtained. On 4/08/2026 11:40 am, an interview was conducted with the director of nursing (DON). The DON stated that 300 cc of urine was obtained in the morning prior to the urinary drainage bag being capped in order to switch from and overnight bag to a leg bag. The DON reported that the catheter bag was capped at approximately 7:00 am and remained capped until approximately 6:30 pm. Review of the nursing documentation revealed that the first shift nurse documented that the foley catheter was patent and draining yellow colored urine, but no urine output was recorded, after the initial 300 cc at 7:00 am, during the shift. The DON acknowledged this documentation, indicating concern. The DON confirmed that the catheter should have been assessed by first shift staff, and lack of urine output should have been identified and reported. The DON was unable to locate documentation of a bladder scan in the medical record. Although it was initially stated that a bladder scan showed 200 cc of residual urine, further review revealed there was no physician order for a bladder scan and no documented evidence that the procedure was completed. On 4/8/26 at 2:00 pm, a clinical record review was conducted. During the clinical record review, it was identified that on the day of the incident involving the foley catheter, the resident reported a pain level of one. There was no nursing documentation describing the incident, assessment findings, or interventions related to the catheter by the nurse assigned to the shift, and no documentation was completed by the nurse who removed the cap form the catheter tubing. Further review revealed no evidence that the incident was assessed, monitored, or communicated in the medical record. The resident did not require additional pain medication and demonstrated no decline in functional or therapy status, continuing participating in therapy as previously. On 4/8/36 at 3:00 pm, a review of facility documentation was conducted. The policy titled, Catheter Care, Urinary, read in part, .Maintaining unobstructed urine flow 1. check the resident frequently to be (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. 2. Unless specifically ordered, do not apply a clap to the catheter. Documentation The following information should be recorded in the resident's medical record: 1. the date and time that catheter care was given, 2. the name and title of the individual giving the catheter care. 3. All assessment data obtained when giving catheter care. No new information was obtained prior to exit conference. 2. Facility staff documented treatment to a skin tear for Resident #11 that was not provided. Resident #11 (R11) was admitted to the facility with diagnoses that included atrial fibrillation, depression, end stage renal disease with hemodialysis, anemia, osteoarthritis, respiratory failure, polyneuropathy, hypertension and congestive heart failure. The minimum data set (MDS) dated [DATE] assessed R11 as cognitively intact. On 4/6/26 at 2:54 p.m., R11 was observed in her room. A dressing was observed on R11's right lower leg with date of 4/2 written on the dressing. R11's clinical record documented a nursing note dated 3/27/26 stating the resident was observed with skin tear noted on the right shin with the resident reporting that she bumped her leg against the wheelchair. This note documented a physician's order dated 3/27/26 to cleanse the right shin skin tear with wound cleanser, pat dry, apply Xeroform and cover with dry dressing each Tuesday, Thursday and Saturday. R11's treatment administration record (TAR) documented dressing changes were completed on 3/28/26, 3/31/26, 4/2/26 and 4/4/26. On 4/6/26 at 3:15 p.m., accompanied by licensed practical nurse (LPN #4), registered nurse (RN #2) and with R11's permission, the dressing on the resident's right lower leg was observed, dated 4/2. LPN #4 was interviewed at this time about the date on the dressing and the orders requiring a dressing change on 4/4/26. LPN #4 stated that the dressing should have been changed on Saturday 4/4/26 as scheduled/ordered. On 4/7/26 at 3:33 p.m., the registered nurse unit manager (RN #3) caring for R11 was interviewed about the dressing with date of 4/2/26 and signed documentation that the dressing change was completed on 4/4/26. RN #3 stated that nurses were absolutely not to sign off the TAR if the treatment was not done. On 4/7/26 at 4:31 p.m., the director of nursing (DON) was interviewed about the treatment documented as done of 4/4/26 when the dressing evidenced the dressing change on 4/2/26. The DON stated she spoke to the nurse that signed off this treatment as done. The DON stated that inaccurate documentation was made by the nurse as the wound care was not provided on 4/4/26. The DON stated the expectation was to follow orders for care and if not followed, contact the provider and document an explanation of why orders were not done. The facility's policy titled Charting and Documentation (revised July 2017) documented, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .The following information is to be documented in the resident medical a record .Treatments or services performed .Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This finding was reviewed with the administrator and DON during a meeting on 4/7/26 at 5:15 p.m. with no further information presented prior to the end of the survey. 3. Resident #4's clinical record inaccurately documented the resident was on contact precautions. Nursing documented Resident #4 had contact precautions in use for eleven days when precautions were in use for less than a day. Resident #4 (R4) was admitted to the facility with diagnoses that included hypertension, congestive heart failure, insomnia, osteoarthritis, atrial fibrillation and diabetes. The minimum data set (MDS) dated [DATE] assessed R4 as cognitively intact. R4's clinical record documented a nurse practitioner note dated 3/25/26 listing that nursing reported the resident had four episodes of diarrhea. An order was entered on 3/25/26 for contact precautions due to suspected c-diff due with a stool culture ordered. The nurse practitioner assessed R4 on 3/26/26 and documented the resident had no further stools and discontinued precautions and stool culture. R4's clinical record documented a current physician's order dated 3/25/26 for contact precautions due to suspected C-diff (clostridium difficile) due to diarrhea. Nursing documented on R4's treatment administration record (TAR) that contact precautions had been in place since 3/25/26 with signoffs each shift, indicating contact precautions were in use during the resident's care. R4 was observed in her room on 4/6/25 at 1:15 p.m., with no signage or indication that contact precautions were in use. Staff administered medications to R4 on 4/7/26 at 8:10 a.m. without use of gowns/gloves and no signage was posted indicating the resident was on contact precautions. 04/07/26 at 9:37 a.m., R4 was interviewed about any use of infection precautions since her admission, with staff use of gowns and/or gloves when entering the room. R4 stated she had not been on any kind of infection precautions. R4 stated she had not been diagnosed with any infections and had nothing like that since I've been here. On 4/8/26 at 8:20 a.m., the registered nurse unit manager (RN #3) caring for R4 was interviewed about the contact precautions order and signoffs by nurses that precautions were in use. RN #3 stated the resident had several loose stools on 3/25/26 and the order for contact precautions was entered as a precaution. RN #3 stated the next day, the resident had no further stools, so the precautions were discontinued. RN #3 stated the order should have been discontinued in the clinical record on 3/26/26. On 4/8/26 at 8:36 a.m., the director of nursing (DON) was interviewed about R4's contact precautions order and nurses signing off that precautions were in place when they were not in use. The DON stated the resident was placed on contact precautions after several loose stools as a precaution. The DON stated the nurse practitioner documented no further stools, so the precautions were discontinued the next day (3/26/26). The DON stated the order should have been discontinued in the clinical record on 3/26/26. The DON stated nurses should not have been signing that precautions were in use when they were not and that nurses should have questioned the order since protective equipment and signage for precautions were not in place. On 4/8/26 at 11:11 a.m., the infection preventionist was interviewed about R4's contact precautions order. The infection preventionist stated the order was entered after several loose stools and then (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was discontinued. The infection preventionist stated R4 was not diagnosed with c-diff and the order should have been discontinued. The facility's policy titled Charting and Documentation (revised July 2017) documented, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .The following information is to be documented in the resident medical a record .Treatments or services performed .Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate . This finding was reviewed with the administrator and DON during a meeting on 4/8/26 at 5:35 p.m. with no further information presented prior to the end of the survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review and clinical record review, the facility failed to follow infection control practices during wound care for one of twenty-nine residents in the survey sample (Resident #11).The findings include:Infection control practices were not followed during a dressing change for Resident #11's skin tear.Resident #11 (R11) was admitted to the facility with diagnoses that included atrial fibrillation, depression, end stage renal disease with hemodialysis, anemia, osteoarthritis, respiratory failure, polyneuropathy, hypertension and congestive heart failure. The minimum data set (MDS) dated [DATE] assessed R11 as cognitively intact.R11's clinical record documented a nursing note dated 3/27/26 stating the resident was observed in the bathroom with skin tear noted on the right shin with the resident reporting that she bumped her leg against the wheelchair. This note documented a physician's order dated 3/27/26 to cleanse the right shin skin tear with wound cleanser, pat dry, apply Xeroform and cover with dry dressing each Tuesday, Thursday and Saturday. On 4/6/26 at 3:38 p.m., with R11's permission, licensed practical nurse (LPN #4) was observed performing wound care/dressing change to the resident's right lower leg skin tear with the following observed. LPN #4 used hand sanitizer, put on a gown and clean gloves then entered the resident's room carrying wound care supplies. LPN #4 touched the room light switch to turn on the overhead light then rearranged/moved R11's personal items from the overbed table. Without sanitizing the table or providing a clean barrier, LPN #4 placed the dressing change supplies that included gauze pads, cover dressing and wound cleanser on the overbed table. With the resident on the bed, LPN #4 placed a clean barrier under the right lower leg. LPN #4 then moved the trash can near to bedside, touching the edges of the trash can with her gloved hand. With no hand hygiene or gloves changed, LPN #4 opened the gauze packages, placing the clean gauze pads on top of the gauze packaging. LPN #4 then removed the soiled dressing from R11's leg. LPN #4 sprayed the wound with cleanser several times as the soiled Xeroform dressing was adhered to the wound. With the same gloves on since entering the room, LPN #4 loosened then removed and discarded the soiled Xeroform gauze from the wound. Without hand hygiene or gloves changed, LPN #4 then cleansed the wound using wound cleanser spray and clean gauze, wiping and discarding several times over the wound and surrounding skin. LPN #4 then removed gloves and without hand hygiene, put on clean gloves prior to placing the new Xeroform gauze on the skin tear and covering the wound with a dry dressing. LPN #4 then removed the barrier from under the leg, discarded used items, removed gloves and used hand sanitizer. On 4/6/26 at 3:50 p.m., LPN #4 was interviewed about the observed dressing change without a clean surface for supplies and lack of hand hygiene/glove changes between contact with dirty/clean items. LPN #4 stated she should have cleaned the overbed table prior to placing clean supplies. Regarding hand hygiene and glove changes, LPN #4 stated she used hand sanitizer prior to entering the room. LPN #4 stated she changed gloves during care and used alcohol wipes on her hands between the glove change. On 4/7/26 at 3:33 p.m., the registered nurse unit manager (RN #3) caring for R11 was interviewed about the observed wound care. RN #3 stated if room items were touched such as the light switch and trash can, the nurse should have performed hand hygiene and put on clean gloves prior to touching the wound. RN #3 stated nurses were expected to follow infection control practices for all wound care.On 4/7/26 at 4:01 p.m., the infection preventionist was interviewed about the observed wound care for R11's skin tear. The infection preventionist stated that nurses were expected to follow infection protocols during wound care. The infection preventionist stated hand hygiene was supposed to be done between glove changes, after handling soiled/dirty items and prior to cleaning the wound. On 4/7/26 at 4:31 p.m., the director of nursing (DON) was interviewed about the observed wound care for R11's skin tear. The DON stated, The basics were not followed. The DON stated that care should have been provided adhering to infection control protocols for wound care. The facility's policy titled Wound Treatment (reviewed July 2024) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495319	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Boulevard Post Acute	9229 Arlington Blvd Fairfax, VA 22031

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented, .The purpose of this procedure is to provide guidelines for the care of wounds to promote healing . This policy documented steps for wound care included, .Assemble the equipment and supplies as needed .Disinfect overbed table .Perform hand hygiene .Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table .Prepare supplies on the clean field using clean technique .mark dressing label or tape with date, time, and initials .prepare a plastic bag or wastebasket for discarded materials .Position resident .Place disposable cloth next to resident (under the wound) to serve as a barrier .Perform hand hygiene and put on clean gloves .Remove soiled dressing and discard into designated container .Remove gloves and perform hand hygiene .Put on clean gloves .Evaluate the appearance of the wound and surrounding skin .Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke .Apply treatment as ordered .Apply dressing as ordered .Reposition the resident if necessary .Discard disposable items into appropriate receptacle. Remove gloves and discard .Perform hand hygiene .Disinfect reusable supplies as indicated (i.e., outsides of containers that were touched by unclean hands, scissor blades, etc.) Return supplies to treatment cart .The facility's policy titled Handwashing/Hand Hygiene (August 2021) documented, .The facility considers hand hygiene the primary means to prevent the spread of infections .Use an alcohol-based hand rub containing at least 60% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations .After handling used dressing, contaminated equipment .After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident .After removing gloves .This finding was reviewed with the administrator and DON during a meeting on 4/7/26 at 5:15 p.m. with no further information presented prior to the end of the survey.