STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hill Health & Rehabilitation	4403 Forest Hill Avenue Richmond, VA 23225

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure Residents are cared for in a manner that promotes maintenance or enhancement of his or her quality of life for one (1) Resident (#24) in a survey sample of 63 Residents. The findings included: For Resident #24 the facility staff failed to adequately bathe, and groom Resident to ensure he was free from body odors and unkempt appearance and failed to dress him in clothing other than a hospital gown and failed to get him out of bed daily so that he may attend activities and have social interaction with peers. Resident #24 was admitted to the facility on [DATE] with diagnoses that include but are not limited to paranoid schizophrenia, diabetes, chronic kidney disease, mild intellectual disabilities, hypertension, hypothyroidism, bipolar disorder, major depressive disorder, severe with psychotic features, and anxiety. The following observations were made of Resident #24. 1/28/25- 2 p.m. observed Resident #24 in bed eyes closed dressed in hospital gown hair greasy and a strong body odor evident. 1/29/25 - 11:30 a.m. Resident #24 in bed watching TV hospital dressed in hospital gown, hair greasy, body odor present. 1/30/25 11:50 a.m. nails long brown substance under nails, in need of shower / bath hair appears greasy Resident has body odor and smells of urine. In bed only in hospital gown and brief. 1/31/25 11:38 AM Resident # 24 in bed dressed in hospital gown nails still appear dirty and hair greasy continues to have body odor. On 1/31/25 at 11:40 a.m., an interview was conducted with Resident #24. When asked does the staff usually get you up and get you dressed, he responded, No not usually, I can't walk. When asked does the staff get you up and put you in the wheelchair, he responded No not unless I have to go somewhere. When asked does the staff get you up and put you in the shower, he stated that they usually bathe him in bed. When asked when the last time is his hair was washed, he stated that he did not know. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Excerpts from the Resident Preference Evaluation dated 6/21/24 read: 1. How important is it for you to choose what you wear? (2.) Somewhat important 2. How important is it to you to listen to music you like? (2) Somewhat important 5. How important is it to you to do things with groups of people? (2) Somewhat important 6.How important is it to you to do your favorite activities? (1) Very important 7 How important is it to you to go outside to get fresh air when the weather is good? (2) Somewhat important On 2/5/25 an interview was conducted with CNA B who was asked if Resident #24 has clothing in his room, CNA B answered yes, he has clothing, when asked if they fit him and were in good repair CNA B stated that the clothing was fine and if he did not have clothing the facility would have gotten him some from the clothing drive. When asked why Resident #24 is always wearing a hospital gown instead of his personal clothing CNA B stated he just got out of the shower. On 2/5/25 at approximately 3:00 p.m. an interview was conducted with the unit manager who stated that it is the expectation of the facility that all Residents are kept clean, odor free, and dressed appropriately in their own personal clothing on a daily basis. On 2/5/25 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure it was clinically appropriate for the self-administration of medications for one (1) resident (Resident # 83) in survey sample of 64 residents. Findings included: For Resident # 83, the facility staff failed to ensure there was a self-administration of medication assessment related to medication found at the bedside. Resident # 83 was admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included but were not limited to: Chronic Obstructive Pulmonary Disease, Hypertension, Chronic Kidney Disease, Diabetes, Acute Respiratory Failure and Congestive Heart Failure. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 12/24/2024. Resident # 83's BIMS (Brief Interview for Mental Status) Score was a 15 out of 15, indicating no cognitive impairment. Resident # 83 required assistance with Activities of Daily Living. Review of the clinical record was conducted on 1/28/2025 to 1/31/2025 and 2/3/2025 to 2/5/2025. During the initial tour on 1/28/2025 at approximately 12:10 p.m., a medication bottle was observed on the nightstand by the bed by the window. There were several items cluttered on the nightstand. The resident was lying in bed when the surveyor walked into the room. The label on the bottle stated the medication was Polyethylene Glycol (a laxative) dated February 9, 2024 with no refills. Resident # 83 stated the bottle of medication was a prescription she picked up a long time ago before coming to the facility. On 1/28/2025 at 1:34 p.m., an interview was conducted with Registered Nurse-B who stated medications should not be left at the bedside without self administration assessments and orders from the Physician. Registered Nurse-B stated none of the residents on the unit had assessments with orders for self administration of medications. Registered Nurse-B stated she did not see the medication bottle with on the nightstand when she administered the medications that morning. On 1/28/2025 at 2:39 p.m., an interview was conducted with the other nurse LPN (Licensed Practical Nurse)-D scheduled to pass medications on the unit that day. Licensed Practical Nurse-D stated bottles of medications should not be left at the bedside without an order from the physician. Registered Nurse-B removed the bottle of medication from the nightstand after explaining to the resident that medications could not be left at the bedside without an order. Resident # 83 stated she did not remember the medication was there. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physicians Orders revealed an active order for the medication Polyethylene Glycol 3350 Oral Powder 17 GM (gram) /Scoop (Polyethylene Glycol 3350) Give 1 scoop by mouth one time a day for constipation. Review of the January 2025 Medication Administration Record revealed scheduled daily administration of the medication Polyethylene Glycol 3350 Oral Powder 17 GM (gram) /Scoop (Polyethylene Glycol 3350) Give 1 scoop by mouth one time a day for constipation. The documentation revealed the medication was administered as ordered. During the end of day debriefings on 2/4/2025, the Administrator, Director of Nursing and Regional Nurse Consultants were informed of the findings. They stated medications should not be left at the bedside unless a resident has been assessed for self administration of medications. A copy of the medication administration policy was requested. Review of the Self-Administration of Medication and Treatments Policy revealed the policy was not dated to indicate when it was implemented or reviewed and revised. The Policy stated Residents have the right to self-administer medications/treatments if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. On 2/5/2025 at 2:12 p.m., an interview was conducted with the Director of Nursing who stated medications should never be left at the bedside unless there has been an assessment by the physician and an order for the medications to be left at the bedside. No further information was provided.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Resident interview, staff interview and clinical record review, the facility staff failed to provide services in the facility with reasonable accommodation of resident needs and preferences, for 4 Residents (# 123, #2, # 76 and # 113) in a survey sample of 63 Residents. The findings included: 1. For Resident # 123, the facility staff failed to ensure the clock on the bedroom wall had the proper time. Resident # 123 was admitted to the facility on [DATE] with the diagnoses of, but not limited to: Dementia with Agitation, Diabetes, Hypertension, and Legal blindness. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 1/8/2025. Resident # 123's BIMS (Brief Interview for Mental Status) Score was a 13 out of 15, indicating no cognitive impairment. Review of the clinical record was conducted on 1/28/2025 to 1/31/2025 and 2/3/2025 to 2/5/2025. During rounds on 1/28/2025 at 1:15 p.m., Resident # 123 was observed lying in the bed. Resident # 123 was alert, oriented and able to converse with the surveyor. Resident # 123 stated the facility staff acted like she didn't know what she was talking about and stated that clock is wrong. The time on the clock in Resident # 123's room closest to her bed was observed to have the time of 2:15. The second hand was working. Resident # 123 stated she technically was blind but could see some things. She pointed to a watch on her right arm and stated it was hard to see the time on it. She stated the watch was very special to her. The room was a quad room designed and equipped to house four residents. However, there were only 2 residents residing in the room. One resident (Resident # 2) was in the bed on the far left corner with the bed in a vertical position and Resident # 123 was in the far right corner with the bed in a horizontal position. There was another clock approximately 6 feet away from Resident # 123's bed that was positioned over a space where another resident must have resided formerly. There was nobody residing in that space during the time of the survey. The time on that clock had the time of 6:42 over the area with an empty bed space. It was observed that the second hand was not working. On 1/29/2025 at 11:02 a.m., the clock had the time of 12:02. The time on that clock over the empty space adjacent to Resident # 123's bed had the time of 6:42. On 1/30/2025 at 9:40 a.m., the clock had the time of 10:40. The time on that clock over the empty space adjacent to Resident # 123's bed had the time of 6:42. On 1/31/2025 at 2:03 p.m., the clock had the time of 3:03. The time on that clock over the empty space adjacent to Resident # 123's bed had the time of 6:42. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/3/2025 at 3:15 p.m., an interview was conducted with Registered Nurse-B who stated it was important for the time on the clocks to be correct. She stated the correct time helped the residents with orientation of time. Staff persons were observed in the room picking up food trays, and delivering ice and water. No staff person addressed the issue of the clock having the wrong time. The Director of Nursing stated the clock in the rooms should have had the correct time because it was important for the orientation of the residents. She stated staff members should have observed the clock was wrong and should have corrected the issue. During the end of day debriefing on 1/31/2025, the Facility Administrator, two Regional Nurse Consultants and Director of Nursing were informed of the findings that the clock closest to Resident # 123's bed was working properly but was always one hour ahead of time and the clock over the empty space was not working and had the time of 6:42. They all stated the clocks in residents' rooms should be accurate. No further information was provided. 2. For Resident # 2, the facility staff failed to ensure the clock on the bedroom wall had the correct time. Resident # 2 was admitted on [DATE] with diagnoses including but not limited to: Epilepsy, Seizures, Confirmed Physical Abuse, Confirmed Psychological Abuse, Major Depressive Disorder, Anxiety Disorder, and Neoplasm of the Brain. Resident #2's most recent MDS (Minimum Data Set) was a Quarterly Assessment with an ARD (Assessment Reference Date) of 12/27/2024 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 13 out of 15 indicating no cognitive impairment. Review of the clinical record was conducted on 1/28/2025 to 1/31/2025 and 2/3/2025 to 2/5/2025. During rounds on 1/28/2025 at 1:15 p.m., Resident # 2 was observed lying in the bed watching TV. Resident # 2 was alert, oriented and able to converse with the surveyor. On 1/29/2025 at 11:02 a.m. during rounds, Resident # 2 was heard yelling loudly in the room. When the surveyor entered the room and asked what was wrong, Resident # 2 stated that she wanted to know why the staff had not brought her lunch. Resident # 2 seemed upset and agitated. The surveyor stated it was only 11:02 and asked what time lunch normally was served. Resident # 2 yelled that they always bring her food late. She looked diagonally across the room to the clock over her roommate's bed and stated it's after 12 and no lunch yet. The time on the clock over the roommate's bed (Resident # 123) was observed to have the time of 12:02. The second hand was working properly. Resident # 2 stated she did not have a clock near her bed so she always looked at the clock over her roommate's bed. When the surveyor told her the time was after 11, Resident # 2 stated the time on the clock said 12 so that's what time she thought it was. The room was a quad room designed and equipped to house four residents. However, there were only 2 residents residing in the room. Resident # 2 was in the bed on the far left corner with the bed in a vertical position and the roommate (Resident # 123) was in the far right corner with the bed in a horizontal position. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was another clock approximately 6 feet away from Resident # 123's bed that was positioned over a space where another resident must have resided formerly. There was nobody residing in that space during the time of the survey. The time on that clock had the time of 6:42 over the area with an empty bed space. It was observed that the second hand was not working. Resident # 2 could look to her left and see the clock over her roommate's bed and the the clock over the empty space beside the roommate. On 1/29/2025 at 11:02 a.m., the clock had the time of 12:02. The time on that clock over the empty space adjacent to Resident # 123's bed had the time of 6:42. On 1/30/2025 at 9:40 a.m., the clock had the time of 10:40. The time on that clock over the empty space adjacent to Resident # 123's bed had the time of 6:42. On 1/31/2025 at 2:03 p.m., the clock had the time of 3:03. The time on that clock over the empty space adjacent to Resident # 123's bed had the time of 6:42. Staff members were observed providing care, delivering and picking up trays during the survey. No staff member addressed the time on the clock. The time on the clock over the roommate's bed was always one hour ahead and the time on the clock over the empty space was 6:42. On 2/3/2025 at 3:15 p.m., an interview was conducted with Registered Nurse-B who stated it was important for the time on the clocks to be correct. She stated the correct time helped the residents with orientation of time. The Director of Nursing stated the clock in the rooms should have had the correct time because it was important for the orientation of the residents. She stated staff members should have observed the clock was wrong and should have corrected the issue. During the end of day debriefing on 1/31/2025, the Facility Administrator, two Regional Nurse Consultants and Director of Nursing were informed of the findings that both clocks in the room had the wrong time. One clock closest to the roommate's bed (Resident # 123) bed was working properly but was always one hour ahead of time and the clock over the empty space was not working and had the time of 6:42. They all stated the clocks in residents' rooms should be accurate. No further information was provided. 3. For Resident # 76, the facility staff failed to ensure the clock on the bedroom wall had the proper time. Resident # 76 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Hemiplegia and Hemiparesis following Cerebral Infarction, Bipolar Disorder, Osteoarthritis, Type 2 Diabetes, Contracture of Left hand, and Blindness in right eye. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/7/2024. Resident # 76's BIMS (Brief Interview for Mental Status) Score was a 13 out of 15, indicating no cognitive impairment. Review of the clinical record was conducted on 1/28/2025 to 1/31/2025 and 2/3/2025 to 2/5/2025. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During rounds on 1/28/2025 at 1:15 p.m., Resident # 76 was observed lying in the bed. Resident # 76 was alert, oriented and able to converse with the surveyor. The time on the clock in Resident # 76's room was above the bed of the roommate (Resident # 113.) The time on the clock was 12:15. The second hand was working properly. On 1/29/2025 at 12:04 p.m., the clock had the time of 11:04. On 1/30/2025 at 10:45 a.m., the clock had the time of 9:45. On 1/31/2025 at 2:10 p.m., the clock had the time of 1:10. Staff persons were observed in the room picking up food trays, and delivering ice and water during the survey. No staff person addressed the issue of the clock having the wrong time. On 2/03/2025 at 01:28 p.m.- Observed the time on the clock was wrong during 5 days of survey- Interview conducted with Resident # 76 who stated he uses his phone but sometimes he can't find the phone. Stated he likes to look at the clock. On 2/3/2025 at 3:15 p.m., an interview was conducted with Registered Nurse-B who stated it was important for the time on the clocks to be correct. She stated the correct time helped the residents with orientation of time. The Director of Nursing stated the clock in the rooms should have had the correct time because it was important for the orientation of the residents. She stated staff members should have observed the clock was wrong and should have corrected the issue. During the end of day debriefing on 2/5/2025, the Facility Administrator, two Regional Nurse Consultants and Director of Nursing were informed of the findings that the clock closest to Resident # 113's bed was working properly but was always one hour behind time. They all stated the clocks in residents' rooms should be accurate. No further information was provided. 4. For Resident #113, the facility staff failed to ensure the clock on the bedroom wall had the proper time. Resident # 113 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Diabetes, Chronic Kidney Disease, Acute and Chronic Respiratory Failure, Hypertension, Non-[NAME] Lymphoma, Congestive Heart Failure, Major Depressive Disorder, Venous Thrombosis and Embolism and Ischemic Heart Disease. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 1/1/2025. Resident # 123's BIMS (Brief Interview for Mental Status) Score was a 14 out of 15, indicating no cognitive impairment. Review of the clinical record was conducted on 1/28/2025 to 1/31/2025 and 2/3/2025 to 2/5/2025. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During rounds on 1/28/2025 at 3:15 p.m., Resident # 113 was observed sitting on the side of the bed and watching television. Resident # 113 was alert, oriented and able to converse with the surveyor. The time on the clock at the head of the bed stated 2:15. On 1/29/2025 at 12:04 p.m., the clock had the time of 11:04. On 1/30/2025 at 10:45 a.m., the clock had the time of 9:45. On 1/31/2025 at 2:10 p.m., the clock had the time of 1:10. On 2/03/2025 at 01:28 p.m.- Observed the time on the clock was wrong during 5 days of survey. An interview was conducted with Resident # 113. When asked about any concerns, Resident # 113 stated he had was wondering why the staff never fixed the time on the clock. He stated they don't even look at the clock. Resident # 113 pointed to a clock on the wall and laughed. The time on the clock in Resident # 113's room was observed to have the time of 12:15. Resident # 113 stated they leave it alone so that they only have to change it once a year. It's only wrong when the time changes. He stated he was going to check to see how long they were going to let it be wrong. He stated he used his phone but sometimes the phone could be off. On 2/3/2025 at 3:15 p.m., an interview was conducted with Registered Nurse-B who stated it was important for the time on the clocks to be correct. She stated the correct time helped the residents with orientation of time. The Director of Nursing stated the clock in the rooms should have had the correct time because it was important for the orientation of the residents. She stated staff members should have observed the clock was wrong and should have corrected the issue. During the end of day debriefing on 1/31/2025, the Facility Administrator, two Regional Nurse Consultants and Director of Nursing were informed of the findings that the clock closest to Resident # 123's bed was working properly but was always one hour behind time. They all stated the clocks in residents' rooms should be accurate. No further information was provided.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on resident interview, staff interview, clinical record review, and review of facility documents, the facility staff failed to allow resident to manage financial affairs for 1 of 38 residents (Resident #135), in the survey sample. The findings included: Resident #135 was originally admitted to the facility 9/10/24. The current diagnoses included Non-ST-elevation Myocardial Infarction, muscle weakness, type 2 diabetes mellitus with hyperglycemia, and essential hypertension. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/17/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #135's cognitive abilities for daily decision making were intact. An interview was conducted on 5/21/25 at 1:45 PM with Resident #135. Resident #135 stated, the facility is trying to kick me out because I owe them money. Resident #135 also stated, a payment plan has been set up with the Business Office Manager but they are still trying to make me leave the facility. A review of a facility document: Form SSA-11-BK (Request To Be Selected As Payee) read that the Business Office Manager applied to have Forest Hill Health and Rehabilitation as the Payee regarding Resident #135's social security benefits. An interview was conducted on 5/22/25 at 1:30 PM with the Business Office Manager. The Business Office Manager stated that on 4/29/25 the facility applied to have Forest Hill Health and Rehabilitation as the Payee regarding Resident #135's social security benefits using Form SSA-11-BK (Request To Be Selected As Payee). The Business Office Manager also stated that Form SSA-787 (Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits) was completed by the Nurse Practitioner (NP) on 4/25/25. The Business Office Manager further stated that the NP answered that Resident #135 is able to manage funds or direct others how to manage them, as well as being able to manage funds in the future on the Form SSA-787 (Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits). A review of Form SSA-787 (Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits) dated 4/25/25 read: Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest? Yes Do you expect the patient to be able to manage funds in the future? Yes An interview was conducted on 5/22/25 at 2:50 PM with Resident #135. Resident #135 stated he is able to manage his own financial affairs. Resident #135 also stated that he never gave permission to the Business Office Manager or the facility to make a request to the Social Security Administration to be selected as the payee regarding his benefits. (continued on next page)

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Business Office/Collection Policy with an effective date of 1/1/25 read: For unpaid Patient Liability balances, the Business Office Manager must notify the resident/POA/Guardian/RP that due to the unpaid balance and refusal to pay we will be filing for Rep Payee. The Business Office Manager must initiate a Rep Payee application to be completed, signed by physician, and submitted to social security before end of month, or must have a signed RFMS agreement authorizing direct deposit. On 5/22/25 at approximately 7:00 p.m., a final interview was conducted with the Administrator, Director of Nursing, two (2) Corporate Nursing Consultants, Minimum Data Set Consultant, Regional Maintenance Director, and Regional Human Resource Director. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. Building B. Wing	02/05/2025

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to ensure two (2) of 63 residents (Resident #39 and Resident #46) in the survey sample were given the opportunity to formulate an advance directive. The findings included; 1. The facility staff failed to ensure Resident #39 had an opportunity to develop an advanced directive. Resident #39 was originally admitted to the facility 11/09/23 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Depression, Unspecified. The 5-day Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/17/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #39 cognitive abilities for daily decision making were moderately impaired. In sectionGG(Functional Abilities Goals) the resident was coded as requiring partial/moderate assistance with eating, oral hygiene. Resident coded as dependent in lower body dressing, personal hygiene and rolling left and right. The care plan dated 11/22/23 read that Resident #39 had an Activities of Daily Living (ADL) self-care performance deficit related to multiple sclerosis, rheumatoid arthritis, spinal stenosis, right foot drop, morbid obesity, osteoarthritis, bilateral hand contractures and personality disorder. The Goal was to have the resident participate in as much of her ADL care as possible. The intervention for the resident requires total dependance by two (2) staff members for toileting and requires max assist to total dependance by two (2) staff members for bed mobility, transfers and one person assist for mobility in wheelchair. A review of the medical records revealed no advanced directives were available or that the resident had an opportunity to develop one. A review of the Physicians Order Summary (POS) revealed resident had a Full Code Status as of 11/10/2023. On 02/03/25 at approximately 2:33 PM., an interview was conducted with Resident #39 concerning an advanced Directive. Resident #39 said that I'm a full code. I don't think that I have an Advance. Directive. 2. The facility staff failed to ensure Resident #46 had an opportunity to formulate an advanced directive. Resident #46 was originally admitted to the facility 1/04/22 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Chronic Kidney Disease. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The annual, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/28/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #46 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities Goals) the resident was coded as requiring supervision with eating, upper body dressing, requires substantial/maximal assistance with toileting hygiene, showers/bathing, lower body dressing and personal hygiene. The care plan dated 7/11/23 read that resident has an ADL self-care performance deficit r/t Weakness, Acute Kidney Failure, history of Falling, Epilepsy and Bipolar Disorder, history of falls. The Goal is the resident will improve current level of function in through the review date (11/21/23). The intervention: Monitor/document/report as needed any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. The Physicians Order Summary for January 2025 reads that Resident has a Full Code status as of 07/15/2024. On 2/04/25 at approximately 1:00 PM., an interview was conducted with the Social Services Director (SSD) concerning advanced Directives. The SSD said that no Advanced Directive were done by Social Services or that he had an opportunity to develop one. On 2/05/25 at approximately 2:30 PM., the nursing staff on unit 4 were asked for the advanced Directive Book but to no book was available. On 2/05/25 at approximately 1:51 PM., an interview was conducted with RN C concerning the advance directives for the above residents. RN C said that they usually keep them in a red folder on the unit (unit 4), but she can't find the folder. On 02/05/25 at approximately 2:09 PM., an interview was conducted with Licensed Practical Nurse (LPN) B. LPN B, said that they did not have an advance directive book on Unit four (4). On 02/05/25 at approximately 2:21 PM., an interview was conducted with the Director of Nursing (DON) concerning the above. The DON also said that upon admission Social Services will complete the advance directive with the resident, family or guardian. The DON also mentioned that on each unit the facility has a code status book. On 2/05/25 at approximately 7:00 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to complete an Advanced Beneficiary Notice (ABN) for two (2) Residents, (Residents #192 and #37) in the four (4) sampled residents. The findings included: Residents #192, and #37 were chosen from a list of residents discharged in the previous 6 months. On 2-3-25 at 9:00 AM, the Business Office Manager was asked for a copy of the Advance Beneficiary Notice for 4 Residents. The Director of Nursing (DON) presented 4 forms that she stated were the ABNs. The forms revealed two (2) of the four (4) sampled Residents received Form CMS-10123 NOMNC (Notice of Medicare Non-Coverage) which were signed by the resident or the authorized representative, and included the estimated date of non-coverage, and appeal information. The other two (2) of the four (4) sampled Residents (Resident #192, and #37) received form CMS-R-131 forms which revealed no date when insurance coverage would end, did not specify a cost for the Resident should they elect to pay for continued services, and did not give information on the appeal process available to them. The form for Resident #192 was filled out by an Occupational Therapy Assistant, and documented spoke with (name). Daughter of the Resident. No date, and no time was documented. No letter was sent. The form for Resident #37 was filled out by an Occupational Therapist, and documented Left voicemail w/RP (responsible party) no name given for that individual, no date, and no time was documented. No letter was sent. Neither of these two (2) Residents nor their representatives signed the forms, no estimated cost of continued services was documented, nor were letters sent to instruct on appeal should the Resident's wish to continue the services. An interview was conducted with the newly hired Social Worker who stated she would normally be the person to administer the NOMNC. She stated that she could see the issues with the 2 NOMNC/ABN's received by surveyors, and listed the failures of the documents after reviewing them both. The facility had a history of not having a vetted, acceptable Social worker at times during the past year, and those dates can be found elsewhere in the statement of deficiencies under Federal Tag - 850. During the end of day debriefing on 2-3-25 the Director of Nursing and Administrator were informed of the findings. The facility staff stated they had nothing further to present.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure personal privacy was afforded to three (3) residents (Residents # 123, #2, and # 46) in a survey sample of 63 residents. 1. For Resident # 123, the facility staff failed to provide a curtain to pull around the bed while providing ADL (Activities of Daily Living) Care. Resident # 123 was admitted to the facility on [DATE] with the diagnoses of, but not limited to: Dementia with Agitation, Diabetes, Hypertension, and Legal blindness. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 1/7/2025. Resident # 123's BIMS (Brief Interview for Mental Status) Score was a 13 out of 15, indicating no cognitive impairment. Review of the clinical record was conducted on 1/28/2025 to 1/31/2025 and 2/3/2025 to 2/5/2025. On 1/29/2025 at approximate 10:40 a.m., a Certified Nursing Assistant was observed providing care to Resident # 123. The Certified Nursing Assistant was helping Resident # 123 get dressed for the day. Resident # 123 was visible to anyone who came into the room. There was no curtain around the bed. The roommate (Resident # 2) was in the room and could see Resident # 123. The Certified Nursing Assistant stated she was an agency employee. The Certified Nursing Assistant stated she pulled the curtain around the roommate (Resident # 2) as far as she could and tried to shield Resident #123 while providing care. She stated it was important to provide privacy. On 2/3/2025 at 3:15 p.m., an interview was conducted with Registered Nurse-B who stated it was important for the residents' to have privacy in their rooms. On 2/4/2025 during the end of day meeting, the Administrator, Corporate Nurse Consultants and Director of Nursing were made aware of the findings. No further information was provided. 2. Resident # 2, the facility staff failed to have a provide a curtain to pull around the bed while providing Activities of Daily Living (ADL) Care. Resident # 2 was admitted on [DATE] with diagnoses including but not limited to: Epilepsy, Seizures, Confirmed Physical Abuse, Confirmed Psychological Abuse, Major Depressive Disorder, Anxiety Disorder, and Neoplasm of the Brain. Resident #2's most recent MDS (Minimum Data Set) was a Quarterly Assessment with an ARD (Assessment Reference Date) of 12/27/2024 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 13 out of 15 indicating no cognitive impairment. Review of the clinical record was conducted on 1/28/2025 to 1/31/2025 and 2/3/2025 to 2/5/2025. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations were made of there being one quarter panel curtain suspended above Resident # 2's bed. The curtain did not extend around the bed to completely provide visual privacy while ADL care was being provided. Resident # 2 had a roommate in the room. The roommate (Resident # 123) was in the room while ADL care was being provided for Resident # 2. The Certified Nursing Assistant stated she was an agency employee. The Certified Nursing Assistant stated she pulled the curtain as far as she could and tried to shield Resident # 2 while providing care. She stated it was important to provide privacy. On 2/3/2025 at 3:15 p.m., an interview was conducted with Registered Nurse-B who stated it was important for the residents' to have privacy in their rooms. On 2/4/2025 during the end of day meeting, the Administrator, Corporate Nurse Consultants and Director of Nursing were made aware of the findings. No further information was provided.3. The facility staff failed to ensure privacy while performing incontinence care for Resident #46. Resident #46 was originally admitted to the facility 1/04/22 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Chronic Kidney Disease. The annual, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/28/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #46 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities Goals) the resident was coded as requiring supervision with eating, upper body dressing, requires substantial/maximal assistance with toileting hygiene, showers/bathing, lower body dressing and personal hygiene. The care plan dated 7/11/23 read that resident has an ADL self-care performance deficit r/t Weakness, Acute Kidney Failure, history of Falling, Epilepsy and Bipolar Disorder, history of falls. The Goal is the resident will improve current level of function in through the review date (11/21/23). The intervention: Monitor/document/report as needed any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function On 01/29/25 at approximately 11:30 AM., while rounding in the hallway on unit 4, Resident #46 was heard yelling for his Certified Nurse's Assistant (CNA) B, by her first name several times. On 01/29/25 at approximately 11:39 AM., CNA B entered Resident #46 room (403B unit 4). The resident had informed her that he had a Bowel Movement (BM). After receiving permission from Resident #46 to observe his care, CNA B began incontinent and ADL care on the resident. There was a partial privacy curtain preventing the resident across from him to seeing the ADL care, the door to room [ROOM NUMBER] B was closed. Visibly from the door the resident could be seen receiving care. A timeline of events: 11:51 AM., there was a knock at the door, two staff quickly entered the room while the resident was exposed, receiving Activities of Daily Living (ADL), incontinent care. 11:54 AM., there was a knock at the door, then quickly, the door opened, entered one staff, resident still exposed, while receiving ADL care. 11:56 AM., there was a knock at the door, the Assistant Director of Nursing (ADON) quickly entered the room and said I'm just rounding. CNA B, said I'm ok. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/25 at approximately 1:56 PM., an interview was conducted with CNA F concerning the above incident. CNA F said that She shouldn't have walked into the residents' room while he was receiving care. CNA F also said that months ago that she informed a nurse that some of the rooms didn't have privacy curtains. CNA F also said that if the rooms don't have privacy curtains, she will just make sure the door is closed. On 2/03/25 at approximately 4:21 PM., an interview was conducted with the Director of Nursing (DON) concerning the privacy curtains. The DON said after knocking on a resident's closed-door staff should wait to hear what the CNA is saying first before entering. On 02/03/25 at approximately 3:19 PM., an interview was conducted with CNA B concerning Resident #46. CNA B said that no one should walk in the room while care is being provided. CNA B also said that the resident only had a portion of a privacy curtain when care was being rendered. On 2/05/25 at approximately 7:00 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 3. Unit two: For Resident #3, the facility staff failed to maintain a clean, comfortable, homelike living environment. On 1-28-25 during resident room observations, the room of Resident #3 was noted to have a sticky, tape style insect trap, hanging from the ceiling in the bathroom. The 2 inch wide by 24 inch long tape was so covered in insects that it had the appearance of fur covering it. A nurse was coming down the hall at that time and was asked to view the area. When asked if he thought it was safe and sanitary for the Resident, he stated no. Resident #3 stated yes, they have pest control bug people come and spray, however, she stated they only spray the halls, not the rooms, because they don't want to move things around in the room. Pest Control Review: During the entire survey there were fruit flies as well as large flies, and cock roaches noted on all three living units, and in the common areas as well. A review of the pest control logs revealed that the facility is having pest control services come to the building monthly, however, the pests continue to be in the facility. The Resident's room was shared with a second Resident. The room tour included but was not limited to the following being observed; broken vinyl window blinds, a urine soaked bathroom with a bedpan full of urine stained panties on the floor, a pervasive smell of urine and feces in the room and on the entire unit. The floor of the room was sticky and made a sucking sound as one walked across it, and the base board was peeling and drooping over in places. The floor was crusted with crumbs, brown debris, and black particles. The walls were scraped and stained, and covered in crayon coloring book pages completed by the Resident, which encircled the walls of the entire room and were also on the room door The bed divider curtain had brown stains and smeared tan substances on it. The Residents both had a 16 ounce Styrofoam cup with a plastic lid and straw in it for water which were stained. The Maintenance Director was a member of the corporate staff and not regular staff in the facility. The facility Maintenance director had resigned leaving the position open for a substantial period of time, and the Corporate Maintenance Director was on site during survey training the new Maintenance Director who had just started while survey was being conducted. On 1-29-25 during a meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns and that unit #2 was not safe, clean and comfortable, and homelike. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2-5-25 at the time of survey exit the facility Administrator, and Director of Nursing stated that pest control services had been in and treated rooms on unit #2, and that they had nothing further to provide. 4. Unit Two: For Resident #130, the facility staff failed to maintain a clean, comfortable, homelike living environment. On 1-28-25 during resident room observations, the room of Resident #130 was noted to have small red bugs on the floor under the bed of the Resident's room mate. The room mate was wearing stained dirty clothing with wet spots noted in his lap while he sat in a wheel chair. A nurse was coming down the hall at that time and was asked to view the area. When asked if he thought it was safe and sanitary for the Resident, he stated no. He further stated he would get the Maintenance Director to have pest control come and treat the room. Resident #130 also stated yes, they have pest control bug people come and spray, however, they only spray the halls, not the rooms, because they don't want to move things around in the room. Pest Control Review; During the entire survey there were fruit flies as well as large flies, and cock roaches noted on all 3 living units, and in the common areas as well. A review of the pest control logs revealed that the facility is having pest control services come to the building monthly, however, the pests continue to be in the facility. The Resident's room tour included but was not limited to the following being observed; broken vinyl window blinds, a urine soaked bathroom a pervasive smell of urine and feces in the room and on the entire unit. The overbed tables, and bedside tables were littered with crumbs, smears, dried food particles, used paper napkins and waste from food containers, and were unclean. The floor of the room was sticky and made a sucking sound as one walked across it, and the base board was peeling and drooping over in places. The floor was crusted with crumbs, brown debris, and black particles. The walls were scraped and stained, and had holes in various areas. The bed divider curtain had brown stains and smeared tan substances on it. The Residents both had a 16 ounce Styrofoam cup with a plastic lid and straw in it for water which were stained. The Maintenance Director was a member of the corporate staff and not regular staff in the facility. The facility Maintenance director had resigned leaving the position open for a substantial period of time, and the Corporate Maintenance Director was on site during survey training the new Maintenance Director who had just started while survey was being conducted. On 1-29-25 during a meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns and that Unit #2 was not safe, clean and comfortable, and homelike. On 2-5-25 at the time of survey exit the facility Administrator, and Director of Nursing stated that pest control services had been in and treated rooms on unit #2, and had eradicated the bed bugs in Resident #130's room, and that they had nothing further to provide. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, resident interviews, staff interviews, facility document reviews, and review of the facility's policy, the facility staff failed to provide a sanitary, comfortable, and homelike environment on three of three units (Unit 2, 3 and 4 only operational units, Unit 1 under renovation) and in the main entryway, which resulted in Substandard Quality of Care. The findings included: 1. Unit Four: Upon entering the facility on 1/31/25 at approximately 11:30 AM, water was observed leaking overhead between the two entryway doors. A large amount of water continued to pool in the entryway making the area unsanitary as people walked and pulled bags through the water into the facility. Each day through 2/5/25 the overhead of the entryway dripped water and it accumulated into puddles which was brought into the facility. At approximately 12:55 PM, after exiting the elevator on the second floor to reach Unit Four, a pervasive stench engulfed the area outside the elevator. Upon reaching the corridor of Unit Four the stench grew in intensity and the search for causative factors revealed, Resident #26 was observed in a wheelchair, urine saturated, wandering the corridor and in and out of other resident rooms. No staff were observed to intervene. At approximately 1:13 PM, a 3/4 full urinal of dark yellow urine was observed hanging on the side of a trash can in room [ROOM NUMBER]. Piles of clothing were observed on the floor between the TV stands, on the TV stand, and in the corner bedside the wardrobe. The wardrobe's right door was falling off. Resident #27 was observed sitting in a wheel chair in room [ROOM NUMBER], he had a disheveled appearance. The resident's skin was extremely dry and scaly, there was an unpleasant body odor and the resident's clothing was remarkably soiled. a. Resident #27 was originally admitted to the facility 01/30/2015 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included COPD and a major depressive disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/2/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #27's cognitive abilities for daily decision making were intact. An interview was conducted with Resident #27 at approximately 1:15 PM. He stated he wanted to keep the long beard but, he very much desired a haircut and maybe a hot bath. Resident #27 was overheard asking a Certified Nursing Assistant (CNA) in the corridor for a haircut and the staff member stated she did not have her clipper with her therefore she could not cut his hair that day. b. During observation rounds on 1/28/25 at 2:15 PM it was observed in room [ROOM NUMBER] that the light fixture above the sink was missing a light fixture cover, and the inside of the sink was very stained with a yellow discoloration. Also, the wall under and around the sink was very dirty with black marks, damage to the wall, and the floor was very dirty around the perimeter of the room where the floor meets the baseboard. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/2/25 approximately 3:09 PM addtional observations were made in room [ROOM NUMBER]. Beside Resident #81's bed, was a large amount of clothing were on the floor and the four bed room had much debris on the floor, a left over breakfast tray on a table and unpleasant odors. Resident #81 was originally admitted to the facility 12/9/2024 after an acute care hospital stay. He had never been discharged from the facility. The current diagnoses included a right buttock wound secondary to a peri-rectal abscess, fecal diversion surgery status post colostomy to prevent reinfecting the wound and heart attack. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/16/2024 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #81's cognitive abilities for daily decision making were intact. An interview was conducted with Resident #81. The resident stated he was not going to pick the clothing up because roaches were beneath the clothing and they would stay there if he did not disturb them. Two small roaches were observed crawling along the floor beside the clothing. The privacy curtain between Resident #81's bed and the bed beside his, had a large amount of a dark brown substance on it and the curtain was missing many top hooks which allowed draping at the top. c. During general observations, in room [ROOM NUMBER] the privacy curtain also required hooks for proper hanging and was it appeared soiled. There was debris on the floor and pieces of paper. In room [ROOM NUMBER] the faucet at the sink allowed the water to drip rapidly. d. Resident #21 returned to room [ROOM NUMBER] at approximately 4:10 PM, his pants were extremely saturated with urine. The urine made a puddle on the floor beneath the resident's chair, next to his bed and when the resident rolled into the hallway, trails of urine was observed up and down the corridor. Resident #21 was originally admitted to the facility 05/27/2022 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included high blood pressure and bilateral lower extremity swelling. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/31/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #21's cognitive abilities for daily decision making were intact. An interview was conducted with Resident #21, he stated he was not the cause of the odors in room [ROOM NUMBER], it was his roommate who does not bathe. Resident #21 stated he does not like living with the bad odors. On 2/1/25 at approximately 10:00 AM upon exiting the elevator on the Unit Four the same pervasive stench engulfed the area outside the elevator. Upon entering the corridor to Unit Four the intense stench remained. Environmental Services staff were observed mopping floors but as you progressed to the higher room numbers the pervasive stench continued to permeate the unit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/4/25 at 4:20 PM an interview was conducted with the Administrator, Director of Nursing and four Corporate staff members. They all acknowledged the pervasive odors as you exit the elevator on the second floor. The Administrator stated they conducted Angel rounds every morning Monday through Friday and if concerns are identified the appropriate department is notified and follow up on the concern is revisited prior to the end of the day. 5. Unit Two: For Resident # 128, the facility staff failed to ensure the walls near the bed were painted. Resident # 128 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Diabetes, Amputation of Left Leg-Above the Knee, Osteomyelitis of Vertebra, Sacral and Sacrococcygeal region, and Benign Prostatic Hyperplasia of lower urinary tract. The most recent Minimum Data Set (MDS) was an admission Assessment with an Assessment Reference Date (ARD) of 9/10/2024. Resident # 128's BIMS (Brief Interview for Mental Status) Score was a 14 out of 15, indicating no cognitive impairment. Review of the clinical record was conducted on 1/28/2025 to 1/31/2025 and 2/3/2025 to 2/5/2025. During rounds on 1/28/2025 at 1:15 p.m., Resident # 128 was observed lying in the bed. Resident # 128 stated the rooms look pretty bad. He stated the walls were left with white patches when the walls were repaired. Resident # 128 stated he did not like the way the room looked with all of the white patches where the walls were repaired. Resident # 128. On 2/3/2025 at 3:15 p.m., an interview was conducted with Registered Nurse-B who stated it was important for the residents' rooms to be comfortable and homelike. She stated the rooms did not look homelike. During the end of day debriefing on 2/3/2025, the Facility Administrator, two Regional Nurse Consultants and Director of Nursing were informed of the findings. No further information was provided. 6. Unit two: For Resident #113, the facility staff failed to ensure a clean, comfortable homelike environment due to the unpainted walls and the presence of roaches. During rounds on 1/28/2025 at 3:15 p.m., Resident # 113 was observed sitting on the side of the bed and watching television. The walls on the side of the bed were noted to have large white colored areas that looked like holes had been patched. Resident # 113 stated the room looked like that for a while. When asked if there were any other problems, he stated there were a lot of roaches were in the facility. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/03/2025 at 01:28 p.m.- An interview was conducted with Resident # 113 who stated there were lots of areas on the walls that were repaired. He stated the walls had not been painted and they looked bad. He stated roaches were in the residents' rooms and in the hallways. He also stated he had seen roaches in the facility several times. On 2/3/2025 at 3:15 p.m., an interview was conducted with Registered Nurse-B who stated it was important for the residents' rooms to be comfortable and homelike. She stated the rooms did not look homelike. During the end of day debriefing on 2/3/2025, the Facility Administrator, two Regional Nurse Consultants and Director of Nursing were informed of the findings. No further information was provided. 7. Unit two: For Resident # 2, the facility staff failed to ensure a clean, comfortable homelike environment. Resident # 2 was admitted on [DATE] with diagnoses including but not limited to: Epilepsy, Seizures, Confirmed Physical Abuse, Confirmed Psychological Abuse, Major Depressive Disorder, Anxiety Disorder, and Neoplasm of the Brain. Resident #2's most recent MDS (Minimum Data Set) was a Quarterly Assessment with an ARD (Assessment Reference Date) of 12/27/2024 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 13 out of 15 indicating no cognitive impairment. Review of the clinical record was conducted on 1/28/2025 to 1/31/2025 and 2/3/2025 to 2/5/2025. Resident # 2 complained that the room looked terrible. She stated she had recently moved to that room and there was stuff everywhere. Clutter was observed in the empty areas where residents formerly resided. The room was equipped for four residents but only two resided there during the survey. On 2/3/2025 at 3:15 p.m., an interview was conducted with Registered Nurse-B who stated it was important for the residents' rooms to be comfortable and homelike. She stated the rooms did not look homelike. During the end of day debriefing on 2/3/2025, the Facility Administrator, two Regional Nurse Consultants and Director of Nursing were informed of the findings. No further information was provided. 8. Unit Three: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/15/25 approximately 1:45 p.m. getting off of the elevator on the Unit three a strong odor of urine and body odor was detected. The shower room on the 300's hall had 2 dirty towels on the floor a washcloth hanging over the arm of the shower chair. The walls were patched up where holes had been repaired but never painted over, the shower chairs were soiled with brown substance, and there was a soiled brief in the corner near the trash can. The shower curtains do not completely cover the shower stalls, and they are stained with brownish yellow substance. On 1/16/25 at approximately 10:30 a.m., getting off of the Unit three elevator once again there was a strong odor of urine and body odor, while interviewing Resident #24 noted his blanket had what appeared to be food stains and the sheet had black marks on it. Throughout the rest of the survey all subsequent trips to the second-floor surveyors encountered this same odor of urine and body odor on the second floor. Throughout the 300's hall floors were noted to be dirty in the hallway and in Resident rooms. Strong stale cigarette smell in the dining room on the first floor as residents smoke in the patio area outside of the dining room door. On 2/3/25 at 11:00 an interview was conducted with Employee H & Employee J from the housekeeping dept. Employee H was asked how often floors are washed she stated they are washed daily. Employee J was asked about the shower curtains, and she stated that the shower curtains were on back order since December. She stated that they have to wash and re-hang whatever is here now until a new shipment comes in. When asked about the odor on the second floor she stated that there are Residents who refuse to bathe and that it is a nursing issue not a housekeeping issue. On 2/5/25 during the end of day meeting the Administrator was made aware of the issues and no further information was provided. Unit Four: 2. On 1/28/25 at approximately 1:45 PM., immediately after stepping off the elevator on Unit 4 were strong urine odors which lasted throughout the survey. A brief tour was conducted on unit four (400 Unit) of various rooms. On 1/29/25 at approximately 12:26 PM., room [ROOM NUMBER]B had a partial privacy curtain, not fully providing the resident privacy from all 3 beds present in his room. On 1/29/25 at approximately 3:45 PM., a brief tour of shower room was conducted. Upon entering the shower room, rusty pipes were observed near the sink and wall area. The walls had several areas of peeling paint, a Hoyer lift was stored in a shower stall. There were missing privacy curtains from 2 shower stalls, towels and hospital gowns were observed on the floor. A roach was observed crawling on the floor. On 01/30/25 at approximately 10:45 AM., an interview was conducted with Resident #33 concerning the shower room. Resident #33 said I want to use the shower down stairs because the shower on this floor has rusty pipes. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/05/25 at approximately 1:56 PM., an interview was conducted with CNA F. CNA F said that months ago she had informed a nurse that some of the rooms didn't have privacy curtains. CNA F also said that if the rooms don't have privacy curtains, she will just make sure the door is closed. A tour was conducted in room [ROOM NUMBER] on 1/28/25 3:48 PM., piles of clothing were observed in several corners of the room, as well as large open trash bags with clothing exposed on the floor. The Resident located in C bed (room [ROOM NUMBER] C) said that she's afraid roaches may be in the clothing and could crawl into her area. On 2/03/25 at approximately 4:41 PM., an interview was conducted with the Director of Nursing (DON), concerning the 400 hall (located on Unit 4) shower room. The DON said maintenance is going to see what can be down about the rust. The DON also said that Resident #33 can use the other shower room on the 300 hall. On 02/03/25 at approximately 2:57 PM., the shower room on the 400 hall was toured with Certified Nurses Aide (CNA) H. CNA H said that only 1 resident at a time can enter the shower room due to having one privacy curtain. 10. Unit Three (memory care, locked unit): On 01/28/2025, during the initial tour of facility, all units were toured. The halls had a strong smell of urine upon exiting the elevator on the second floor. Residents were observed in wheelchairs, and some ambulating, in the halls. The Memory care unit had a nurse assigned to the door as the door lock was broken. The Blinds, in rooms [ROOM NUMBER], of the Memory Care Unit, all had damage, broken slats, and openings on the sides preventing privacy. On 02/03/2025, at approximately 2:00 p.m., an interview was conducted with the Regional Maintenance Director. When asked if he was aware that there are multiple rooms on the memory unit with broken and ill-fitting blinds? He stated that he is aware that there are a number or window blinds and privacy curtains that need to be replaced. He went to say, He just hired a maintenance director for the building and that he is training him. He also stated that the blinds and curtain hooks have been ordered but are on back order. On 02/04/2025, at approximately 1:30 p.m., the above findings were shared with the Administrator and Regional Administrator. Regional Administrator states that on 01/01/2025, she re-educated the staff regarding Angel Rounds and introduced a new form to be used during morning rounds. The Rounds include a wall-to-wall tour with documentation and follow up regarding anything that is out of order in the common areas, on the units and in the residents' rooms. An opportunity was offered to the facility's staff to present additional information. A copy of the Angel Round Forms was provided by the Regional Administrator. The forms documents some of the broken items seen on observation and that some of the items needed to repair or replace the item had been requested through Tells, the service request system, but there was no documentation of the broken blinds in the rooms listed. On 2/04/2025 during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 9. Conference room: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation rounds on 1/28/25 at 3:00 PM and on 2/5/25 at 2:10 PM it was observed in the Conference Room that (2) two light fixtures had a large number of dead pests in the light fixtures covers.

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F 0586 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not prohibit or in any way discourage a resident from communicating with federal, state, or local officials. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, staff interviews, Resident interviews, clinical record reviews, and facility documentation review, the facility staff discouraged one Resident from communication with external local entities/police during an abuse allegation, and did not allow evidence from a police report of the abuse situation for 2 Residents (Residents #131, and #130) in a survey sample size of 63 residents. The findings included: The facility failures described above resulted in the sexual abuse/harassment of Resident #131 by Resident #130, without police protection. Resident #131 (victim) was admitted to the facility on [DATE]. Diagnoses included but were not limited to: Traumatic Brain Injury (TBI) after a motor vehicle accident, diplopia, muscle weakness, unsteadiness on feet, abnormal gait and mobility, wheelchair use, and cognitive communication deficit, although there was no communication deficit noted at the time of survey. Resident #131's most recent Minimum Data Set with an Assessment Reference Date of 1-23-25 was coded as a discharge assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and his own responsible party. The Resident required touch assistance from one staff member for transferring and was wheelchair bound at times and was able to stand or walk independently for short distances. He required set up or touch assistance only with hygiene and bathing. The Resident denied complaints against any other staff or Residents since his admission on [DATE]. The Resident was discharged to a group home on 1-23-25 to be closer to family and to the least restrictive environment. Resident #130 (aggressor of victim #131) was admitted to the facility on [DATE]. Hospital discharge records indicated that the Resident was alert and oriented to person, place and time, and was ambulatory. Diagnoses included but were not limited to: Major depressive disorder, recurrent anxiety, Chronic hepatitis C, type two diabetes, nicotine dependence, fractured left heel with infected wound sepsis due to Methicillin Susceptible Staphylococcus Aureus, enhanced barrier precautions, and history of infectious parasitic disease. Resident #130's most recent Minimum Data Set with an Assessment Reference Date of 12-17-24 was coded as a significant change assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicated no cognitive impairment. The Resident was his own responsible party. The Resident required partial to moderate assistance from one staff member for hygiene and bathing. Resident #130 was observed during survey as ambulating without assistance or device. Resident #130 went out of the facility daily using the public city bus transportation and repeatedly returned under the influence of drugs and alcohol. Instances of this were recorded in the nursing progress notes to include the following most recent to survey. (continued on next page)

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F 0586 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9-19-24 6:43 am Resident room noted with a strong odor of weeds [sic] by (Certified Nursing Assistant) CNA, nurse and CNA went in to ask resident, resident confirmed he has been smoking weed, we asked him to turn it over, he declined, resident educated about the implication of that, he was told his action will be reported to management. Describe any interventions attempted: Resident told he will be reported to management Effectiveness of Interventions: Resident will continue to be monitored. 12-20-24 7:24 a.m. (documentation time). Note Text: 4:10 am (time of actual observation) Writer notified of patient lethargic in dining room. Writer into dining room, patient seen with his head (laid backward supine fashion) behind wheelchair, lethargic and hard to arouse. Obtained vitals at 4:13 am 65/40, 56, 16, 100% RA (oxygen saturation on room air alone), BS 140 (blood sugar). Called resident several times, he responded and said, I'm high as a bitch. Writer asked resident several times what he had taken, he refused to say. 911 called made per his nurse. 911 into building. Assessed patient, resident remained with a low BP and heart rate. EMTs encouraged resident to go to hospital. Resident refused. Educated the resident on the importance of going to the hospital to monitor low BP and heart rate, resident continued to refuse. Multiple nurses from units educated the patient on the importance of his health. Encouraged resident to go with EMT to be seen at hospital. Resident then became aggressive saying he wasn't going to the hospital because there was nothing wrong with him. EMTs left building. Writer and nurse attempted to take resident to his room, he refused. Resident remained in dining room area. MD (physician) note - 12-20-24 - [Resident #130 name redacted] was found asleep in in his wheelchair. He reported that he was high. He was difficult to arouse, BPs were in the 60-70s systolic. EMS was called. Upon arrival his BP was still low, but he refused to go the hospital. He is at baseline this morning when I see him. All reports reviewed and spoke with staff about the incident. I am holding his BP meds over the weekend. No reports of fever, chills, chest pain, shortness of breath, nausea, vomiting, or diarrhea. ' 1-3-25 - 10:22 pm. Note Text: Nurse went to resident door, there was strong smell of weed in room, coming right to the hallway. Nurse supervisor notified. A review of Resident #130's care plan revealed the following entry regarding the use of illicit drugs and or alcohol: FOCUS: The Resident is at risk of complications due to a history of illicit drug use. Revision on: 12-16-24. GOAL: The Resident will not have any adverse reaction to alcoholism thru review period. Date Initiated: 12-16-2024. Target Date: 3-16-25. INTERVENTIONS: (3) 1. Observe Resident for signs and symptoms of intoxication or withdrawal from drugs such as tremors nausea/vomiting (severe) sweating and notify MD (doctor) as indicated. Date Initiated: 12-16-2024. 2. Administer medication as ordered. Date Initiated: 12-16-2024. 3. Vitals as needed. Date Initiated: 12-16-2024. (continued on next page)

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F 0586 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-7-25 at 11:14 am nursing progress notes documented Verbal spat with roommate .both parties speaking in elevated tones, no physical contact noted both parties separated. On 1-7-25 at 12:23 pm Resident #15 agreed to a room change, and his spouse was notified. Adult Protective Services (APS) was called by an anonymous caller at the facility and the incident of sexual abuse was reported to them. The caller stated in the APS report of 1-7-25 that the facility Administration did not notify police, and they (the Administration) stated the reason as that can't happen (because) is that Resident (Resident #131 victim) would be charged with assault for pushing Resident (#130 aggressor) out of the doorway so that Resident (#131) could escape. This note indicated that there was physical contact known by staff at the time which was denied in the 1-7-25 nursing note. It was also alleged by the caller to APS that Resident #130 had been making sexual advances toward Resident #131 and wanted to get in his pants. It was also alleged that Resident #131 was asked by facility staff Why can't you just go home? The caller went on to state that Resident #131 had been moved 4 times for different assaults, verbal and such, but this was the only sexual assault. This assertion of frequent moves was found to be true as Resident #131's census in the facility documented those moves. The APS caller stated that on this day (1-7-25) the situation escalated and Resident #130 blocked the door of the room and told Resident #131 you are going to let me F K you. The caller stated that Resident #130 proceeded to touch, molest, and sexually assault Resident #131 who began yelling and screaming, and pushed Resident #130 out of the doorway into the hallway to escape when staff came to see what the commotion was about. Resident #131 told them immediately what had happened. On 1-9-25 at 1:00 pm an interview was conducted with LPN A who stated that they are aware of the Residents going out on LOA (Leave of Absence) and coming back high, also stating but we cannot be with them at all times and cannot stop them leaving the facility. When asked what is done if they catch them smoking or drinking or using drugs in the facility, she stated, We document in the chart, notify the supervisor and educate them, that is all we can really do. When asked if the care plan should reflect the behaviors and interventions, she stated that it should. On 1-9-25 (the second day of survey) at 3:00 pm, Resident #130 was interviewed during an investigation involving Resident drug, alcohol, and weapons abuses that were found to be actively occurring in the facility. This Resident was found to be involved in drug abuse while a Resident. The Resident was asked about an altercation with his roommate which was documented in the nursing progress notes as having occurred on 1-7-25. Resident #130 stated he bought Resident #131 cigarettes and Resident #131 refused to pay him for them. He stated he had indeed used drugs but not in the facility, only outside. This statement was found to be false as staff stated they had removed drugs and drug paraphernalia from his room, and documented that at 4:00 AM on 12-20-24 the Resident was found in the dining room after using drugs in the facility, and was also using in the facility on 9-19-24, and 1-3-25. (continued on next page)

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F 0586 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-9-25 at 3:30 pm, Resident #131 in person, and his spouse by phone were interviewed. They both stated that Resident #130 had made advances toward Resident #131, however, Resident #131 stated he made it Clear that I am straight, married, and got no interest in no [NAME]. Resident #131 stated he would ask me to dress in front of him to see my chest, and I didn't care about that, because he said he would get me some cigarettes, but when he cornered me in the room and wouldn't let me leave the room and grabbed my D k and said I'm gonna F k you in the A , that was it! I screamed for help and pushed him through the door and the nurses almost got knocked down coming in, they heard it all just ask them. Resident #131 stated the temp agency nurse (name) and the other nurse who works here all the time (name) came. Resident #131 stated He (#130 name) and (Resident #106 name) smoke stuff in the room and have overdosed sometimes. I just want out of here. Resident #131 was asked if he had reported the sexual abuse, and he stated I told the nurses, they saw it happen! I told the Administrator who said I would be arrested for pushing him if I called the police, and I've told everybody, but they just moved me to another room. On 1-9-25 A copy of all Facility Reported Incidents (FRI's) for the prior 6 months were requested. 9 were provided by the Administrator, and all 9 followed the standardized format and documentation included notification of the state agency the Virginia Department of Health Office of Licensure and Certification (VDH/OLC), the state Long Term Care Ombudsman, and Adult Protective Services (APS). The 9 completed FRI's were all prior to 9-20-24. On 1-9-25 at 4:00 pm the facility Administrator was asked for any investigation from 1-7-25 involving Residents #130, and #131. On 1-10-25 at 5:00 pm Resident #130 was interviewed by surveyors and stated I feel as though I'm being targeted by a staff member. The Director of Nursing (DON) she don't like me and wants me out of here. She believes anything anyone tells her. He continued to say, Yes I smoke weed but not on the property and I use heroin sometimes, not a lot. The surveyor asked how do you use it, and he replied, I smoke it. The surveyor asked if he received it from someone in the facility. He replied, No I get it outside. He was asked where do you use it? His response was I use it at the bus stop, I go out almost every day. He was asked if he was caught by staff in the facility with drugs or alcohol, and he replied, No they said I was smoking weed in my room, but I won't. He was questioned about the accusations from his roommate, and he stated, I bought him cigarettes, I didn't touch that [NAME] I didn't ask him for no sex. He didn't give me money for the cigarettes he is a liar. They gave me a notice to leave but I got nowhere to go. On 1-10-25 The Administrator delivered a 2-page document dated 1-10-25 entitled Facility Reported Incident (FRI), Date reported 1-10-25, and was signed by the current Administrator. The synopsis was a simple typed document on a clean white unlined sheet of copy paper, and did not state that it was an initial FRI, nor a 5 day follow up. The document described a portion of the incident of 1-7-25, and the fact that Resident #131 alleged that his roommate (Resident #130) had made sexual advances to him and had attempted to block the doorway to keep him (Resident #131) from leaving the room. This was the third time that the allegation of abuse was made to someone in the facility, and to others. The first being the day of the occurrence to staff witnesses, the second to APS who reported it to the facility, to police, and the state agency, and the third on this day 1-10-25. (continued on next page)

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	495327	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0586 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The document reported that Resident #131 had moved Resident #130 out of the way and exited the room. The document included that Resident #131 stated again he was tired of his roommate (Resident #130) making sexual advances at him and he wanted to be out of that room. Resident #131 also stated he wanted to be discharged . The Administrator documented on 1-10-25 that Resident #130 denied the allegation of sexual abuse, and that the facility had concluded that the allegation was unsubstantiated, and was first reported to them on this day. These assertions are incorrect as staff were aware and present on 1-7-25 when the abuse was alleged to have occurred and was first documented. Further the Resident stated to the Administrator (as written in the above portion of the Administrators document) that he was blocked from leaving by his roommate, he was tired of his roommate (Resident #130) making sexual advances at him and he wanted to be out of that room. Sexual abuse and sexual harassment are both crimes. By the facility staff's documentation, and own admission this was reported repeatedly to them, observed by floor baseline staff when it occurred, reported to APS by a complainant, and they continued to report it as unsubstantiated. The facility Resident Protections from abuse policy failures included all of the following 4 areas; 1. The facility was expected to complete background checks on all employees to protect the Resident population from abuse, also training was to be conducted annually for staff. (Training) 2. The Abuse policy document also stated that Residents would be protected if an allegation of abuse was made, and the police involved if that allegation alleged that a crime had happened. (Protection) 3. The Abuse policy document also stated that a comprehensive investigation would be conducted. (Investigation) 4. The document further stated that the state agency and other stake holders would be notified within 24 hours of an allegation of abuse, and that the report would occur within 2 hours if injury occurred. Then the initial report would be followed by a five day follow up report which would be sent to the state agency after the facility investigated to reveal their findings. (Reporting) The facility staff failed to conduct required education for staff, failed to complete background checks in compliance with regulations. The facility staff failed to report the allegation of abuse to the state agency until the state agency reported it to them again 3 days after the allegation was made to, and witnessed by, staff. Police were not called after an allegation that a crime had occurred which was requested by the Resident and his spouse, and a comprehensive investigation was not conducted until the state agency asked for one 3 days after the allegation of abuse was known by staff The facility Abuse policies were not implemented specifically involving and including the following evidence; TRAINING failure: Protections from Abuse and other annual training records in the facility were reviewed and revealed that Certified Nursing Assistants (CNA's) 12 hours of required annual training was not completed for 4 of the 6 employees reviewed, and background checks for staff were also found to be deficient. (continued on next page)

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F 0586 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-10-25 Two nursing staff members spoke to surveyors on agreement of anonymity as they feared retaliation if it were known that they had spoken to surveyors. The two Nursing staff members worked on the units where Residents #131, and #130 were housed and both agreed that Resident #130 bought cigarettes for Resident #131, however, they stated that they had never known of a problem with that as no one complained about it, and they agreed that Resident #131 always went outside to smoke and had not created an issue. One was an agency nurse who worked in the facility, and one was a facility employee. Both stated they were aware of the incident involving Residents #130, and #131, and stated they wondered when the situation would blow up because Resident #130 was obviously grooming and pursuing Resident #131 (name), with the cigarettes, and Resident #131 (name) was married. The nurses were asked if the Administration was aware and they both stated yeah they knew, we all knew. During interview on 1-29-25 and review of the clinical record, it was found that the Social Worker had only been there a short time, however, was aware of the incident with Resident's #131, and #130. She stated that Resident #131 (name) had been discharged on 1-23-25 to a group home in (name) closer to family a near by county. She also stated that Resident #130 would be discharging on 1-29-25 to a different group home closer to the facility. At that time the Administrator was informed that the investigation was incomplete, and no FRI was ever received at the state agency VDH/OLC for the first allegation of abuse. She was further notified they had not implemented their policies on abuse. The allegations were never reported to the state agency until the day after surveyors asked for an investigation. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any added staff supervision for Resident #130 to prevent the abuse from continuing with another Resident. No staff ever reported the suspicion of a crime, and no police report was ever filed. The first alleged report by the Administrator was incomplete and had errors in information giving the appearance of a verbal altercation and that the victim was not touched. APS, was not notified of the alleged abuse by facility Administration, and was instead notified by a complainant resulting in an investigation being opened by the state agency. On 1-30-25 at approximately 4:00 p.m., the facility Administrator, Corporate Registered Nurse, and DON were notified of the findings. They stated they had no further information or documentation to offer.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, staff interviews, Resident interviews, clinical record reviews, and facility documentation review, the facility staff failed to protect one Resident from abuse by a room mate with known illicit drug and alcohol abuse in their shared room for 1 Resident (Residents #131) in a survey sample size of 63 residents. The findings included: Resident #131 was exposed to, and not protected from alleged sexual harassment and abuse, and facility known illicit drug and alcohol abuse in their shared room by his room mate (Resident #130). Resident #131 (victim) was admitted to the facility on [DATE]. Diagnoses included but were not limited to: Traumatic Brain Injury (TBI) after a motor vehicle accident, diplopia, muscle weakness, unsteadiness on feet, abnormal gait and mobility, wheelchair use, and cognitive communication deficit, although there was no communication deficit noted at the time of survey. Resident #131's most recent Minimum Data Set with an Assessment Reference Date of 1-23-25 was coded as a discharge assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and his own responsible party. The Resident required touch assistance from one staff member for transferring and was wheelchair bound at times and was able to stand or walk independently for short distances. He required set up or touch assistance only with hygiene and bathing. The Resident denied complaints against any other staff or Residents since his admission on [DATE]. The Resident was discharged to a group home on 1-23-25 to be closer to family and to the least restrictive environment. Resident #130 (aggressor of victim #131) was admitted to the facility on [DATE]. Hospital discharge records indicated that the Resident was alert and oriented to person, place and time, and was ambulatory. Diagnoses included but were not limited to: Major depressive disorder, recurrent anxiety, Chronic hepatitis C, type two diabetes, nicotine dependence, fractured left heel with infected wound sepsis due to Methicillin Susceptible Staphylococcus Aureus, enhanced barrier precautions, and history of infectious parasitic disease. Resident #130's most recent Minimum Data Set with an Assessment Reference Date of 12-17-24 was coded as a significant change assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicated no cognitive impairment. The Resident was his own responsible party. The Resident required partial to moderate assistance from one staff member for hygiene and bathing. Resident #130 was observed during survey as ambulating without assistance or device. Resident #130 went out of the facility daily using the public city bus transportation and repeatedly returned under the influence of drugs and alcohol. Instances of this were recorded in the nursing progress notes to include the following most recent to survey. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9-19-24 6:43 am Resident room noted with a strong odor of weeds [sic] by (Certified Nursing Assistant) CNA, nurse and CNA went in to ask resident, resident confirmed he has been smoking weed, we asked him to turn it over, he declined, resident educated about the implication of that, he was told his action will be reported to management. Describe any interventions attempted: Resident told he will be reported to management Effectiveness of Interventions: Resident will continue to be monitored. 12-20-24 7:24 a.m. (documentation time). Note Text: 4:10 am (time of actual observation) Writer notified of patient lethargic in dining room. Writer into dining room, patient seen with his head (laid backward supine fashion) behind wheelchair, lethargic and hard to arouse. Obtained vitals at 4:13 am 65/40, 56, 16, 100% RA (oxygen saturation on room air alone), BS 140 (blood sugar). Called resident several times, he responded and said, I'm high as a bitch. Writer asked resident several times what he had taken, he refused to say. 911 called made per his nurse. 911 into building. Assessed patient, resident remained with a low BP and heart rate. EMTs encouraged resident to go to hospital. Resident refused. Educated the resident on the importance of going to the hospital to monitor low BP and heart rate, resident continued to refuse. Multiple nurses from units educated the patient on the importance of his health. Encouraged resident to go with EMT to be seen at hospital. Resident then became aggressive saying he wasn't going to the hospital because there was nothing wrong with him. EMTs left building. Writer and nurse attempted to take resident to his room, he refused. Resident remained in dining room area. MD (physician) note - 12-20-24 - [Resident #130 name redacted] was found asleep in in his wheelchair. He reported that he was high. He was difficult to arouse, BPs were in the 60-70s systolic. EMS was called. Upon arrival his BP was still low, but he refused to go the hospital. He is at baseline this morning when I see him. All reports reviewed and spoke with staff about the incident. I am holding his BP meds over the weekend. No reports of fever, chills, chest pain, shortness of breath, nausea, vomiting, or diarrhea. ' 1-3-25 - 10:22 pm. Note Text: Nurse went to resident door, there was strong smell of weed in room, coming right to the hallway. Nurse supervisor notified. A review of Resident #130's care plan revealed the following entry regarding the use of illicit drugs and or alcohol: FOCUS: The Resident is at risk of complications due to a history of illicit drug use. Revision on: 12-16-24. GOAL: The Resident will not have any adverse reaction to alcoholism thru review period. Date Initiated: 12-16-2024. Target Date: 3-16-25. INTERVENTIONS: (3) 1. Observe Resident for signs and symptoms of intoxication or withdrawal from drugs such as tremors nausea/vomiting (severe) sweating and notify MD (doctor) as indicated. Date Initiated: 12-16-2024. 2. Administer medication as ordered. Date Initiated: 12-16-2024. 3. Vitals as needed. Date Initiated: 12-16-2024. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-7-25 at 11:14 am nursing progress notes documented Verbal spat with roommate .both parties speaking in elevated tones, no physical contact noted both parties separated. On 1-7-25 at 12:23 pm Resident #15 agreed to a room change, and his spouse was notified. Adult Protective Services (APS) was called by an anonymous caller at the facility and the incident of sexual abuse was reported to them. The caller stated in the APS report of 1-7-25 that the facility Administration did not notify police, and they (the Administration) stated the reason as that can't happen (because) is that Resident (Resident #131 victim) would be charged with assault for pushing Resident (#130 aggressor) out of the doorway so that Resident (#131) could escape. This note indicated that there was physical contact known by staff at the time which was denied in the 1-7-25 nursing note. It was also alleged by the caller to APS that Resident #130 had been making sexual advances toward Resident #131 and wanted to get in his pants. It was also alleged that Resident #131 was asked by facility staff Why can't you just go home? The caller went on to state that Resident #131 had been moved 4 times for different assaults, verbal and such, but this was the only sexual assault. This assertion of frequent moves was found to be true as Resident #131's census in the facility documented those moves. The APS caller stated that on this day (1-7-25) the situation escalated and Resident #130 blocked the door of the room and told Resident #131 you are going to let me F K you. The caller stated that Resident #130 proceeded to touch, molest, and sexually assault Resident #131 who began yelling and screaming, and pushed Resident #130 out of the doorway into the hallway to escape when staff came to see what the commotion was about. Resident #131 told them immediately what had happened. On 1-9-25 at 1:00 pm an interview was conducted with LPN A who stated that they are aware of the Residents going out on LOA (Leave of Absence) and coming back high, also stating but we cannot be with them at all times and cannot stop them leaving the facility. When asked what is done if they catch them smoking or drinking or using drugs in the facility, she stated, We document in the chart, notify the supervisor and educate them, that is all we can really do. When asked if the care plan should reflect the behaviors and interventions, she stated that it should. On 1-9-25 (the second day of survey) at 3:00 pm, Resident #130 was interviewed during an investigation involving Resident drug, alcohol, and weapons abuses that were found to be actively occurring in the facility. This Resident was found to be involved in drug abuse while a Resident. The Resident was asked about an altercation with his roommate which was documented in the nursing progress notes as having occurred on 1-7-25. Resident #130 stated he bought Resident #131 cigarettes and Resident #131 refused to pay him for them. He stated he had indeed used drugs but not in the facility, only outside. This statement was found to be false as staff stated they had removed drugs and drug paraphernalia from his room, and documented that at 4:00 AM on 12-20-24 the Resident was found in the dining room after using drugs in the facility, and was also using in the facility on 9-19-24, and 1-3-25. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The document reported that Resident #131 had moved Resident #130 out of the way and exited the room. The document included that Resident #131 stated again he was tired of his roommate (Resident #130) making sexual advances at him and he wanted to be out of that room. Resident #131 also stated he wanted to be discharged . The Administrator documented on 1-10-25 that Resident #130 denied the allegation of sexual abuse, and that the facility had concluded that the allegation was unsubstantiated, and was first reported to them on this day. These assertions are incorrect as staff were aware and present on 1-7-25 when the abuse was alleged to have occurred and was first documented. Further the Resident stated to the Administrator (as written in the above portion of the Administrators document) that he was blocked from leaving by his roommate, he was tired of his roommate (Resident #130) making sexual advances at him and he wanted to be out of that room. Sexual abuse and sexual harassment are both crimes. By the facility staff's documentation, and own admission this was reported repeatedly to them, observed by floor baseline staff when it occurred, reported to APS by a complainant, and they continued to report it as unsubstantiated. The facility Resident Protections from abuse policy failures included all of the following 4 areas; 1. The facility was expected to complete background checks on all employees to protect the Resident population from abuse, also training was to be conducted annually for staff. (Training) 2. The Abuse policy document also stated that Residents would be protected if an allegation of abuse was made, and the police involved if that allegation alleged that a crime had happened. (Protection) 3. The Abuse policy document also stated that a comprehensive investigation would be conducted. (Investigation) 4. The document further stated that the state agency and other stake holders would be notified within 24 hours of an allegation of abuse, and that the report would occur within 2 hours if injury occurred. Then the initial report would be followed by a five day follow up report which would be sent to the state agency after the facility investigated to reveal their findings. (Reporting) The facility staff failed to conduct required education for staff, failed to complete background checks in compliance with regulations. The facility staff failed to report the allegation of abuse to the state agency until the state agency reported it to them again 3 days after the allegation was made to, and witnessed by, staff. Police were not called after an allegation that a crime had occurred which was requested by the Resident and his spouse, and a comprehensive investigation was not conducted until the state agency asked for one 3 days after the allegation of abuse was known by staff The facility Abuse policies were not implemented specifically involving and including the following evidence; TRAINING failure: Protections from Abuse and other annual training records in the facility were reviewed and revealed that Certified Nursing Assistants (CNA's) 12 hours of required annual training was not completed for 4 of the 6 employees reviewed, and background checks for staff were also found to be deficient. (continued on next page)

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	495327	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hill Health & Rehabilitation	4403 Forest Hill Avenue Richmond, VA 23225

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PROTECTION failure: Resident #131 was not afforded police intervention, he was protected by a room move, however, there were no other Resident interviews to ascertain if any other Residents in the building had ever experienced this abuse, and if from this abuser. INVESTIGATION failure: None of the staff witnesses of the 1-7-25 incident were interviewed, nor were statements received, and Resident #4's previous and current roommates were not interviewed. The spouse of Resident #131 was not interviewed, and other Residents on the unit were not interviewed. The FRI document stated that on 1-10-25 the first notification by the Resident was obtained. This was incorrect, as staff witnessed the incident partially, if not fully, and documented it. A witness to the incident called APS on 1-7-25. The Resident was blockaded from leaving his room which was witnessed by staff, as he was told police would arrest him for pushing his aggressor, proving involuntary seclusion/kidnapping, and he screamed for help which resulted in staff intervention. Further the Resident wanted a room change because of the allegation which was made by Resident #131 to staff. The allegation of abuse was alleged by a witness to APS, alleged by the Resident's spouse, alleged by the Resident, and by Administration in their synopsis/FRI (facility reported incident) to the state agency on 1-10-25. The 1-10-25 initial facility document does not include many of the avenues that were available to the facility for a complete investigation, and thus they were unable to reach a more comprehensive conclusion of events. Initial REPORTING failure: The 1-10-25 FRI document was the first report by the facility after the allegation of a sexual abuse that facility staff were made aware of on 1-7-25. This document was derived on 1-10-25 only after surveyors requested documentation of it, and 3 days after the abuse occurred. Any allegation of abuse is mandated to be reported within 24 hours if no serious injury occurred to the state agency (VDH/OLC) Virginia Department of Health/Office of Licensure and Certification. The Department of Social Services office of Adult protective Services (APS) were not notified by the facility, and the police were not called by the facility as was requested by Resident #131 and his spouse on the day of the occurrence. INVESTIGATION follow up RESULTS failure: The 5-day mandated follow up reporting after a full investigation; The Administrator's synopsis on 1-10-25 alleges that the abuse was unsubstantiated. A review of all the above evidence by the state agency reveals it to be substantiated, in part, or in all. A police investigation would have been appropriate in this case, as both Residents were alert, and oriented to person, place, time, and situation, however, this was not afforded to Resident #131. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-10-25 Two nursing staff members spoke to surveyors on agreement of anonymity as they feared retaliation if it were known that they had spoken to surveyors. The two Nursing staff members worked on the units where Residents #131, and #130 were housed and both agreed that Resident #130 bought cigarettes for Resident #131, however, they stated that they had never known of a problem with that as no one complained about it, and they agreed that Resident #131 always went outside to smoke and had not created an issue. One was an agency nurse who worked in the facility, and one was a facility employee. Both stated they were aware of the incident involving Residents #130, and #131, and stated they wondered when the situation would blow up because Resident #130 was obviously grooming and pursuing Resident #131 (name), with the cigarettes, and Resident #131 (name) was married. The nurses were asked if the Administration was aware and they both stated yeah they knew, we all knew. During interview on 1-29-25 and review of the clinical record, it was found that the Social Worker had only been there a short time, however, was aware of the incident with Resident's #131, and #130. She stated that Resident #131 (name) had been discharged on 1-23-25 to a group home in (name) closer to family a near by county. She also stated that Resident #130 would be discharging on 1-29-25 to a different group home closer to the facility. At that time the Administrator was informed that the investigation was incomplete, and no FRI was ever received at the state agency VDH/OLC for the first allegation of abuse. She was further notified they had not implemented their policies on abuse. The allegations were never reported to the state agency until the day after surveyors asked for an investigation. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any added staff supervision for Resident #130 to prevent the abuse from continuing with another Resident. No staff ever reported the suspicion of a crime, and no police report was ever filed. The first alleged report by the Administrator was incomplete and had errors in information giving the appearance of a verbal altercation and that the victim was not touched. APS, was not notified of the alleged abuse by facility Administration, and was instead notified by a complainant resulting in an investigation being opened by the state agency. On 1-30-25 at approximately 4:00 p.m., the facility Administrator, Corporate Registered Nurse, and DON were notified of the findings. They stated they had no further information or documentation to offer.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility failed to ensure residents on three of three living units were free from misappropriation of resident property, to include specifics for one Resident #441 in a sample of 63 residents. The findings included; On three of three units the facility staff failed to prevent misappropriation of resident property. 1. On 1/31/2025 at 1:10 p.m., an interview was conducted with the Social Services Assistant who stated the facility staff conducted clothing drives for residents. He stated that whenever clothing was located in the Laundry department that did not have labels with names of residents identified, those items were placed in an area for residents to search through at a later time. The Social Services Assistant stated family members were not asked to search through the unlabeled clothing when there were complaints about missing clothing. On 1/31/2025 at 2:20 p.m., an interview was conducted with the Housekeeping Director who stated all clothing without labels that came to the laundry would be placed in a designated area. The Housekeeping Director stated that sometimes the laundry staff would find personal items rolled in the soiled linens. There was no way to determine who the personal items belonged to if there were no names on the items. The unlabelled items could come from any of the three units. The Housekeeping Director stated residents and families could search in the Designated area if accompanied by a facility staff member. On 2/4/2025 at 1:10 p.m., an interview was conducted with the Director of Social Services and the Social Services Assistant who both stated they did not have any information about unlabeled clothing. Both were new in their positions at the facility. They stated the facility should try to ensure resident's belongings get returned to them. They stated families and residents were encouraged to put their names in their clothing so they could be identified. Review of the Grievances Log revealed documentation of complaints from residents and families about missing clothing. One surveyor reported that a family member of one of the Residents complained of seeing another resident wearing his jacket. The family member told that surveyor that he knew for a fact that the jacket did not belong to the resident who was seen wearing it. During the end of day debriefing on 2/4/2025, the facility Administrator, Director of Nursing and Corporate Consultants were informed of the findings that the facility did not ensure there was no misappropriation of resident property. They stated the facility should ensure residents' have their personal belongings returned to them. No further information was provided. 2. The facility failed to prevent misappropriation of Residents #441's property. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #441 was admitted to the facility on [DATE], with the diagnoses of, but not limited to, sequalae cerebral infarct, diabetes mellitus, major depressive disorder, and dysphagia. The resident was discharged to another facility on 07/02/2024 and did not return. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 06/19/2024 coded Resident #441 with a Brief Interview for Mental Status (BIMS) with a score of 14 out of a possible score of 15 demonstrating minimal cognitive impairment. On 01/28/2025, during the initial tour of facility, residents were observed in wheelchairs in the first-floor activity room going to the smoking area attached to the activity room, dressed in jackets and coats. The activity director stated that some of the residents obtained coats, jackets and clothing items from the clothing drive on 01/24/2025. On 01/31/2025, at 11:15 a.m., an interview was conducted with Facility Housekeeping manager and the Regional Housekeeping manager who stated that the clothing issue has improved since they purchased a new label maker. They also educated the unit managers to re-educate staff and families that all clothing items should be labeled. The Housekeeping Manager states that they had a clothing drive coordinated with Social Services and the Activity Director. Residents were allowed to look through unidentified and unclaimed clothing items (lost and found) that remained in the laundry department along with donated clothing. The residents could pick items that they wanted. The clothing items were then labeled with the resident's name and the resident was allowed to keep the items. On 01/31/2025, a review of the facility grievance logs revealed, although there were no grievances related to Resident #441 missing clothing or a jacket, there were multiple grievances regarding other residents in the facility missing clothing and personal property. On 01/31/2025, and interview was conducted with the Director of Nursing (DON). She was asked if she was aware that there were multiple reports residents missing clothing. The DON stated that she is new to the facility, but that she was informed that resident clothing was going to laundry unidentified therefor not being returned to the residents. She went on to say that they a new label maker and iron and have re-educated the staff on units regarding the importance of having all resident clothing items labeled. A closed record review was conducted during 3 days of the survey 01/28/2025-02/03/2025 revealed that there was no documentation that it was reported that resident #441 was missing clothing or personal items. On 2/03/2025 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, staff interviews, Resident interviews, clinical record reviews, and facility documentation review, the facility staff failed to implement their abuse policies to protect Residents, report abuse timely, investigate fully, and allow a police report of the abuse for 4 Residents (Residents #130, #131, #7, and #39) in a survey sample size of 63 residents. The findings included: 1. The facility failures described above resulted in the sexual abuse/harassment of Resident #131 by Resident #130. Resident #131 (victim) was admitted to the facility on [DATE]. Diagnoses included but were not limited to: Traumatic Brain Injury (TBI) after a motor vehicle accident, diplopia, muscle weakness, unsteadiness on feet, abnormal gait and mobility, wheelchair use, and cognitive communication deficit, although there was no communication deficit noted at the time of survey. Resident #131's most recent Minimum Data Set with an Assessment Reference Date of 1-23-25 was coded as a discharge assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and his own responsible party. The Resident required touch assistance from one staff member for transferring and was wheelchair bound at times and was able to stand or walk independently for short distances. He required set up or touch assistance only with hygiene and bathing. The Resident denied complaints against any other staff or Residents since his admission on [DATE]. The Resident was discharged to a group home on 1-23-25 to be closer to family and to the least restrictive environment. Resident #130 (aggressor of victim #131) was admitted to the facility on [DATE]. Hospital discharge records indicated that the Resident was alert and oriented to person, place and time, and was ambulatory. Diagnoses included but were not limited to: Major depressive disorder, recurrent anxiety, Chronic hepatitis C, type two diabetes, nicotine dependence, fractured left heel with infected wound sepsis due to Methicillin Susceptible Staphylococcus Aureus, enhanced barrier precautions, and history of infectious parasitic disease. Resident #130's most recent Minimum Data Set with an Assessment Reference Date of 12-17-24 was coded as a significant change assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicated no cognitive impairment. The Resident was his own responsible party. The Resident required partial to moderate assistance from one staff member for hygiene and bathing. Resident #130 was observed during survey as ambulating without assistance or device. Resident #130 went out of the facility daily using the public city bus transportation and repeatedly returned under the influence of drugs and alcohol. Instances of this were recorded in the nursing progress notes to include the following most recent to survey. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9-19-24 6:43 am Resident room noted with a strong odor of weeds [sic] by (Certified Nursing Assistant) CNA, nurse and CNA went in to ask resident, resident confirmed he has been smoking weed, we asked him to turn it over, he declined, resident educated about the implication of that, he was told his action will be reported to management. Describe any interventions attempted: Resident told he will be reported to management Effectiveness of Interventions: Resident will continue to be monitored. 12-20-24 7:24 a.m. (documentation time). Note Text: 4:10 am (time of actual observation) Writer notified of patient lethargic in dining room. Writer into dining room, patient seen with his head (laid backward supine fashion) behind wheelchair, lethargic and hard to arouse. Obtained vitals at 4:13 am 65/40, 56, 16, 100% RA (oxygen saturation on room air alone), BS 140 (blood sugar). Called resident several times, he responded and said, I'm high as a bitch. Writer asked resident several times what he had taken, he refused to say. 911 called made per his nurse. 911 into building. Assessed patient, resident remained with a low BP and heart rate. EMTs encouraged resident to go to hospital. Resident refused. Educated the resident on the importance of going to the hospital to monitor low BP and heart rate, resident continued to refuse. Multiple nurses from units educated the patient on the importance of his health. Encouraged resident to go with EMT to be seen at hospital. Resident then became aggressive saying he wasn't going to the hospital because there was nothing wrong with him. EMTs left building. Writer and nurse attempted to take resident to his room, he refused. Resident remained in dining room area. MD (physician) note - 12-20-24 - [Resident #130 name redacted] was found asleep in in his wheelchair. He reported that he was high. He was difficult to arouse, BPs were in the 60-70s systolic. EMS was called. Upon arrival his BP was still low, but he refused to go the hospital. He is at baseline this morning when I see him. All reports reviewed and spoke with staff about the incident. I am holding his BP meds over the weekend. No reports of fever, chills, chest pain, shortness of breath, nausea, vomiting, or diarrhea. ' 1-3-25 - 10:22 pm. Note Text: Nurse went to resident door, there was strong smell of weed in room, coming right to the hallway. Nurse supervisor notified. A review of Resident #130's care plan revealed the following entry regarding the use of illicit drugs and or alcohol: FOCUS: The Resident is at risk of complications due to a history of illicit drug use. Revision on: 12-16-24. GOAL: The Resident will not have any adverse reaction to alcoholism thru review period. Date Initiated: 12-16-2024. Target Date: 3-16-25. INTERVENTIONS: (3) 1. Observe Resident for signs and symptoms of intoxication or withdrawal from drugs such as tremors nausea/vomiting (severe) sweating and notify MD (doctor) as indicated. Date Initiated: 12-16-2024. 2. Administer medication as ordered. Date Initiated: 12-16-2024. 3. Vitals as needed. Date Initiated: 12-16-2024. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-7-25 at 11:14 am nursing progress notes documented Verbal spat with roommate .both parties speaking in elevated tones, no physical contact noted both parties separated. On 1-7-25 at 12:23 pm Resident #15 agreed to a room change, and his spouse was notified. Adult Protective Services (APS) was called by an anonymous caller at the facility and the incident of sexual abuse was reported to them. The caller stated in the APS report of 1-7-25 that the facility Administration did not notify police, and they (the Administration) stated the reason as that can't happen (because) is that Resident (Resident #131 victim) would be charged with assault for pushing Resident (#130 aggressor) out of the doorway so that Resident (#131) could escape. This note indicated that there was physical contact known by staff at the time which was denied in the 1-7-25 nursing note. It was also alleged by the caller to APS that Resident #130 had been making sexual advances toward Resident #131 and wanted to get in his pants. It was also alleged that Resident #131 was asked by facility staff Why can't you just go home? The caller went on to state that Resident #131 had been moved 4 times for different assaults, verbal and such, but this was the only sexual assault. This assertion of frequent moves was found to be true as Resident #131's census in the facility documented those moves. The APS caller stated that on this day (1-7-25) the situation escalated and Resident #130 blocked the door of the room and told Resident #131 you are going to let me F K you. The caller stated that Resident #130 proceeded to touch, molest, and sexually assault Resident #131 who began yelling and screaming, and pushed Resident #130 out of the doorway into the hallway to escape when staff came to see what the commotion was about. Resident #131 told them immediately what had happened. On 1-9-25 at 1:00 pm an interview was conducted with LPN A who stated that they are aware of the Residents going out on LOA (Leave of Absence) and coming back high, also stating but we cannot be with them at all times and cannot stop them leaving the facility. When asked what is done if they catch them smoking or drinking or using drugs in the facility, she stated, We document in the chart, notify the supervisor and educate them, that is all we can really do. When asked if the care plan should reflect the behaviors and interventions, she stated that it should. On 1-9-25 (the second day of survey) at 3:00 pm, Resident #130 was interviewed during an investigation involving Resident drug, alcohol, and weapons abuses that were found to be actively occurring in the facility. This Resident was found to be involved in drug abuse while a Resident. The Resident was asked about an altercation with his roommate which was documented in the nursing progress notes as having occurred on 1-7-25. Resident #130 stated he bought Resident #131 cigarettes and Resident #131 refused to pay him for them. He stated he had indeed used drugs but not in the facility, only outside. This statement was found to be false as staff stated they had removed drugs and drug paraphernalia from his room, and documented that at 4:00 AM on 12-20-24 the Resident was found in the dining room after using drugs in the facility, and was also using in the facility on 9-19-24, and 1-3-25. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-9-25 at 3:30 pm, Resident #131 in person, and his spouse by phone were interviewed. They both stated that Resident #130 had made advances toward Resident #131, however, Resident #131 stated he made it Clear that I am straight, married, and got no interest in no [NAME]. Resident #131 stated he would ask me to dress in front of him to see my chest, and I didn't care about that, because he said he would get me some cigarettes, but when he cornered me in the room and wouldn't let me leave the room and grabbed my D k and said I'm gonna F k you in the A , that was it! I screamed for help and pushed him through the door and the nurses almost got knocked down coming in, they heard it all just ask them. Resident #131 stated the temp agency nurse (name) and the other nurse who works here all the time (name) came. Resident #131 stated He (#130 name) and (Resident #106 name) smoke stuff in the room and have overdosed sometimes. I just want out of here. Resident #131 was asked if he had reported the sexual abuse, and he stated I told the nurses, they saw it happen! I told the Administrator who said I would be arrested for pushing him if I called the police, and I've told everybody, but they just moved me to another room. On 1-9-25 A copy of all Facility Reported Incidents (FRI's) for the prior 6 months were requested. 9 were provided by the Administrator, and all 9 followed the standardized format and documentation included notification of the state agency the Virginia Department of Health Office of Licensure and Certification (VDH/OLC), the state Long Term Care Ombudsman, and Adult Protective Services (APS). The 9 completed FRI's were all prior to 9-20-24. On 1-9-25 at 4:00 pm the facility Administrator was asked for any investigation from 1-7-25 involving Residents #130, and #131. On 1-10-25 at 5:00 pm Resident #130 was interviewed by surveyors and stated I feel as though I'm being targeted by a staff member. The Director of Nursing (DON) she don't like me and wants me out of here. She believes anything anyone tells her. He continued to say, Yes I smoke weed but not on the property and I use heroin sometimes, not a lot. The surveyor asked how do you use it, and he replied, I smoke it. The surveyor asked if he received it from someone in the facility. He replied, No I get it outside. He was asked where do you use it? His response was I use it at the bus stop, I go out almost every day. He was asked if he was caught by staff in the facility with drugs or alcohol, and he replied, No they said I was smoking weed in my room, but I won't. He was questioned about the accusations from his roommate, and he stated, I bought him cigarettes, I didn't touch that [NAME] I didn't ask him for no sex. He didn't give me money for the cigarettes he is a liar. They gave me a notice to leave but I got nowhere to go. On 1-10-25 The Administrator delivered a 2-page document dated 1-10-25 entitled Facility Reported Incident (FRI), Date reported 1-10-25, and was signed by the current Administrator. The synopsis was a simple typed document on a clean white unlined sheet of copy paper, and did not state that it was an initial FRI, nor a 5 day follow up. The document described a portion of the incident of 1-7-25, and the fact that Resident #131 alleged that his roommate (Resident #130) had made sexual advances to him and had attempted to block the doorway to keep him (Resident #131) from leaving the room. This was the third time that the allegation of abuse was made to someone in the facility, and to others. The first being the day of the occurrence to staff witnesses, the second to APS who reported it to the facility, to police, and the state agency, and the third on this day 1-10-25. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The document reported that Resident #131 had moved Resident #130 out of the way and exited the room. The document included that Resident #131 stated again he was tired of his roommate (Resident #130) making sexual advances at him and he wanted to be out of that room. Resident #131 also stated he wanted to be discharged . The Administrator documented on 1-10-25 that Resident #130 denied the allegation of sexual abuse, and that the facility had concluded that the allegation was unsubstantiated, and was first reported to them on this day. These assertions are incorrect as staff were aware and present on 1-7-25 when the abuse was alleged to have occurred and was first documented. Further the Resident stated to the Administrator (as written in the above portion of the Administrators document) that he was blocked from leaving by his roommate, he was tired of his roommate (Resident #130) making sexual advances at him and he wanted to be out of that room. Sexual abuse and sexual harassment are both crimes. By the facility staff's documentation, and own admission this was reported repeatedly to them, observed by floor baseline staff when it occurred, reported to APS by a complainant, and they continued to report it as unsubstantiated. The facility Resident Protections from abuse policy failures included all of the following 4 areas; 1. The facility was expected to complete background checks on all employees to protect the Resident population from abuse, also training was to be conducted annually for staff. (Training) 2. The Abuse policy document also stated that Residents would be protected if an allegation of abuse was made, and the police involved if that allegation alleged that a crime had happened. (Protection) 3. The Abuse policy document also stated that a comprehensive investigation would be conducted. (Investigation) 4. The document further stated that the state agency and other stake holders would be notified within 24 hours of an allegation of abuse, and that the report would occur within 2 hours if injury occurred. Then the initial report would be followed by a five day follow up report which would be sent to the state agency after the facility investigated to reveal their findings. (Reporting) The facility staff failed to conduct required education for staff, failed to complete background checks in compliance with regulations. The facility staff failed to report the allegation of abuse to the state agency until the state agency reported it to them again 3 days after the allegation was made to, and witnessed by, staff. Police were not called after an allegation that a crime had occurred which was requested by the Resident and his spouse, and a comprehensive investigation was not conducted until the state agency asked for one 3 days after the allegation of abuse was known by staff The facility Abuse policies were not implemented specifically involving and including the following evidence; TRAINING failure: Protections from Abuse and other annual training records in the facility were reviewed and revealed that Certified Nursing Assistants (CNA's) 12 hours of required annual training was not completed for 4 of the 6 employees reviewed, and background checks for staff were also found to be deficient. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PROTECTION failure: Resident #131 was not afforded police intervention, he was protected by a room move, however, there were no other Resident interviews to ascertain if any other Residents in the building had ever experienced this abuse, and if from this abuser. INVESTIGATION failure: None of the staff witnesses of the 1-7-25 incident were interviewed, nor were statements received, and Resident #4's previous and current roommates were not interviewed. The spouse of Resident #131 was not interviewed, and other Residents on the unit were not interviewed. The FRI document stated that on 1-10-25 the first notification by the Resident was obtained. This was incorrect, as staff witnessed the incident partially, if not fully, and documented it. A witness to the incident called APS on 1-7-25. The Resident was blockaded from leaving his room which was witnessed by staff, as he was told police would arrest him for pushing his aggressor, proving involuntary seclusion/kidnapping, and he screamed for help which resulted in staff intervention. Further the Resident wanted a room change because of the allegation which was made by Resident #131 to staff. The allegation of abuse was alleged by a witness to APS, alleged by the Resident's spouse, alleged by the Resident, and by Administration in their synopsis/FRI (facility reported incident) to the state agency on 1-10-25. The 1-10-25 initial facility document does not include many of the avenues that were available to the facility for a complete investigation, and thus they were unable to reach a more comprehensive conclusion of events. Initial REPORTING failure: The 1-10-25 FRI document was the first report by the facility after the allegation of a sexual abuse that facility staff were made aware of on 1-7-25. This document was derived on 1-10-25 only after surveyors requested documentation of it, and 3 days after the abuse occurred. Any allegation of abuse is mandated to be reported within 24 hours if no serious injury occurred to the state agency (VDH/OLC) Virginia Department of Health/Office of Licensure and Certification. The Department of Social Services office of Adult protective Services (APS) were not notified by the facility, and the police were not called by the facility as was requested by Resident #131 and his spouse on the day of the occurrence. INVESTIGATION follow up RESULTS failure: The 5-day mandated follow up reporting after a full investigation; The Administrator's synopsis on 1-10-25 alleges that the abuse was unsubstantiated. A review of all the above evidence by the state agency reveals it to be substantiated, in part, or in all. A police investigation would have been appropriate in this case, as both Residents were alert, and oriented to person, place, time, and situation, however, this was not afforded to Resident #131. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-10-25 Two nursing staff members spoke to surveyors on agreement of anonymity as they feared retaliation if it were known that they had spoken to surveyors. The two Nursing staff members worked on the units where Residents #131, and #130 were housed and both agreed that Resident #130 bought cigarettes for Resident #131, however, they stated that they had never known of a problem with that as no one complained about it, and they agreed that Resident #131 always went outside to smoke and had not created an issue. One was an agency nurse who worked in the facility, and one was a facility employee. Both stated they were aware of the incident involving Residents #130, and #131, and stated they wondered when the situation would blow up because Resident #130 was obviously grooming and pursuing Resident #131 (name), with the cigarettes, and Resident #131 (name) was married. The nurses were asked if the Administration was aware and they both stated yeah they knew, we all knew. During interview on 1-29-25 and review of the clinical record, it was found that the Social Worker had only been there a short time, however, was aware of the incident with Resident's #131, and #130. She stated that Resident #131 (name) had been discharged on 1-23-25 to a group home in (name) closer to family a near by county. She also stated that Resident #130 would be discharging on 1-29-25 to a different group home closer to the facility. At that time the Administrator was informed that the investigation was incomplete, and no FRI was ever received at the state agency VDH/OLC for the first allegation of abuse. She was further notified they had not implemented their policies on abuse. The allegations were never reported to the state agency until the day after surveyors asked for an investigation. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any added staff supervision for Resident #130 to prevent the abuse from continuing with another Resident. No staff ever reported the suspicion of a crime, and no police report was ever filed. The first alleged report by the Administrator was incomplete and had errors in information giving the appearance of a verbal altercation and that the victim was not touched. APS, was not notified of the alleged abuse by facility Administration, and was instead notified by a complainant resulting in an investigation being opened by the state agency. On 1-30-25 at approximately 4:00 p.m., the facility Administrator, Corporate Registered Nurse, and DON were notified of the findings. They stated they had no further information or documentation to offer. 2. Resident #7 while in psychosis and having suicidal ideation was admitted to the hospital was found to have a switch blade in her bedside table on 1/26/25, on the same day was re-admitted to the facility on [DATE]. The facility staff failed to report the above allegation within the required time frame of 2 hours to the State Survey Agency. Resident #7 was originally admitted to the facility 12/04/23 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Schizoaffective Disorder and Bipolar Disorder Unspecified. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/16/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #7 cognitive abilities for daily decision making were intact. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In sectionG(Functional Status) the resident was coded as requiring supervision of one person with transfers, bed mobility, eating and toileting. The Care Plan dated 12/05/23 read that Resident #7 has a mood problem related to: schizoaffective disorder, depression, anxiety and bipolar disorder. The resident has a history of hospitalization through suicidal ideation. The goal for the resident was that the resident will have improved mood state through the next review date. Interventions for the resident are to monitor medications as ordered and Behavioral consults as needed. During the initial tour an interview was conducted to Resident #7 concerning hospitalizations. Resident #7 said that she went to the hospital recently for having a cough but was recently admitted back to the facility. A change of condition note dated on 01/26/2025 at 5:34 PM., Resident alerted writer that she was actively SI (Suicidal Ideation) with plan to cut herself. Resident admitted to having switchblade in her bedside drawer. Writer entered residents' room to find carpenter knife in her top drawer on the right-hand side. Resident states the staff put it in her drawer. Writer notified provider on call, resident refused to take any medications at this time, stating I need to go to the hospital if you don't call 911 I will. Writer informed provider of this who advised writer to send her to the ER for further evaluation. 911 called, charge nurse notified, residents POA contacted with no answer, will try to call again. VSS 137/69, 18RR, 97.6T, 70HR, 96%RA. Resident is A&OX3. An interview was conducted on 02/05/25 at approximately 2:57 PM., with Licensed Practical Nurse (LPN) H. LPN H said that while working the 3-11 shift, Resident #7 said that she was feeling suicidal, wanted to go to the hospital and was going to use the switch blade in top drawer on the right side of her bed. LPN H also said that she grabbed the weapon the knife and the resident told her to hurry up and call the police. LPN H said that the police confiscated the weapon from her. On 02/05/25 at approximately 2:28 PM., an interview was conducted with LPN J concerning Resident #7. LPN J said that she was called up stairs by the facility staff informing her that Resident #7 had a Swiss knife. LPN J said that once she saw the Swiss knife it looked like something a [NAME] would use to clean fish, it had a wine cork remover, a screwdriver and a nail file attached to it. Once I came upstairs and entered the resident's room, she informed me that it (Swiss knife) was in her drawer, but the nurse had informed me that she took it. resident said that she wanted to kill herself. the resident was sent out for psych eval. she told EMTS that it was in her drawer. On 2/04/25 at approximately 4:20 PM., an end of day meeting was conducted with Administrator, the Director of Nursing (DON)., the Regional/Corporate staff, Regional Risk Management, the Regional Nurse Consultant and with the [NAME] President of Clinical Services concerning Resident #7. They were asked if an incident report or facility synopsis had been documented concerning the above incident involving a knife. The Administrator said that no facility synopsis had been filed but a soft file should have been completed instead. The administrator also mentioned that witnessed statements were received today as well as staff interviews. The above staff were also asked if death or harm could have been caused if the resident had used the Swiss Knife to cut herself. No comments were made. Swiss Army knife (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Swiss Army knife is a pocketknife, generally multi-tooled. The term Swiss Army knife was coined by American soldiers after World War II because they had trouble pronouncing the German word Offiziersmesser, meaning officer's knife. The Swiss Army knife generally has a drop-point main blade plus other types of blades and tools, such as a screwdriver, a can opener, a saw blade, a pair of scissors, and many others. These are folded into the handle of the knife through a pivot point mechanism. https://en.wikipedia.org/wiki/Swiss_Army_knife. 3. The facility staff failed to report allegations of abuse in a timely manner to the State Survey Agency after Resident #39 alleged being physically abused by a staff member. Resident #39 was originally admitted to the facility 11/09/23 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Depression, Unspecified. The 5-day Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/17/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #39 cognitive abilities for daily decision making were moderately impaired. In sectionGG(Functional Abilities Goals) the resident was coded as requiring partial/moderate assistance with eating, oral hygiene. Resident coded as dependent in lower body dressing, personal hygiene and rolling left and right. The care plan dated 11/22/23 read that Resident #39 had an Activities of Daily Living (ADL) self-care performance deficit related to multiple sclerosis, rheumatoid arthritis, spinal stenosis, right foot drop, morbid obesity, osteoarthritis, bilateral hand contractures and personality disorder. The Goal was to have the resident participate in as much of her ADL care as possible. The intervention for the resident requires total dependance by 2 staff members for toileting and requires max assist to total dependance by 2 staff members for bed mobility, transfers and one person assist for mobility in wheelchair. A review of a nursing note dated 2/04/25 at 12:33 PM., read: State surveyors question this writer about concerns that resident stating that there was an incident with a cna handling her roughly during incontinent care, when this writer spoke with resident concerning this incident, resident denied speaking to surveyor about incident, stating it never happened. Progress note on 2/05/25 at 12 Midnight: Patient with h/o depression, on no psychotropics. She was seen on 9.18.24 and no change was made to her treatment regimen. She is being seen today at the staff request because she reported to the department of health that a CNA was rough with her during care in early 2024. She is found in bed today; she is alert, calm and pleasant. She says she is doing well. She says this incident took place in April 2024. She says a CNA who was caring for her pushed her too far towards the wall. She felt this person was too rough with me. She says she reported this to the unit manager immediately and this individual never cared for her again. She says she also reported this to the VDH because she felt she needed they needed to know. She says she is surprised it took until today for someone from the VDH to come see her. She says she was told this CNA is no longer here but the reason for her living is not related to her incident with her. She says nothing like that happened to her ever again and she feels safe here. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Facility Reported Synopsis dated 2/05/25 read that Resident #39 alleged she was handled roughly by staff during incontinent care. The incident occurred April or May of 2024. The alleged staff member is no longer employed with the facility. On 01/28/25 at approximately 3:48 PM., during the initial tour Resident #39 alleged that a Certified Nurses Aide was rough with her while turning her onto her side to provide incontinent care. The Abuse/Neglect/Misappropriation/Crime Policy reads dated 10/17/23 reads: There is zero tolerance for abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center. Procedure: Any suspected or witnessed incidents of patient abuse, neglect, theft against a patient should be reported to the administration, an internal investigation conducted, appropriate and timely reporting to the State Survey Agency and other legally designated agencies, as well as staff corrective action, suspension, and/or termination as necessary. Failure for an employee to report any suspected or witnessed incident of mistreatment, abuse, neglect against a patient will result in corrective action. Immediately upon notification of any alleged violations involving, abuse, neglect or exploitation the administrator will immediately report to the state agency, but no later than 2 hours after the allegation is made. On 2/05/25 at approximately 7:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, staff interviews, Resident interviews, clinical record reviews, and facility documentation review, the facility staff failed to report an allegation of abuse to the state agency, police, and other stake holders timely for 4 Residents (Residents #131, #130, #7, and #39) in a survey sample size of 63 residents. The findings included: 1. The facility failures described above resulted in the sexual abuse/harassment of Resident #131 by Resident #130. Resident #131 (victim) was admitted to the facility on [DATE]. Diagnoses included but were not limited to: Traumatic Brain Injury (TBI) after a motor vehicle accident, diplopia, muscle weakness, unsteadiness on feet, abnormal gait and mobility, wheelchair use, and cognitive communication deficit, although there was no communication deficit noted at the time of survey. Resident #131's most recent Minimum Data Set with an Assessment Reference Date of 1-23-25 was coded as a discharge assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and his own responsible party. The Resident required touch assistance from one staff member for transferring and was wheelchair bound at times and was able to stand or walk independently for short distances. He required set up or touch assistance only with hygiene and bathing. The Resident denied complaints against any other staff or Residents since his admission on [DATE]. The Resident was discharged to a group home on 1-23-25 to be closer to family and to the least restrictive environment. Resident #130 (aggressor of victim #131) was admitted to the facility on [DATE]. Hospital discharge records indicated that the Resident was alert and oriented to person, place and time, and was ambulatory. Diagnoses included but were not limited to: Major depressive disorder, recurrent anxiety, Chronic hepatitis C, type two diabetes, nicotine dependence, fractured left heel with infected wound sepsis due to Methicillin Susceptible Staphylococcus Aureus, enhanced barrier precautions, and history of infectious parasitic disease. Resident #130's most recent Minimum Data Set with an Assessment Reference Date of 12-17-24 was coded as a significant change assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicated no cognitive impairment. The Resident was his own responsible party. The Resident required partial to moderate assistance from one staff member for hygiene and bathing. Resident #130 was observed during survey as ambulating without assistance or device. Resident #130 went out of the facility daily using the public city bus transportation and repeatedly returned under the influence of drugs and alcohol. Instances of this were recorded in the nursing progress notes to include the following most recent to survey. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9-19-24 6:43 am Resident room noted with a strong odor of weeds [sic] by (Certified Nursing Assistant) CNA, nurse and CNA went in to ask resident, resident confirmed he has been smoking weed, we asked him to turn it over, he declined, resident educated about the implication of that, he was told his action will be reported to management. Describe any interventions attempted: Resident told he will be reported to management Effectiveness of Interventions: Resident will continue to be monitored. 12-20-24 7:24 a.m. (documentation time). Note Text: 4:10 am (time of actual observation) Writer notified of patient lethargic in dining room. Writer into dining room, patient seen with his head (laid backward supine fashion) behind wheelchair, lethargic and hard to arouse. Obtained vitals at 4:13 am 65/40, 56, 16, 100% RA (oxygen saturation on room air alone), BS 140 (blood sugar). Called resident several times, he responded and said, I'm high as a bitch. Writer asked resident several times what he had taken, he refused to say. 911 called made per his nurse. 911 into building. Assessed patient, resident remained with a low BP and heart rate. EMTs encouraged resident to go to hospital. Resident refused. Educated the resident on the importance of going to the hospital to monitor low BP and heart rate, resident continued to refuse. Multiple nurses from units educated the patient on the importance of his health. Encouraged resident to go with EMT to be seen at hospital. Resident then became aggressive saying he wasn't going to the hospital because there was nothing wrong with him. EMTs left building. Writer and nurse attempted to take resident to his room, he refused. Resident remained in dining room area. MD (physician) note - 12-20-24 - [Resident #130 name redacted] was found asleep in in his wheelchair. He reported that he was high. He was difficult to arouse, BPs were in the 60-70s systolic. EMS was called. Upon arrival his BP was still low, but he refused to go the hospital. He is at baseline this morning when I see him. All reports reviewed and spoke with staff about the incident. I am holding his BP meds over the weekend. No reports of fever, chills, chest pain, shortness of breath, nausea, vomiting, or diarrhea. ' 1-3-25 - 10:22 pm. Note Text: Nurse went to resident door, there was strong smell of weed in room, coming right to the hallway. Nurse supervisor notified. A review of Resident #130's care plan revealed the following entry regarding the use of illicit drugs and or alcohol: FOCUS: The Resident is at risk of complications due to a history of illicit drug use. Revision on: 12-16-24. GOAL: The Resident will not have any adverse reaction to alcoholism thru review period. Date Initiated: 12-16-2024. Target Date: 3-16-25. INTERVENTIONS: (3) 1. Observe Resident for signs and symptoms of intoxication or withdrawal from drugs such as tremors nausea/vomiting (severe) sweating and notify MD (doctor) as indicated. Date Initiated: 12-16-2024. 2. Administer medication as ordered. Date Initiated: 12-16-2024. 3. Vitals as needed. Date Initiated: 12-16-2024. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-7-25 at 11:14 am nursing progress notes documented Verbal spat with roommate .both parties speaking in elevated tones, no physical contact noted both parties separated. On 1-7-25 at 12:23 pm Resident #15 agreed to a room change, and his spouse was notified. Adult Protective Services (APS) was called by an anonymous caller at the facility and the incident of sexual abuse was reported to them. The caller stated in the APS report of 1-7-25 that the facility Administration did not notify police, and they (the Administration) stated the reason as that can't happen (because) is that Resident (Resident #131 victim) would be charged with assault for pushing Resident (#130 aggressor) out of the doorway so that Resident (#131) could escape. This note indicated that there was physical contact known by staff at the time which was denied in the 1-7-25 nursing note. It was also alleged by the caller to APS that Resident #130 had been making sexual advances toward Resident #131 and wanted to get in his pants. It was also alleged that Resident #131 was asked by facility staff Why can't you just go home? The caller went on to state that Resident #131 had been moved 4 times for different assaults, verbal and such, but this was the only sexual assault. This assertion of frequent moves was found to be true as Resident #131's census in the facility documented those moves. The APS caller stated that on this day (1-7-25) the situation escalated and Resident #130 blocked the door of the room and told Resident #131 you are going to let me F K you. The caller stated that Resident #130 proceeded to touch, molest, and sexually assault Resident #131 who began yelling and screaming, and pushed Resident #130 out of the doorway into the hallway to escape when staff came to see what the commotion was about. Resident #131 told them immediately what had happened. On 1-9-25 at 1:00 pm, an interview was conducted with LPN A who stated that they are aware of the Residents going out on LOA (Leave of Absence) and coming back high, also stating but we cannot be with them at all times and cannot stop them leaving the facility. When asked what is done if they catch them smoking or drinking or using drugs in the facility, she stated, We document in the chart, notify the supervisor and educate them, that is all we can really do. When asked if the care plan should reflect the behaviors and interventions, she stated that it should. On 1-9-25 (the second day of survey) at 3:00 pm, Resident #130 was interviewed during an investigation involving Resident drug, alcohol, and weapons abuses that were found to be actively occurring in the facility. This Resident was found to be involved in drug abuse while a Resident. The Resident was asked about an altercation with his roommate which was documented in the nursing progress notes as having occurred on 1-7-25. Resident #130 stated he bought Resident #131 cigarettes and Resident #131 refused to pay him for them. He stated he had indeed used drugs but not in the facility, only outside. This statement was found to be false as staff stated they had removed drugs and drug paraphernalia from his room, and documented that at 4:00 AM on 12-20-24 the Resident was found in the dining room after using drugs in the facility, and was also using in the facility on 9-19-24, and 1-3-25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-9-25 at 3:30 pm, Resident #131 in person, and his spouse by phone were interviewed. They both stated that Resident #130 had made advances toward Resident #131, however, Resident #131 stated he made it Clear that I am straight, married, and got no interest in no [NAME]. Resident #131 stated he would ask me to dress in front of him to see my chest, and I didn't care about that, because he said he would get me some cigarettes, but when he cornered me in the room and wouldn't let me leave the room and grabbed my D k and said I'm gonna F k you in the A , that was it! I screamed for help and pushed him through the door and the nurses almost got knocked down coming in, they heard it all just ask them. Resident #131 stated the temp agency nurse (name) and the other nurse who works here all the time (name) came. Resident #131 stated He (#130 name) and (Resident #106 name) smoke stuff in the room and have overdosed sometimes. I just want out of here. Resident #131 was asked if he had reported the sexual abuse, and he stated I told the nurses, they saw it happen! I told the Administrator who said I would be arrested for pushing him if I called the police, and I've told everybody, but they just moved me to another room. On 1-9-25 A copy of all Facility Reported Incidents (FRI's) for the prior 6 months were requested. Nine (9) were provided by the Administrator, and all 9 followed the standardized format and documentation included notification of the state agency the Virginia Department of Health Office of Licensure and Certification (VDH/OLC), the state Long Term Care Ombudsman, and Adult Protective Services (APS). The 9 completed FRI's were all prior to 9-20-24. On 1-9-25 at 4:00 pm the facility Administrator was asked for any investigation from 1-7-25 involving Residents #130, and #131. On 1-10-25 at 5:00 pm Resident #130 was interviewed by surveyors and stated I feel as though I'm being targeted by a staff member. The Director of Nursing (DON) she don't like me and wants me out of here. She believes anything anyone tells her. He continued to say, Yes I smoke weed but not on the property and I use heroin sometimes, not a lot. The surveyor asked how do you use it, and he replied, I smoke it. The surveyor asked if he received it from someone in the facility. He replied, No I get it outside. He was asked where do you use it? His response was I use it at the bus stop, I go out almost every day. He was asked if he was caught by staff in the facility with drugs or alcohol, and he replied, No they said I was smoking weed in my room, but I won't. He was questioned about the accusations from his roommate, and he stated, I bought him cigarettes, I didn't touch that [NAME] I didn't ask him for no sex. He didn't give me money for the cigarettes he is a liar. They gave me a notice to leave but I got nowhere to go. On 1-10-25, the Administrator delivered a 2-page document dated 1-10-25 entitled Facility Reported Incident (FRI), Date reported 1-10-25, and was signed by the current Administrator. The synopsis was a simple typed document on a clean white unlined sheet of copy paper, and did not state that it was an initial FRI, nor a 5 day follow up. The document described a portion of the incident of 1-7-25, and the fact that Resident #131 alleged that his roommate (Resident #130) had made sexual advances to him and had attempted to block the doorway to keep him (Resident #131) from leaving the room. This was the third time that the allegation of abuse was made to someone in the facility, and to others. The first being the day of the occurrence to staff witnesses, the second to APS who reported it to the facility, to police, and the state agency, and the third on this day 1-10-25. (continued on next page)

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	495327	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hill Health & Rehabilitation	4403 Forest Hill Avenue Richmond, VA 23225

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The document reported that Resident #131 had moved Resident #130 out of the way and exited the room. The document included that Resident #131 stated again he was tired of his roommate (Resident #130) making sexual advances at him and he wanted to be out of that room. Resident #131 also stated he wanted to be discharged . The Administrator documented on 1-10-25 that Resident #130 denied the allegation of sexual abuse, and that the facility had concluded that the allegation was unsubstantiated, and was first reported to them on this day. These assertions are incorrect as staff were aware and present on 1-7-25 when the abuse was alleged to have occurred and was first documented. Further the Resident stated to the Administrator (as written in the above portion of the Administrators document) that he was blocked from leaving by his roommate, he was tired of his roommate (Resident #130) making sexual advances at him and he wanted to be out of that room. Sexual abuse and sexual harassment are both crimes. By the facility staff's documentation, and own admission this was reported repeatedly to them, observed by floor baseline staff when it occurred, reported to APS by a complainant, and they continued to report it as unsubstantiated. The facility Resident Protections from abuse policy failures included all of the following 4 areas; 1. The facility was expected to complete background checks on all employees to protect the Resident population from abuse, also training was to be conducted annually for staff. (Training) 2. The Abuse policy document also stated that Residents would be protected if an allegation of abuse was made, and the police involved if that allegation alleged that a crime had happened. (Protection) 3. The Abuse policy document also stated that a comprehensive investigation would be conducted. (Investigation) 4. The document further stated that the state agency and other stake holders would be notified within 24 hours of an allegation of abuse, and that the report would occur within 2 hours if injury occurred. Then the initial report would be followed by a five day follow up report which would be sent to the state agency after the facility investigated to reveal their findings. (Reporting) The facility staff failed to conduct required education for staff, failed to complete background checks in compliance with regulations. The facility staff failed to report the allegation of abuse to the state agency until the state agency reported it to them again 3 days after the allegation was made to, and witnessed by, staff. Police were not called after an allegation that a crime had occurred which was requested by the Resident and his spouse, and a comprehensive investigation was not conducted until the state agency asked for one 3 days after the allegation of abuse was known by staff. The facility Abuse policies were not implemented specifically involving and including the following evidence; TRAINING failure: Protections from Abuse and other annual training records in the facility were reviewed and revealed that Certified Nursing Assistants (CNA's) 12 hours of required annual training was not completed for 4 of the 6 employees reviewed, and background checks for staff were also found to be deficient. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PROTECTION failure: Resident #131 was not afforded police intervention, he was protected by a room move, however, there were no other Resident interviews to ascertain if any other Residents in the building had ever experienced this abuse, and if from this abuser. INVESTIGATION failure: None of the staff witnesses of the 1-7-25 incident were interviewed, nor were statements received, and Resident #4's previous and current roommates were not interviewed. The spouse of Resident #131 was not interviewed, and other Residents on the unit were not interviewed. The FRI document stated that on 1-10-25 the first notification by the Resident was obtained. This was incorrect, as staff witnessed the incident partially, if not fully, and documented it. A witness to the incident called APS on 1-7-25. The Resident was blockaded from leaving his room which was witnessed by staff, as he was told police would arrest him for pushing his aggressor, proving involuntary seclusion/kidnapping, and he screamed for help which resulted in staff intervention. Further the Resident wanted a room change because of the allegation which was made by Resident #131 to staff. The allegation of abuse was alleged by a witness to APS, alleged by the Resident's spouse, alleged by the Resident, and by Administration in their synopsis/FRI (facility reported incident) to the state agency on 1-10-25. The 1-10-25 initial facility document does not include many of the avenues that were available to the facility for a complete investigation, and thus they were unable to reach a more comprehensive conclusion of events. Initial REPORTING failure: The 1-10-25 FRI document was the first report by the facility after the allegation of a sexual abuse that facility staff were made aware of on 1-7-25. This document was derived on 1-10-25 only after surveyors requested documentation of it, and 3 days after the abuse occurred. Any allegation of abuse is mandated to be reported within 24 hours if no serious injury occurred to the state agency (VDH/OLC) Virginia Department of Health/Office of Licensure and Certification. The Department of Social Services office of Adult protective Services (APS) were not notified by the facility, and the police were not called by the facility as was requested by Resident #131 and his spouse on the day of the occurrence. INVESTIGATION follow up RESULTS failure: The 5-day mandated follow up reporting after a full investigation; The Administrator's synopsis on 1-10-25 alleges that the abuse was unsubstantiated. A review of all the above evidence by the state agency reveals it to be substantiated, in part, or in all. A police investigation would have been appropriate in this case, as both Residents were alert, and oriented to person, place, time, and situation, however, this was not afforded to Resident #131. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-10-25 Two nursing staff members spoke to surveyors on agreement of anonymity as they feared retaliation if it were known that they had spoken to surveyors. The two Nursing staff members worked on the units where Residents #131, and #130 were housed and both agreed that Resident #130 bought cigarettes for Resident #131, however, they stated that they had never known of a problem with that as no one complained about it, and they agreed that Resident #131 always went outside to smoke and had not created an issue. One was an agency nurse who worked in the facility, and one was a facility employee. Both stated they were aware of the incident involving Residents #130, and #131, and stated they wondered when the situation would blow up because Resident #130 was obviously grooming and pursuing Resident #131 (name), with the cigarettes, and Resident #131 (name) was married. The nurses were asked if the Administration was aware and they both stated yeah they knew, we all knew. During interview on 1-29-25 and review of the clinical record, it was found that the Social Worker had only been there a short time, however, was aware of the incident with Resident's #131, and #130. She stated that Resident #131 (name) had been discharged on 1-23-25 to a group home in (name) closer to family a near by county. She also stated that Resident #130 would be discharging on 1-29-25 to a different group home closer to the facility. At that time the Administrator was informed that the investigation was incomplete, and no FRI was ever received at the state agency VDH/OLC for the first allegation of abuse. She was further notified they had not implemented their policies on abuse. The allegations were never reported to the state agency until the day after surveyors asked for an investigation. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any added staff supervision for Resident #130 to prevent the abuse from continuing with another Resident. No staff ever reported the suspicion of a crime, and no police report was ever filed. The first alleged report by the Administrator was incomplete and had errors in information giving the appearance of a verbal altercation and that the victim was not touched. APS, was not notified of the alleged abuse by facility Administration, and was instead notified by a complainant resulting in an investigation being opened by the state agency. On 1-30-25 at approximately 4:00 p.m., the facility Administrator, Corporate Registered Nurse, and DON were notified of the findings. They stated they had no further information or documentation to offer. The facility's staff failed to report allegations of abuse or self-harm within a timely manner for Resident #7. 2. Resident #7 while in psychosis and having suicidal ideation was admitted to the hospital was found to have a switch blade in her bedside table on 1/26/25, on the same day was re-admitted to the facility on [DATE]. The facility staff failed to report the above allegation within the required time frame of 2 hours to the State Survey Agency. Resident #7 was originally admitted to the facility 12/04/23 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Schizoaffective Disorder and Bipolar Disorder Unspecified. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/16/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #7 cognitive abilities for daily decision making were intact. In sectionG(Functional Status) the resident was coded as requiring supervision of one person with transfers, bed mobility, eating and toileting. The Care Plan dated 12/05/23 read that Resident #7 has a mood problem related to: schizoaffective disorder, depression, anxiety and bipolar disorder. The resident has a history of hospitalization through suicidal ideation. The goal for the resident was that the resident will have improved mood state through the next review date. Interventions for the resident are to monitor medications as ordered and Behavioral consults as needed. During the initial tour an interview was conducted to Resident #7 concerning hospitalizations. Resident #7 said that she went to the hospital recently for having a cough but was recently admitted back to the facility. A change of condition note dated on 01/26/2025 at 5:34 PM., Resident alerted writer that she was actively SI (Suicidal Ideation) with plan to cut herself. Resident admitted to having switchblade in her bedside drawer. Writer entered residents' room to find carpenter knife in her top drawer on the right-hand side. Resident states the staff put it in her drawer. Writer notified provider on call, resident refused to take any medications at this time, stating I need to go to the hospital if you don't call 911 I will. Writer informed provider of this who advised writer to send her to the ER for further evaluation. 911 called, charge nurse notified, residents POA contacted with no answer, will try to call again. VSS 137/69, 18RR, 97.6T, 70HR, 96%RA. Resident is A&OX3. An interview was conducted on 02/05/25 at approximately 2:57 PM., with Licensed Practical Nurse (LPN) H. LPN H said that while working the 3-11 shift, Resident #7 said that she was feeling suicidal, wanted to go to the hospital and was going to use the switch blade in top drawer on the right side of her bed. LPN H also said that she grabbed the weapon the knife and the resident told her to hurry up and call the police. LPN H said that the police confiscated the weapon from her. On 02/05/25 at approximately 2:28 PM., an interview was conducted with LPN J concerning Resident #7. LPN J said that she was called up stairs by the facility staff informing her that Resident #7 had a Swiss knife. LPN J said that once she saw the Swiss knife it looked like something a [NAME] would use to clean fish, it had a wine cork remover, a screwdriver and a nail file attached to it. Once I came upstairs and entered the resident's room, she informed me that it (Swiss knife) was in her drawer, but the nurse had informed me that she took it. resident said that she wanted to kill herself. the resident was sent out for psych eval. she told EMTS that it was in her drawer. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/04/25 at approximately 4:20 PM., an end of day meeting was conducted with Administrator, the Director of Nursing (DON)., the Regional/Corporate staff, Regional Risk Management, the Regional Nurse Consultant and with the [NAME] President of Clinical Services concerning Resident #7. They were asked if an incident report or facility synopsis had been documented concerning the above incident involving a knife. The Administrator said that no facility synopsis had been filed but a soft file should have been completed instead. The administrator also mentioned that witnessed statements were received today as well as staff interviews. The above staff were also asked if death or harm could have been caused if the resident had used the Swiss Knife to cut herself. No comments were made. Swiss Army knife The Swiss Army knife is a pocketknife, generally multi-tooled. The term Swiss Army knife was coined by American soldiers after World War II because they had trouble pronouncing the German word Offiziersmesser, meaning officer's knife. The Swiss Army knife generally has a drop-point main blade plus other types of blades and tools, such as a screwdriver, a can opener, a saw blade, a pair of scissors, and many others. These are folded into the handle of the knife through a pivot point mechanism. https://en.wikipedia.org/wiki/Swiss_Army_knife. 3. Resident #39. The facility staff failed to report allegations of abuse in a timely manner to the State Survey Agency after resident alleged being physically abused by a staff member. Resident #39 was originally admitted to the facility 11/09/23 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Depression, Unspecified. The 5-day Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/17/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #39 cognitive abilities for daily decision making were moderately impaired. In sectionGG(Functional Abilities Goals) the resident was coded as requiring partial/moderate assistance with eating, oral hygiene. Resident coded as dependent in lower body dressing, personal hygiene and rolling left and right. The care plan dated 11/22/23 read that Resident #39 had an Activities of Daily Living (ADL) self-care performance deficit related to multiple sclerosis, rheumatoid arthritis, spinalstenosis, right foot drop, morbid obesity, osteoarthritis, bilateral hand contractures and personality disorder. The Goal was to have the resident participate in as much of her ADL care as possible. The intervention for the resident requires total dependance by 2 staff members for toileting and requires max assist to total dependance by 2 staff members for bed mobility, transfers and one person assist for mobility in wheelchair. A review of a nursing note dated 2/04/25 at 12:33 PM., read: State surveyors question this writer about concerns that resident stating that there was an incident with a cna handling her roughly during incontinent care, when this writer spoke with resident concerning this incident, resident denied speaking to surveyor about incident, stating it never happened. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note on 2/05/25 at 12 Midnight: Patient with h/o depression, on no psychotropics. She was seen on 9.18.24 and no change was made to her treatment regimen. She is being seen today at the staff request because she reported to the department of health that a CNA was rough with her during care in early 2024. She is found in bed today; she is alert, calm and pleasant. She says she is doing well. She says this incident took place in April 2024. She says a CNA who was caring for her pushed her too far towards the wall. She felt this person was too rough with me. She says she reported this to the unit manager immediately and this individual never cared for her again. She says she also reported this to the VDH because she felt she needed they needed to know. She says she is surprised it took until today for someone from the VDH to come see her. She says she was told this CNA is no longer here but the reason for her living is not related to her incident with her. She says nothing like that happened to her ever again and she feels safe here. A review of Facility Reported Synopsis dated 2/05/25 read that Resident #39 alleged she was handled roughly by staff during incontinent care. The incident occurred April or May of 2024. The alleged staff member is no longer employed with the facility. On 01/28/25 at approximately 3:48 PM., during the initial tour Resident #39 alleged that a Certified Nurses Aide was rough with her while turning her onto her side to provide incontinent care. On 2/05/25 at approximately 7:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Abuse/Neglect/Misappropriation/Crime Policy reads dated 10/17/23 reads: There is zero tolerance for abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center. Procedure: Any suspected or witnessed incidents of patient abuse, neglect, theft against a patient should be reported to the administration, an internal investigation conducted, appropriate and timely reporting to the State Survey Agency and other legally designated agencies, as well as staff corrective action, suspension, and/or termination as necessary. Failure for an employee to report any suspected or witnessed incident of mistreatment, abuse, neglect against a patient will result in corrective action. Immediately upon notification of any alleged violations involving, abuse, neglect or exploitation the administrator will immediately report to the [TRUNCATED]

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, staff interviews, Resident interviews, clinical record reviews, and facility documentation review, the facility staff failed to investigate an allegation of abuse fully for 2 Residents (Residents #131, and #130) in a survey sample size of 63 residents. The findings included: 1. The facility failures described above resulted in the sexual abuse/harassment of Resident #131 by Resident #130. Resident #131 (victim) was admitted to the facility on [DATE]. Diagnoses included but were not limited to: Traumatic Brain Injury (TBI) after a motor vehicle accident, diplopia, muscle weakness, unsteadiness on feet, abnormal gait and mobility, wheelchair use, and cognitive communication deficit, although there was no communication deficit noted at the time of survey. Resident #131's most recent Minimum Data Set with an Assessment Reference Date of 1-23-25 was coded as a discharge assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and his own responsible party. The Resident required touch assistance from one staff member for transferring and was wheelchair bound at times and was able to stand or walk independently for short distances. He required set up or touch assistance only with hygiene and bathing. The Resident denied complaints against any other staff or Residents since his admission on [DATE]. The Resident was discharged to a group home on 1-23-25 to be closer to family and to the least restrictive environment. Resident #130 (aggressor of victim #131) was admitted to the facility on [DATE]. Hospital discharge records indicated that the Resident was alert and oriented to person, place and time, and was ambulatory. Diagnoses included but were not limited to: Major depressive disorder, recurrent anxiety, Chronic hepatitis C, type two diabetes, nicotine dependence, fractured left heel with infected wound sepsis due to Methicillin Susceptible Staphylococcus Aureus, enhanced barrier precautions, and history of infectious parasitic disease. Resident #130's most recent Minimum Data Set with an Assessment Reference Date of 12-17-24 was coded as a significant change assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicated no cognitive impairment. The Resident was his own responsible party. The Resident required partial to moderate assistance from one staff member for hygiene and bathing. Resident #130 was observed during survey as ambulating without assistance or device. Resident #130 went out of the facility daily using the public city bus transportation and repeatedly returned under the influence of drugs and alcohol. Instances of this were recorded in the nursing progress notes to include the following most recent to survey. 9-19-24 6:43 am Resident room noted with a strong odor of weeds [sic] by (Certified Nursing Assistant) CNA, nurse and CNA went in to ask resident, resident confirmed he has been smoking weed, we asked him to turn it over, he declined, resident educated about the implication of that, he was told his action will be reported to management. Describe any interventions attempted: Resident told he will be reported to management Effectiveness of Interventions: Resident will continue to be monitored. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12-20-24 7:24 a.m. (documentation time). Note Text: 4:10 am (time of actual observation) Writer notified of patient lethargic in dining room. Writer into dining room, patient seen with his head (laid backward supine fashion) behind wheelchair, lethargic and hard to arouse. Obtained vitals at 4:13 am 65/40, 56, 16, 100% RA (oxygen saturation on room air alone), BS 140 (blood sugar). Called resident several times, he responded and said, I'm high as a bitch. Writer asked resident several times what he had taken, he refused to say. 911 called made per his nurse. 911 into building. Assessed patient, resident remained with a low BP and heart rate. EMTs encouraged resident to go to hospital. Resident refused. Educated the resident on the importance of going to the hospital to monitor low BP and heart rate, resident continued to refuse. Multiple nurses from units educated the patient on the importance of his health. Encouraged resident to go with EMT to be seen at hospital. Resident then became aggressive saying he wasn't going to the hospital because there was nothing wrong with him. EMTs left building. Writer and nurse attempted to take resident to his room, he refused. Resident remained in dining room area. MD (physician) note - 12-20-24 - [Resident #130 name redacted] was found asleep in in his wheelchair. He reported that he was high. He was difficult to arouse, BPs were in the 60-70s systolic. EMS was called. Upon arrival his BP was still low, but he refused to go the hospital. He is at baseline this morning when I see him. All reports reviewed and spoke with staff about the incident. I am holding his BP meds over the weekend. No reports of fever, chills, chest pain, shortness of breath, nausea, vomiting, or diarrhea. ' 1-3-25 - 10:22 pm. Note Text: Nurse went to resident door, there was strong smell of weed in room, coming right to the hallway. Nurse supervisor notified. A review of Resident #130's care plan revealed the following entry regarding the use of illicit drugs and or alcohol: FOCUS: The Resident is at risk of complications due to a history of illicit drug use. Revision on: 12-16-24. GOAL: The Resident will not have any adverse reaction to alcoholism thru review period. Date Initiated: 12-16-2024. Target Date: 3-16-25. INTERVENTIONS: (3) 1. Observe Resident for signs and symptoms of intoxication or withdrawal from drugs such as tremors nausea/vomiting (severe) sweating and notify MD (doctor) as indicated. Date Initiated: 12-16-2024. 2. Administer medication as ordered. Date Initiated: 12-16-2024. 3. Vitals as needed. Date Initiated: 12-16-2024. On 1-7-25 at 11:14 am nursing progress notes documented Verbal spat with roommate .both parties speaking in elevated tones, no physical contact noted both parties separated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-7-25 at 12:23 pm Resident #15 agreed to a room change, and his spouse was notified. Adult Protective Services (APS) was called by an anonymous caller at the facility and the incident of sexual abuse was reported to them. The caller stated in the APS report of 1-7-25 that the facility Administration did not notify police, and they (the Administration) stated the reason as that can't happen (because) is that Resident (Resident #131 victim) would be charged with assault for pushing Resident (#130 aggressor) out of the doorway so that Resident (#131) could escape. This note indicated that there was physical contact known by staff at the time which was denied in the 1-7-25 nursing note. It was also alleged by the caller to APS that Resident #130 had been making sexual advances toward Resident #131 and wanted to get in his pants. It was also alleged that Resident #131 was asked by facility staff Why can't you just go home? The caller went on to state that Resident #131 had been moved 4 times for different assaults, verbal and such, but this was the only sexual assault. This assertion of frequent moves was found to be true as Resident #131's census in the facility documented those moves. The APS caller stated that on this day (1-7-25) the situation escalated and Resident #130 blocked the door of the room and told Resident #131 you are going to let me F K you. The caller stated that Resident #130 proceeded to touch, molest, and sexually assault Resident #131 who began yelling and screaming, and pushed Resident #130 out of the doorway into the hallway to escape when staff came to see what the commotion was about. Resident #131 told them immediately what had happened. On 1-9-25 at 1:00 pm an interview was conducted with LPN A who stated that they are aware of the Residents going out on LOA (Leave of Absence) and coming back high, also stating but we cannot be with them at all times and cannot stop them leaving the facility. When asked what is done if they catch them smoking or drinking or using drugs in the facility, she stated, We document in the chart, notify the supervisor and educate them, that is all we can really do. When asked if the care plan should reflect the behaviors and interventions, she stated that it should. On 1-9-25 (the second day of survey) at 3:00 pm, Resident #130 was interviewed during an investigation involving Resident drug, alcohol, and weapons abuses that were found to be actively occurring in the facility. This Resident was found to be involved in drug abuse while a Resident. The Resident was asked about an altercation with his roommate which was documented in the nursing progress notes as having occurred on 1-7-25. Resident #130 stated he bought Resident #131 cigarettes and Resident #131 refused to pay him for them. He stated he had indeed used drugs but not in the facility, only outside. This statement was found to be false as staff stated they had removed drugs and drug paraphernalia from his room, and documented that at 4:00 AM on 12-20-24 the Resident was found in the dining room after using drugs in the facility, and was also using in the facility on 9-19-24, and 1-3-25. (continued on next page)

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	495327	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hill Health & Rehabilitation	4403 Forest Hill Avenue Richmond, VA 23225

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-9-25 at 3:30 pm, Resident #131 in person, and his spouse by phone were interviewed. They both stated that Resident #130 had made advances toward Resident #131, however, Resident #131 stated he made it Clear that I am straight, married, and got no interest in no [NAME]. Resident #131 stated he would ask me to dress in front of him to see my chest, and I didn't care about that, because he said he would get me some cigarettes, but when he cornered me in the room and wouldn't let me leave the room and grabbed my D k and said I'm gonna F k you in the A , that was it! I screamed for help and pushed him through the door and the nurses almost got knocked down coming in, they heard it all just ask them. Resident #131 stated the temp agency nurse (name) and the other nurse who works here all the time (name) came. Resident #131 stated He (#130 name) and (Resident #106 name) smoke stuff in the room and have overdosed sometimes. I just want out of here. Resident #131 was asked if he had reported the sexual abuse, and he stated I told the nurses, they saw it happen! I told the Administrator who said I would be arrested for pushing him if I called the police, and I've told everybody, but they just moved me to another room. On 1-9-25 A copy of all Facility Reported Incidents (FRI's) for the prior 6 months were requested. 9 were provided by the Administrator, and all 9 followed the standardized format and documentation included notification of the state agency the Virginia Department of Health Office of Licensure and Certification (VDH/OLC), the state Long Term Care Ombudsman, and Adult Protective Services (APS). The 9 completed FRI's were all prior to 9-20-24. On 1-9-25 at 4:00 pm the facility Administrator was asked for any investigation from 1-7-25 involving Residents #130, and #131. On 1-10-25 at 5:00 pm Resident #130 was interviewed by surveyors and stated I feel as though I'm being targeted by a staff member. The Director of Nursing (DON) she don't like me and wants me out of here. She believes anything anyone tells her. He continued to say, Yes I smoke weed but not on the property and I use heroin sometimes, not a lot. The surveyor asked how do you use it, and he replied, I smoke it. The surveyor asked if he received it from someone in the facility. He replied, No I get it outside. He was asked where do you use it? His response was I use it at the bus stop, I go out almost every day. He was asked if he was caught by staff in the facility with drugs or alcohol, and he replied, No they said I was smoking weed in my room, but I won't. He was questioned about the accusations from his roommate, and he stated, I bought him cigarettes, I didn't touch that [NAME] I didn't ask him for no sex. He didn't give me money for the cigarettes he is a liar. They gave me a notice to leave but I got nowhere to go. On 1-10-25 The Administrator delivered a 2-page document dated 1-10-25 entitled Facility Reported Incident (FRI), Date reported 1-10-25, and was signed by the current Administrator. The synopsis was a simple typed document on a clean white unlined sheet of copy paper, and did not state that it was an initial FRI, nor a 5 day follow up. The document described a portion of the incident of 1-7-25, and the fact that Resident #131 alleged that his roommate (Resident #130) had made sexual advances to him and had attempted to block the doorway to keep him (Resident #131) from leaving the room. This was the third time that the allegation of abuse was made to someone in the facility, and to others. The first being the day of the occurrence to staff witnesses, the second to APS who reported it to the facility, to police, and the state agency, and the third on this day 1-10-25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The document reported that Resident #131 had moved Resident #130 out of the way and exited the room. The document included that Resident #131 stated again he was tired of his roommate (Resident #130) making sexual advances at him and he wanted to be out of that room. Resident #131 also stated he wanted to be discharged . The Administrator documented on 1-10-25 that Resident #130 denied the allegation of sexual abuse, and that the facility had concluded that the allegation was unsubstantiated, and was first reported to them on this day. These assertions are incorrect as staff were aware and present on 1-7-25 when the abuse was alleged to have occurred and was first documented. Further the Resident stated to the Administrator (as written in the above portion of the Administrators document) that he was blocked from leaving by his roommate, he was tired of his roommate (Resident #130) making sexual advances at him and he wanted to be out of that room. Sexual abuse and sexual harassment are both crimes. By the facility staff's documentation, and own admission this was reported repeatedly to them, observed by floor baseline staff when it occurred, reported to APS by a complainant, and they continued to report it as unsubstantiated. The facility Resident Protections from abuse policy failures included all of the following 4 areas; 1. The facility was expected to complete background checks on all employees to protect the Resident population from abuse, also training was to be conducted annually for staff. (Training) 2. The Abuse policy document also stated that Residents would be protected if an allegation of abuse was made, and the police involved if that allegation alleged that a crime had happened. (Protection) 3. The Abuse policy document also stated that a comprehensive investigation would be conducted. (Investigation) 4. The document further stated that the state agency and other stake holders would be notified within 24 hours of an allegation of abuse, and that the report would occur within 2 hours if injury occurred. Then the initial report would be followed by a five day follow up report which would be sent to the state agency after the facility investigated to reveal their findings. (Reporting) The facility staff failed to conduct required education for staff, failed to complete background checks in compliance with regulations. The facility staff failed to report the allegation of abuse to the state agency until the state agency reported it to them again 3 days after the allegation was made to, and witnessed by, staff. Police were not called after an allegation that a crime had occurred which was requested by the Resident and his spouse, and a comprehensive investigation was not conducted until the state agency asked for one 3 days after the allegation of abuse was known by staff The facility Abuse policies were not implemented specifically involving and including the following evidence; TRAINING failure: Protections from Abuse and other annual training records in the facility were reviewed and revealed that Certified Nursing Assistants (CNA's) 12 hours of required annual training was not completed for 4 of the 6 employees reviewed, and background checks for staff were also found to be deficient. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PROTECTION failure: Resident #131 was not afforded police intervention, he was protected by a room move, however, there were no other Resident interviews to ascertain if any other Residents in the building had ever experienced this abuse, and if from this abuser. INVESTIGATION failure: None of the staff witnesses of the 1-7-25 incident were interviewed, nor were statements received, and Resident #4's previous and current roommates were not interviewed. The spouse of Resident #131 was not interviewed, and other Residents on the unit were not interviewed. The FRI document stated that on 1-10-25 the first notification by the Resident was obtained. This was incorrect, as staff witnessed the incident partially, if not fully, and documented it. A witness to the incident called APS on 1-7-25. The Resident was blockaded from leaving his room which was witnessed by staff, as he was told police would arrest him for pushing his aggressor, proving involuntary seclusion/kidnapping, and he screamed for help which resulted in staff intervention. Further the Resident wanted a room change because of the allegation which was made by Resident #131 to staff. The allegation of abuse was alleged by a witness to APS, alleged by the Resident's spouse, alleged by the Resident, and by Administration in their synopsis/FRI (facility reported incident) to the state agency on 1-10-25. The 1-10-25 initial facility document does not include many of the avenues that were available to the facility for a complete investigation, and thus they were unable to reach a more comprehensive conclusion of events. Initial REPORTING failure: The 1-10-25 FRI document was the first report by the facility after the allegation of a sexual abuse that facility staff were made aware of on 1-7-25. This document was derived on 1-10-25 only after surveyors requested documentation of it, and 3 days after the abuse occurred. Any allegation of abuse is mandated to be reported within 24 hours if no serious injury occurred to the state agency (VDH/OLC) Virginia Department of Health/Office of Licensure and Certification. The Department of Social Services office of Adult protective Services (APS) were not notified by the facility, and the police were not called by the facility as was requested by Resident #131 and his spouse on the day of the occurrence. INVESTIGATION follow up RESULTS failure: The 5-day mandated follow up reporting after a full investigation; The Administrator's synopsis on 1-10-25 alleges that the abuse was unsubstantiated. A review of all the above evidence by the state agency reveals it to be substantiated, in part, or in all. A police investigation would have been appropriate in this case, as both Residents were alert, and oriented to person, place, time, and situation, however, this was not afforded to Resident #131. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1-10-25 Two nursing staff members spoke to surveyors on agreement of anonymity as they feared retaliation if it were known that they had spoken to surveyors. The two Nursing staff members worked on the units where Residents #131, and #130 were housed and both agreed that Resident #130 bought cigarettes for Resident #131, however, they stated that they had never known of a problem with that as no one complained about it, and they agreed that Resident #131 always went outside to smoke and had not created an issue. One was an agency nurse who worked in the facility, and one was a facility employee. Both stated they were aware of the incident involving Residents #130, and #131, and stated they wondered when the situation would blow up because Resident #130 was obviously grooming and pursuing Resident #131 (name), with the cigarettes, and Resident #131 (name) was married. The nurses were asked if the Administration was aware and they both stated yeah they knew, we all knew. During interview on 1-29-25 and review of the clinical record, it was found that the Social Worker had only been there a short time, however, was aware of the incident with Resident's #131, and #130. She stated that Resident #131 (name) had been discharged on 1-23-25 to a group home in (name) closer to family a near by county. She also stated that Resident #130 would be discharging on 1-29-25 to a different group home closer to the facility. At that time the Administrator was informed that the investigation was incomplete, and no FRI was ever received at the state agency VDH/OLC for the first allegation of abuse. She was further notified they had not implemented their policies on abuse. The allegations were never reported to the state agency until the day after surveyors asked for an investigation. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any added staff supervision for Resident #130 to prevent the abuse from continuing with another Resident. No staff ever reported the suspicion of a crime, and no police report was ever filed. The first alleged report by the Administrator was incomplete and had errors in information giving the appearance of a verbal altercation and that the victim was not touched. APS, was not notified of the alleged abuse by facility Administration, and was instead notified by a complainant resulting in an investigation being opened by the state agency. On 1-30-25 at approximately 4:00 p.m., the facility Administrator, Corporate Registered Nurse, and DON were notified of the findings. They stated they had no further information or documentation to offer.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the resident record review, staff interviews and a review of facility documents, the facility staff failed to notify the Office of the State Long-Term Care Ombudsman in writing of a hospital discharge for 1 of 63 residents (Resident #50), in the survey sample. The findings included: Resident #50 was originally admitted to the facility 10/27/2016 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included a stroke with right hemiparesis and expressive aphasia. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/22/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were moderately impaired. A nurses' note dated 11/10/24 at 3:36 AM stated the resident was observed with a large amount of dark bloody liquid coming from his rectum and the resident complained of lower abdominal pain that radiated to the groin area. The note further stated the on-call Practitioner was notified and an order was received to transfer the resident to the emergency room by ambulance. Another nurse's note dated 11/10/24 at 12:07 PM stated the resident was admitted to the local hospital with a diagnosis of a GI Bleed. An interview was conducted with the Social Services Director (SSD) on 2/5/25 at approximately 3:30 PM. The SSD stated there was no documentation that the Office of the State Long-Term Care Ombudsman was notified of Resident #50's 11/10/24 discharge to the hospital. The SSD stated she had faxed the information after ours interview and conformation would be provided as soon as it was available. On 2/5/25 at approximately 4:20 PM, a final interview was conducted with the Administrator, Director of Nursing and four Corporate Consultants. The administrative team was informed of the above information. No additional information was provided and no concerns were voiced.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) assessment for 1 of 63 residents in the survey sample (Resident # 139), a closed record resident. The findings include: Resident #139 was originally admitted to the facility 11/27/24 after an acute care hospital stay. The resident had an unplanned discharged from the facility on 12/01/24. The current diagnoses included; Chronic Pain Syndrome and Unspecified Fracture of the Lower end of Left Radius, Subsequent Encounter for Closed Fracture with Routine Healing. The 5-day, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/01/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #139 cognitive abilities for daily decision making were intact. Resident # 139's MDS dated [DATE] coded the resident as being admitted to the hospital instead of coding that resident was discharged to the community. The current diagnoses included; Chronic Pain Syndrome and Unspecified Fracture of the Lower end of Left Radius, Subsequent Encounter for Closed Fracture with Routine Healing. A review of nursing notes on 12/1/2024 9:09 PM., read: Resident left AMA. A review of the clinical record documented a MDS dated [DATE]. Coded section A2105 as short-term going to the hospital. On 2/05/25 at approximately 11:25 AM., an interview was conducted with the MDS Coordinator (MDS) N, concerning The Centers for Medicare & Medicaid Services. (CMS) generated Hospital discharge. The MDS N said that the resident's 12/01/24 discharge says she was discharged to a hospital, but according to the medical records the resident left Against Medical Advice (AMA). The MDS N, also said that according to the progress notes, it looks like an inaccurate assessment. On 2/05/25 at approximately 12:20 PM., The MDS, N returned saying that according to the medical records, the resident was coded in error that Resident #139 went to the hospital. (1)Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, Centers for Medicare & Medicaid Services, Revised October 2023. On 2/05/25 at approximately 7:00 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interview, the facility staff failed to ensure a Pre-admission Screening and Resident Review (PASARR) was completed prior to admission for 4 Residents (Residents #3, #32, #59, and #132) in a sample of 63 residents. The Findings included: 1. Resident #3 was admitted on [DATE] with diagnoses including: Bipolar Disorder, Anxiety, and Dementia. Physicians orders for medications were reviewed and revealed psychotropic medications actively being administered for those diagnoses. On 1-30-25, an observation was conducted of Resident #3. The Resident was sitting in her room in a wheel chair and talked with the surveyor who had entered the room and addressed her in a greeting, while attempting conversation and interview. The Resident was also talking to herself with questions and answers to an apparent inner monolog with herself. On 1-30-25 a review of Resident #3's clinical record was conducted. No previous to Long Term Care Skilled Nursing (after acute hospitalization) admission PASARR (preadmission screening & resident review) had been completed. The PASARR assesses for mental illness or intellectual disability needs prior to admission, and none were found in the Electronic Health Record (EHR). Facility staff were asked to locate any previous PASARR documents, and they stated none had been completed for this admission. On 1-31-25 the new social worker delivered a medicaid Assisted Living Annual Reassessment document dated 8-28-19, and stated this is all we have. Imbedded in the document was a DMAS-96 (Department of Medical Assistant Services) completed PASARR II document for the Resident, however there were errors and the document was incomplete. No previous or current PASARR I was found. It is notable to mention that the employee records review revealed no social worker in the building for months, and on 2 different occasions in the past year. The new Social worker (#3 in the past year) had just recently begun and was interviewed on 1-30-25 and 1-31-25. She revealed that the former Social worker resigned and had been there only a short while, and that the social worker before that had only been in the position for a short while. This indicates a lack of oversight in meeting the needs of Residents to include preadmission screenings. On 1-31-25 the Social worker's license and curriculum vitae were requested for verification and vetting as part of the employee records review for competency of staff. It was noted that the required course work and degree required by state and federal regulation for this employee was sufficient for the role. The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 1-31-25. The Administrator stated, we will correct this immediately and indicated they would be auditing residents' PASARR's. No further documents were provided. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident # 32, facility staff failed to ensure a Preadmission Screening and Resident Review (PASARR) was completed prior to admission. Resident # 32 was admitted on [DATE] with diagnoses including but not limited to: Bipolar Disorder, Diabetes, Amputation of Right lower leg, End Stage Renal Disease, Dialysis, and Atrial Fibrillation. Resident #32's most recent MDS (Minimum Data Set) was a Quarterly Assessment with an ARD (Assessment Reference Date) of 1/10/2025 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of 15 indicating no cognitive impairment. Review of the clinical record revealed that Resident #32 did not have a PASARR level 1 completed prior to admission to the facility from the acute care hospital. Physicians orders for medications were reviewed and revealed the following psychotropic medications actively being administered and ongoing behavior monitoring: Duloxetine HCL (Hydrochloride) Capsule Delayed Release Particles 20 milligrams Give 1 capsule by mouth Further review of Resident # 32's clinical record was conducted on 1/30/2025. No previous to admission PASARR (preadmission screening & resident review) for mental illness or intellectual disability was found in the Electronic Health Record. Facility staff were asked to locate any previous PASARR documents, and they stated none had been completed prior to that date. A copy of the facility's policy was requested and received. The PASARR Policy stated the following on Pg. 2 Paragraph 4: Relationship Between LTSS and PASARR 1) Prior to an individual's admission, the Social Worker, Admissions Coordinator, or designee will review the completed screening forms via e-PAS and obtain a copy for placement in the electronic medical record. i) Nursing Facilities shall not accept paper screening forms as proof that admission criteria have been met and documented. 2) Because the PASRR screening is coupled with the LTSS Screening for Medicaid program, the screening team responsible for conducting the PASRR screening prior to admission is determined by who is required to complete the LTSS Screening a) (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prior to admission (hospital- inpatient, community-residing in community/Assisted Living) i) Already Medicaid members ii) Financially eligible by way of application as verified by the ePAS system b) Nursing Facility i) Medicare ii) Private Pay On 2/3/2025 at approximately 1:00 p.m., an interview was conducted with the Social Worker who stated that she was a new employee who was hired on 1/6/2025. She stated was aware that PASARRs should be done prior to admission and that it should have been done prior to the resident's admission. The Social Worker stated she would check the clinical record of Resident # 32 for any documentation of a PASARR being done prior to admission. On 2/4/2025 at approximately 2:15 p.m., an interview was conducted with the Director of Nursing (DON) who stated that PASARRs should be completed prior to admission to the facility. On 2/4/2025 at 3:30 p.m., the Social Worker reported that she found no documentation that a PASARR was done on Resident # 32 prior to admission. On 2/4/2025 during the end of day meeting, the Administrator, Corporate Nurse Consultants and Director of Nursing were made aware of the findings. No further information was provided. 2. For Resident #59 the facility staff failed to ensure that a PASARR (Pre-admission Screening and Resident Review) was conducted prior to admission to the facility, and none has been done since his admission on [DATE]. Resident #59 was admitted to the facility on [DATE] with diagnoses that included but were not limited to diabetes, PTSD (Post Traumatic Stress Disorder), benign prostatic hyperplasia, major depressive disorder, hemiplegia following a cerebral infarction, mood disorder due to known physiological condition, hearing loss and blindness in one eye. (continued on next page)

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #59's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/27/24 coded Resident #59 as having a BIMS (Brief Interview of Mental Status Score) of 10 / 15, indicating severe cognitive impairment. Resident #59's clinical record revealed that he had orders for medications that included: Paxil 20 mg every day [an anti-depressant] Divalproex Sodium 125 mg every 12 hours related to mood disorder On 2/5/25 at approximately 1:00 p.m., an interview was conducted with the Director of Social Services [Employee D] who stated that she was aware that PASARRs should be done prior to admission. She stated that if the PASARR was not done prior to admission, she would complete them once the residents were admitted to the facility. She stated that she had only been at the facility for 1 month now and was not aware that this Resident did not have a completed PASARR. On 2/5/25 at approximately 2:15 p.m., an interview was conducted with the Director of Nursing (DON) and the Administrator who stated that PASARRs should be completed prior to admission to the facility. A review of the PASARR Policy revealed the following excerpt: PASARR Policy Pg. 2 Paragraph 4 Relationship Between LTSS and PASARR 1) Prior to an individual's admission the Social Worker , Admissions Coordinator, or designee will review the completed screening forms via e-PAS and obtain a copy for placement in the electronic medical record. i) Nursing Facilities shall not accept paper screening forms as proof that admission criteria have been met and documented. 2) Because the PASRR screening is coupled with the LTSS Screening for Medicaid program, the screening team responsible for conducting the PASRR screening prior to admission is de-determined by who is required to complete the LTSS Screening a) Prior to admission (hospital- inpatient, community residing in community / Assisted Living) (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i) Already Medicaid members ii) Financially eligible by way of application as verified by the ePAS system b) Nursing Facility i) Medicare ii) Private Pay On 12/18/2024 during the end of day meeting, the Administrator and Director of Nursing were made aware of the issues and no further information was provided. 4. The facility staff failed to obtain or complete a Preadmission Screening and Resident Review (PASRR) Level I for Resident #132. Resident #132 was originally admitted to the facility 9/23/24. The resident's diagnoses included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, schizoaffective disorder, and essential hypertension. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/30/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #132's cognitive abilities for daily decision making were moderately impaired. An interview was conducted on 2/4/25 at 3:08 PM with the Director of Social Services. The Director of Social Services stated that the facility does not have a PASRR level I for Resident #132. The Director of Social Services also stated that this should have been received by the facility at the time the resident was admitted to the facility, or the facility should have completed a PASRR level I for Resident #132 after the resident was admitted . A review of Resident #132's medical records revealed that a Preadmission Screening and Resident Review (PASRR) Level I was not completed for Resident #132. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 6:55 PM a final interview was conducted with the Administrator, Director of Nursing, Regional MDS, Regional Nursing Consultant, Regional Maintenance Director, [NAME] President of Clinical Services, Regional Risk Management, and Regional Director of Operations. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and facility documentation review the facility staff failed to review and revise the care plans for 5 Residents (#42, 106, 124, 130, and #132) in a survey sample of 63 Residents. The findings included: For Resident #42 the facility staff failed to review and revise the care plan after non-compliance with alcohol and substance abuse incidents. Resident #42 was admitted to the facility on [DATE] with diagnoses that included but were not limited to COPD (Chronic Obstructive Pulmonary Disease), bipolar disorder, sleep apnea, hypertension, fusion of cervical spine, heart failure, major depressive disorder, history of venous thrombosis, (blood clot), anxiety disorder and viral hepatitis C. A review of the clinical record revealed the following incidents involving Resident #42: 7/15/24, 9/9/24 and 10/3/24 Resident #1 was caught smoking in the facility. 10/11/24 - Cheeking PRN Narcotic Pain Meds (storing meds in cheek to avoid swallowing, this is done to hoard medication for later consumption) 10/22/24 - Sent to ER for intoxication 12/27/24 - Sent to ER for AMS (Altered Mental Status) ER notes document Resident #1 admitted to use of heroin. 12/30/24 - MD notes refer to Resident #1 being on LOA (Leave of Absence) and being sent to the ER while on LOA for overdose of heroin. A review of the clinical record revealed the following care plan entry with regard to substance use: FOCUS: BEHAVIORS- the resident has admitted behaviors of drug and alcohol abuse when leaving the facility. Date Initiated: 01/03/2025. GOAL: [left blank; no data entered] INTERVENTION: Notify MD as indicated Date Initiated: 01/03/2025 Referral to inpatient drug abuse recovery center. Date Initiated: 01/03/2025 Revision on: 01/03/2025 FOCUS: Potential for safety hazard, injury r/t smoking. Date Initiated: 06/13/2024 GOAL - [Resident #1 name redacted] will not smoke without supervision through the review date. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Date Initiated: 06/13/2024 Revision on: 06/13/2024 Notify charge nurse immediately if it is suspected that [NAME] has violated facility smoking policy. Date Initiated: 06/13/2024 Observe oral hygiene. Date Initiated: 06/13/2024 Smoking allowed only in designated smoking areas. Smoking only allowed by long term residents that have been grandfathered in by policy. Date Initiated: 06/13/2024 While smoking, will have direct supervision by staff or family member. Date Initiated: 06/13/2024. 2. For Resident #106 the facility staff failed to review and revise the care plan after non-compliance with alcohol and substance abuse incidents and non-compliance with weapons in the facility. Resident #106 was admitted to the facility on [DATE] with diagnoses that included but were not limited to history of multiple medical problems including gunshot wound to the head with stroke secondary to injury, hemiplegia, moderate recurrent major depression disorder, seizure disorder, late effect of traumatic brain injury, insomnia, and muscle spasms. A review of the clinical record revealed the following incidents involving Resident #106: 8/21/24 - Resident #106 admitted to taking money from roommate to buy alcohol and methamphetamine 9/9/24 - Resident #106 was found knife / boxcutter. 9/16/24 - Alcohol found on Resident #106 who was showing signs of AMS (Altered Mental Status) and was sent to ED found to be positive for alcohol, marijuana and cocaine use. 12/16/24 - Resident #106 found with AMS and admitted to staff obtaining Suboxone and beer and using them both in facility. 12/23/24 - Resident #106 was sent to the ER for AMS returned without paperwork from ER 12/31/24 - Resident #106 was found in the facility with alcohol 1/4/25 - Resident #106 was found making weapons in his room with lighter and fork (removed all but 1 of the tines on 2 forks found burning them with a lighter) A review of the care plan revealed the following with regard to smoking, and substance abuse. The care plan did not address the weapon making in the facility. FOCUS: Potential for safety hazard, injury r/t smoking. Date Initiated: 05/23/2024 GOAL: Will not cause injury to self or others, or damage to property r/t smoking. Date Initiated: 05/23/2024 Revision on: 05/30/2024 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	INTERVENTION: Keep all smoking materials at nurses station. Smoking materials to be returned to nurse's station after smoke break. Date Initiated: 05/23/2024 While smoking, will have direct supervision by staff or family member. Date Initiated: 05/23/2024. FOCUS: BEHAVIORS: the resident has drug and alcohol behaviors when leaving the facility and has been caught with alcohol while in the facility Date Initiated: 01/03/2025 GOAL -The resident's behaviors will cause them less distress thru the review period Date Initiated: 01/16/2025 he resident's behaviors will not cause them or other resident's distress thru the review period Date Initiated: 01/16/2025 INTERVENTIONS: 1:1 activities as needed Date Initiated: 01/16/2025 Explain all procedures to the resident before starting and allow the resident time to adjust to changes Date Initiated: 01/20/2025 Physician review of medications as needed Date Initiated: 01/16/2025 referred to inpatient recovery for drug and alcohol abuse. Date Initiated: 01/03/2025 Revision on: 01/03/2025 3. For Resident #124 the facility staff failed to review and revise the care plan after non-compliance with alcohol and substance use. Resident #124 was admitted to the facility on [DATE] with diagnoses acute osteomyelitis, type diabetes, chronic viral hepatitis, hypertension, complications of skin graft, major depressive disorder, chronic kidney disease, and diabetic foot ulcer. A review of the clinical record revealed the following incidents involving Resident #124: 12/12/24 - Resident #124 found with chest pain and shortness of breath after going LOA 7-11 am admitted to snorting and unknown substance that he believes it was laced with fentanyl. NP asked resident to do a drugs test. Resident refused to go to ER and Refused drug testing. 12/13/24 - Sent to the ER - Resident #124 found sweating profusely and stated, I feel like I'm withdrawing from something, admitted to snorting something starting 3 days ago and not knowing what it was, also stated I snorted a little something this morning. 1/4/25 - Sent to the ER for withdrawals. A review of the care plan revealed the following with regard to smoking, and substance abuse. Focus - HX OF DRUG USE: The resident is at risk for complications due to a history of illicit drugs use Date Initiated: 12/16/2024 Revision on: 12/16/2024 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	GOAL: The resident will not have any adverse reactions related to alcoholism thru review period Date Initiated: 12/16/2024 Target Date: 03/16/2025 INTERVENTION: Observe resident for any signs and symptoms of intoxication or withdrawal from drugs such as tremors, nausea/vomiting(severe), sweating and notify MD as indicated Date Initiated: 12/16/2024 Administer medication as ordered Date Initiated: 12/16/2024 vitals as needed Date Initiated: 12/16/2024. 4. For Resident #130 the facility staff failed to review and revise the care plan after non-compliance with alcohol and substance use. Resident #130 was admitted to the facility on [DATE] with diagnoses included but were not limited to sepsis due to methicillin susceptible staph, major depressive disorder, anxiety disorder, acquired hypertension, acute kidney failure, type 2 diabetes, nicotine dependence, protein calorie malnutrition, and history of infectious parasitic disease. A review of the clinical record revealed the following incidents involving Resident #130: 9/9/24 - Resident #130 was caught smoking marijuana in room refused to give it to staff. 12/20/24 - Resident #130 was found by staff at 4:00 a.m. in dining room with AMS (Altered Mental Status), very lethargic sitting in wheelchair stated, I'm high as a bitch. Refused to go to the ER 1/3/25 - Staff reported strong odor of marijuana in Resident #130's room. A review of the clinical record revealed the following care plan entry with regard to the use of illicit drugs and or alcohol: FOCUS: BEHAVIORS: the resident has behaviors of (SPECIFY) Resident has behavior in using drugs and alcohol while on premise. Drugs have been confiscated from resident's room. Date Initiated: 11/06/2024 Revision on: 01/03/2025 GOAL: the resident's behaviors will cause them less distress thru the review period Date Initiated: 11/06/2024 Target Date: 01/06/2025 INTERVENTIONS: Approach with a calm quiet voice, divert attention, and remove from the situation and take to an alternative location as needed Date Initiated: 11/06/2024 Assure the resident they are safe and being cared for if they become distressed Date Initiated: 11/06/2024 Explain all procedures to the resident before starting and allow the resident time to adjust to changes Date Initiated: 11/06/2024 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monitor behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved and situations. Date Initiated: 11/06/2024 Notify MD as indicated Date Initiated: 11/06/2024 Physician review of medications as needed Date Initiated: 11/06/2024 A review of the facility policy entitled Care Planning Comprehensive Person-Centered, revealed the following excerpts: 15. Behavior intervention plan (BIP) may be developed when a resident exhibit behaviors that may place the resident, other resident or staff at risk or impedes on their rights. a. The BIP will be developed in collaboration with the resident, interdisciplinary team and mental health professionals as appropriate. b. The BIP will be incorporated into the resident's comprehensive care plan i. The BIP will be reviewed and updated as needed to address changes in the resident's behaviors. c. The BIP will clearly identify the behaviors being addressed, interventions/approaches to reduce behaviors and expected outcomes. The BIP will also include consequences and actions that may be taken should the resident not comply with the agreed expectations. i. The plan will honor the residents rights and dignity. 16. The care planning / interdisciplinary Team is responsible for the review and updating of care plans a. When requested by the resident / resident representative b. When there has been a significant change in the resident's condition. c. When the desired outcome is not met. d. When goals needs and preferences change e. At least quarterly and after each OBRA MDS assessment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the morning of 1/12/25 an interview was conducted with the DON who was asked about care plans of Resident #'s 42, 106, 124 and 130 with regard to drug and alcohol use. When asked if the care plans had adequately addressed supervision of Residents after it was discovered they were using illicit drugs and / or alcohol, she stated that they had not. When asked what they could have implemented she stated that they could have implemented 1:1 supervision, and nursing assessments after LOA (Leave of Absence) from the building. On 1/12/25 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 5. Resident #132. The facility staff failed to revise the care plan timely in the area of receiving 1:1 staff supervision (Resident #132). Resident #132 was originally admitted to the facility 9/23/24. The resident's diagnoses included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, schizoaffective disorder, and essential hypertension. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/30/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #132's cognitive abilities for daily decision making were moderately impaired. Observations were made of Resident #132 on 1/29/25 at 11:30 AM having 1:1 staff supervision. A review of the Care Plan interventions on 1/29/25 at 11:50 AM did not reveal Resident #132 having 1:1 staff supervision. An interview was conducted on 1/29/25 at 2:25 PM with the MDS (Minimum Data Set) Coordinator. The MDS Coordinator stated that Resident #132 has been receiving 1:1 staff supervision since 1/1/25. The MDS Coordinator also stated that the care plan was not updated in a timely manner. The MDS Coordinator further stated that she updated the care plan today however the care plan should have been updated at an earlier date due to Resident #132 being on 1:1 staff supervision for a few weeks now. On 2/5/25 at 6:55 PM a final interview was conducted with the Administrator, Director of Nursing, Regional MDS, Regional Nursing Consultant, Regional Maintenance Director, [NAME] President of Clinical Services, Regional Risk Management, and Regional Director of Operations. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 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, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to follow the professional standards of quality regarding treatments for one (1) resident (Resident # 24) in survey sample of 63 residents. The findings included: The facility staff failed to implement medication policy to ensure that Resident #24 had all of his medications on hand as ordered by the physician, and further failed to administer the medications and treatments as ordered by the physician. Resident #24 was admitted to the facility on [DATE] with diagnoses that include but are not limited to paranoid schizophrenia, diabetes, chronic kidney disease, mild intellectual disabilities, hypertension, hypothyroidism, bipolar disorder, major depressive disorder, severe with psychotic features, and anxiety. A review of the clinical record revealed that Resident #24 had orders that included: [NAME] Moisture Barrier Cream (Skin Protectants, Misc.) Apply to Sacrum, buttocks topically every day and evening shift for protection/prevention -Start Date- 09/29/2020 0700 -Hold Date from 01/27/2025 to 01/30/2025 Cerave Lotion with Petroleum Jelly Apply to face & bilateral legs topically two times a day for scabs/ dry skin -Start Date-03/07/2024 1700 -Hold Date from 01/27/2025 to 01/30/2025 Eucerin Advanced Repair External Cream (Emollient) Apply to bilateral heels topically every day and evening shift for dry Heels -Start Date- 08/02/2023 0700 -Hold Date from 01/27/2025 to 01/30/2025 A review of the clinical record revealed that the above ordered creams were documented in the progress notes as unavailable or awaiting from pharmacy on the following dates: [NAME] Moisture Barrier Cream [twice daily] - 1/4, 1/10, 1/22 - 1/31 and 2/1 - 2/5/2025 Cerave Lotion with Petroleum Jelly [twice daily] - 1/10, 1/22 - 1/31 and 2/1 - 2/5/2025 Eucerin Advanced Repair External Cream [twice daily] - 1/4, 1/10, 1/22 - 1/31 and 2/1 - 2/5/2025 On 2/5/25 at approximately 3:00 p.m., an interview was conducted with LPN C who was asked the procedure if a medication is unavailable, she stated that they are to the physician to see if they would like to substitute it with a different med that is available, notify the family or the Resident and then change the order, and document the changes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the afternoon of 2/5/25 the DON was asked what the expectation is for nurses when medications are unavailable and she stated, The nurse should call first check the stat box, then call the pharmacy to find out what is available, and when the medication can be obtained, then call the physician and make them aware of the issue, and see if they would like to change the order, or place it on hold until the medication arrives. Then they need to put in any new orders and discontinue any old ones if they were changed, phone the pharmacy and make them aware. Notify the Resident and or Responsible Party. A review of the Policy # 6.10 entitled Unavailable Medications effective date 09/2018 revised on 8/2020, read: The nursing staff shall: 1. Notify the attending physician (or on-call physician when applicable) of the situation and explain the circumstances, expected availability, and the alternative therapies available. If the facility nurse is unable to obtain a response from the attending physician or on-call physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders and or direction. 2. Obtain a new order rand cancel / discontinue the order for the non-available medications. 3. Notify the pharmacy of the replacement order. On 2/5/25 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure proper Activities of Daily Living services were provided for three (3) residents (Residents #123, #83 and #24) in a survey sample of 63 residents. The findings included: 1. For Resident # 123, the facility staff failed to provide lotion after bathing. Resident #123 was admitted to the facility on [DATE] with the diagnoses of, but not limited to: Dementia with Agitation, Diabetes, Hypertension, and Legal blindness. The most recent Minimum Data Set (MDS) was an admission Assessment with an Assessment Reference Date (ARD) of 9/10/2024. Resident # 123's BIMS (Brief Interview for Mental Status) Score was a 14 out of 15, indicating no cognitive impairment. Review of the clinical record was conducted on 1/28/2025 to 1/31/2025 and 2/3/2025 to 2/5/2025. Resident #123 complained about not getting lotion on her body. She stated some facility staff members told her it was written on her chart that she could not have lotion. She stated they never use lotion on me. The surveyor entered the room on 2/3/2025 while the Certified Nursing Assistant was providing care to the residents in the room. Resident #123 was loudly telling the Certified Nursing Assistant that she wanted lotion. It was observed that no lotion was applied to Resident # 123's skin. The Certified Nursing Assistant stated she provided ADL care but did not see any lotion for the resident. Resident #123 asked the surveyor why she could not have lotion on her skin. She stated she had used lotion since she was [AGE] years old and wanted to continue using it. There was no lotion noted on the nightstand where other personal items were located. Review of the Physicians Orders revealed no documentation of orders being written regarding no use of lotion on the skin. Review of the care plan revealed no documentation of lotion not being used on the skin. On 2/4/2025 at approximately 2:00 p.m., an interview was conducted with Licensed Practical Nurse-E who stated residents should have lotion applied to the skin after bathing or per their request. Licensed Practical Nurse-E stated lotion was available for the residents to use. During the end of day debriefing, the facility Administrator, Director of Nursing and Corporate Consultants were informed of the findings. No further information was provided. 2. For Resident # 83, the facility staff failed to provide care to the feet. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the initial tour of the facility on 1/28/2025 at 1:30 p.m., Resident # 83 was observed lying in bed. The left foot was uncovered. Observation of the toenails on the left foot revealed the toenails were long, and dark in color. The left great toenail was approximately a half inch to 3/4 of an inch long, dark purple in color with jagged edges. The nail on the second toe was approximately a half inch long, discolored and pointed in shape. The skin on the feet looked very dry. On 1/28/2025 at approximately 2:30 p.m., an interview was conducted with Resident # 83 who stated she was embarrassed about her feet. She stated her toenails needed to be cut. Resident # 83 stated she did not want anybody to see her feet. She stated it had been a long time since she had foot care. Review of the clinical record was conducted 1/28/2025 -1/31/2025 and 2/3/2025- 2/5/2025. Review of the Podiatry records revealed that Resident # 83 was listed as one of the Residents to be seen in October 2024 and August 2024. Review of the clinical record revealed no documentation that the resident was treated by the Podiatrist during those months. On 1/29/2025 at 11:50 a.m., an interview was conducted with Registered Nurse-B who stated proper nail care should be provided to residents. She stated the nursing staff would do routine skin care. Registered Nurse-B stated Resident # 83 should be seen by the Podiatrist for nail care. She stated Resident # 83 was a Diabetic and needed proper nail care to prevent complications. She stated she was unsure of the last time Resident # 83 was seen by the Podiatrist. Resident # 83 stated the Podiatrist usually came to the facility monthly on Saturdays and saw residents according to those placed on a list. Registered Nurse-B stated the facility staff should provide skin care to the feet routinely. On 2/4/2025 at 3:05 p.m., an interview was conducted with the Unit Secretary who stated she was the one who scheduled appointments for residents with the Podiatrist. She stated the Podiatrist came every two months on a Saturday. She stated the facility had a new Podiatrist who started approximately 5 months ago. Review of the clinical record revealed only one Podiatrist note that was written in June of 2023. Further review revealed no other documentation of foot care being provided. On 2/4/2025 during the end of day meeting, the Administrator, Corporate Nurse Consultants and Director of Nursing were made aware of the findings. No further information was provided. 3. For Resident # 24, the facility staff failed to provide ADL care. Resident #24 was observed on several days with greasy hair, long fingernails with visible debris under the nails, had an odor of urine and body odor and was in the bed dressed in a hospital gown all day. Resident #24 was admitted to the facility on [DATE] with diagnoses that include but are not limited to paranoid schizophrenia, diabetes, chronic kidney disease, intellectual disabilities, hypertension, hypothyroidism, bipolar disorder, major depressive disorder, severe with psychotic features, and anxiety. Resident #24's most recent BIMS (Brief Interview of Mental Status) score dated 12/23/24 coded Resident #24 as having a BIMS score of 13/15 indicating intact cognitive skills for daily decision making. (continued on next page)

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	495327	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hill Health & Rehabilitation	4403 Forest Hill Avenue Richmond, VA 23225

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following observations were made of Resident #24: 01/30/25 11:50 AM- Nails long brown substance under nails, in need of shower/bath, hair appears greasy Resident has body odor and smells of urine. In bed only in hospital gown and brief. 01/31/25 11:38 AM- Resident # 24 in bed dressed in hospital gown nails still appear dirty and hair greasy. Continues to have body odor. Interview with Resident #24: When asked does the staff usually get you up and get you dressed, he responded, No not usually, I can't walk. When asked does the staff get you up and put you in the wheelchair he responded, No not unless I have to go somewhere. When asked does the staff get you up and put you in the shower, he stated that they usuallygave him bed baths. When asked when the last time is his hair was washed, he stated that he did not know. A review of the Point of Care documentation (CNA documentation of ADL care) revealed that during the period of time from 12/16/24 -12/31/24 Resident #24 had no documented showers. During the period of time from 1/1/25 through 2/1/25, Resident #24 had two (2) showers documented. On 2/3/25 at approximately 11:00 a.m., an interview was conducted with CNA B who stated that Resident #24 was care planned for refusing a shower. When asked does if that means he does not get one CNA B stated that they usually just wash him up in the bed. When asked how many times a week does a Resident get a shower and CNA B stated that usually Residents are scheduled for 2 showers a week. A review of the Resident's care plan revealed the following : FOCUS: [Resident #24 name redacted] has an ADL self-care performance deficit r/t Confusion, Dementia, Impaired balance, Limited Mobility, Intellectual disability, functional quadriplegia. He req. assist from staff with bed mobility, transfers, dressing, toileting, personal hygiene,and bathing. GOAL:[Resident name redacted] Mr. [NAME] will receive appropriate staff support with adl care daily through next review. Date Initiated: 12/12/2018 Revision on: 01/29/2025 Target Date: 03/25/2025 INTERVENTIONS: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date Initiated: 12/12/2018 Revision on: 12/12/2018 [Resident name redacted] is able to: feed self after set up assist from staff. Date Initiated: 12/12/2018 [Resident name redacted] requires assistance by staff to dress. Date Initiated: 12/12/2018 Revision on: 09/29/2020 [Resident name redacted] requires assistance by staff to turn and reposition in bed. Date Initiated: 12/12/2018 Revision on: 07/24/2019 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Resident name redacted] requires assistance from staff to provide bath/shower. Date Initiated: 12/12/2018 Revision on: 09/29/2020 [Resident name redacted] requires assistance by staff for transfers. Date Initiated: 12/12/2018 Revision on: 09/29/2020 [Resident name redacted] receives assistance by staff for incontinence care. Date Initiated: 12/12/2018 Revision on: 09/29/2020. 02/03/25 01:04 PM Resident # 24 positioned too low in bed to sit up and eat properly, Resident had lima beans and gravy on his blanket which was under his chin, fruit cup was not opened and Resident was struggling to open it attempted with spoon to poke hole in it then attempted with fork still unable to open it, drink was unopened in cup, and Resident ate rice with his fingers. attempted with fork but kept falling off and he ended up picking up by hand. A review of Resident #24's MDS with an ARD (Assessment Reference Date) of 12/23/24 question GG0130A3 states that the Resident requires Set Up / Clean Up Assistance, On 2/3/25 at 1:10 p.m. an interview was conducted with LPN D (Unit Manager) who stated that the danger of Resident #24 being so low in the bed is that he could aspirate or choke on his food. When asked is this the expectation of how a Resident should be set up for meals and she stated that the expectation for CNA's to set up Resident's tray are all food and drink containers should be opened he should have his bed upright as close to a 90-degree angle as is comfortable and he should be sitting upright in the bed. On 2/5/25 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview clinical record review and facility documentation the facility staff failed to ensure Residents receive treatment and assistive devices to maintain vision for 1 Resident in a survey sample of 38 Residents. The findings included: For Resident #125 the facility staff failed to ensure the Resident received vision services for a resident with a diagnosis of glaucoma. Resident #125 was admitted to the facility on [DATE] with diagnoses that included but we're not limited to UTI, kidney stones, protein calorie malnutrition, asthma, epilepsy, repeated falls, COPD, chronic renal failure, colostomy, major depressive disorder, DVT, muscle weakness, traumatic brain injury, acute angle - closure, glaucoma, dysphasia, and hypertension. Resident #125 is wheelchair, bound and requires assistance with all aspects of care except for eating. His most recent BIMS (Brief Interview of Mental Status) scored the resident at 15 out of 15 indicating no cognitive impairment. On 5/21/25 at 11:00 a.m. Resident #125 was interviewed and he stated that he could not see well. He indicated that he had been diagnosed with glaucoma before he was admitted to the facility and that he needed glasses because it was now getting hard to see his phone. On 5/21/25 an interview was conducted with the Social Worker who stated that Resident #125 was scheduled for the optometrist on 5/1/25, however he refused. When asked if the appointment was rescheduled, she indicated that it had not been. A review of the clinical record revealed that the Resident was not on any prescribed eye drops to control the intraocular pressure and had no follow up exams with the ophthalmologist since admission. On 5/22/25 during the end of day meeting the Administrator was made aware of the concern and no further information was provided.

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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, facility documentation review and clinical record review, the facility failed to prevent, assess, identify and treat an avoidable pressure ulcer for one Resident (Resident #63) in a survey sample of 63 Residents. The findings included: Resident #63 was originally admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of, but not limited to Alzheimer's, muscle weakness, difficulty walking, vitamin deficiency, cognitive communication deficit, chronic kidney disease, anxiety, and repeated falls. Resident #63's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 12/7/2024 was a quarterly assessment. The MDS coded Resident #63 with a BIMS (Brief Interview for Mental Status) score of 00 out of 15 possible points, indicating severe cognitive impairment. The MDS coded Resident #63 as dependent with Activities of Daily Living (ADL's), dependent or 2 persons assist for all function abilities and frequently incontinent for bowel and bladder. On 1/28/2025 at approximately 12:55 p.m., during initial tour of the facility, Resident #63 was observed sitting in a wheelchair in day room of the Memory Care unit. Gauze dressing observed to the right lower extremity. Resident #63 was alert but not oriented. On 02/05/2024, at 2:00p.m. an interview was conducted with wound care nurse. When asked if she could confirm the date Resident #63 pressure ulcers to the left and right lower extremities were observed and documented. The wound care nurse states that she was new to the facility, but she was able for find notes that in the residents record the resident did admit with a pressure ulcer on 02/13/2024. She could not find any documentation in the wound care book or the residents record regarding pressure ulcers to the right and left lower extremities prior to 06/05/2024. When asked when skin evaluations are conducted. She stated by nursing weekly, daily with Activities of Daily Living (ADL) Care, physician assessments, and whenever an issue is reported. Facility policies and procedures were reviewed. The policy titled Skin assessments stated that skin assessments would be conducted by nursing weekly and daily with ADL care. A review of Resident #63 clinical record was conducted 01/28/2025-01/31/2025 and 02/03/2025-02/05/2025 and revealed: The 12/21/2023, Care plan revealed no documentation Focus: Resident has potential for impairment for skin integrity. Goal: Resident will have no impaired skin integrity through next review. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 02/24/2024, Care plan revealed Focus: Resident is at nutrition risk r/t obesity alzheimers, prediabetes, depression, suicidal ideations, HTN, HLD, vitamin deficiency. Goal: Resident will maintain adequate nutrition status without s/sx of malnutrition with no further weight gain through next review date. Intervention: Diet as ordered and per resident's preferences. Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. RD to monitor and f/u per protocol. Weigh per facility protocol. A review of the care plans revealed no documentation of focus, goal or intervention related to pressure ulcers 02/13/2024-06/05/2024. The 08/17/2023, Nutritional At-Risk Assessment revealed: Height: 59.0 inches. Weight: 155 pounds. Related diagnosis: Alzheimer's with early onset, history of falling, aphasia, prediabetes, major depressive disorder, essential hypertension, hyperlipidemia, and vitamin deficiency. -Diet: Regular, Fluid consistency: thin. Weight: stable; Nutritional Needs: Calorie Needs: 1410-1762, explanation of Calculations 20-25k cals/kg. Protein needs: 56-85, Explanations of calculation 0.8-1.2 PRO/kg; Fluid needs: 1410-1762. -Plan of Care: Problem statement: Annual assessment for 70yo COVID-19+ LTC female w/hx of pre-DM, HTN, HLD, vit deficiency, alzheimer's disease, depression. Ht 59, wt 155#, BMI 31.3. No significant weight change x 30, 60, 90, 180 days. Diet is CCD w/regular textures. PO 76-100% overall per PCC. Goal: No chewing/swallowing problems reported. Skin wnl. Pertinent meds: donepezil, atorvastatin, B complex vit, losartan, hydrochlorothiazide, vit D, memantine, bowel regimen, antidepressant. Labs 6/1 na 140, k 4.2, cl 103, bun 19.5, creat 0.52, ca 8.5, hgb 10.9 L, hct 34.2 L. Intervention: No nutrition-related recommendation at this time, continue to monitor PO and weight change status. The 02/13/2024, discharge summary from CJW Medical Center hospital, revealed Discharge diagnosis: encephalopathy secondary to urinary tract infection Hospital course: This is a [AGE] year-old female with PMH HTN, advanced dementia, Depression and DLD presents to hospital from nursing home by EMS with altered mental status. History is very difficult to obtain and very scant since patient is only alert oriented times 0. Patient presented septic with leukocytosis 18K, and etiology Urinary Tract Infection. [NAME] Cx grew gram positive and gram negative. Objective Head/Eyes: atraumatic, EOMI, PERRLA Neck: no JVD Cardiovascular: regular rate rhythm, no murmur Respiratory: aerating well, clear to auscultation, no distress Abdomen: non-tender, normal bowel sounds, soft, no distention Extremities: no edema Musculoskeletal: normal inspection Neuro/CNS: CNII-XII intact, verbal, not oriented to person, place or time - baseline Skin: dry, intact, no rash Psychiatry: unable to evaluate Free Text Obj Notes Free Text Obj (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notes: GENERAL: not alert oriented to place/time/self, able to follow simple commands SKIN: No rashes HEENT: No jaundice. No oral thrush or ulcerations. No sinus tenderness NECK: No JVD, supple; no palpable lymphadenopathy LUNGS: Clear to auscultation. No wheezes or crackles HEART: S1, S2; regular rate and rhythm. No murmurs ABDOMEN: Bowel sounds positive. Soft, no tenderness, no palpable organomegaly EXTREMITIES: Negative for edema, positive pulses NEURO: Awake, alert and oriented to place, person and time. No focal deficits MS: No joint swelling or muscle tenderness. Discharge Instructions: PCP follow-up: PCP: NO PRIMARY OR FAMILY PHYSICIAN Discharge to: Nursing Home (ICF,ECF) Additional Discharge Routines: Add. instructions Diet: Soft bite sized diet Additional instructions: follow up blood pressure at facility no longer to take blood pressure medications complete antibiotic Quality: Discharge Advanced Care Plan 65 or Older Discussed with: patient, nurse Current Medications Current medication review: I attest that the foregoing medication list in the medical record is true, accurate, and complete to the best of my knowledge. The 02/13/2024, Weekly Wound Evaluation Assessment revealed that Resident #63 had one pressure ulcer to the Coccyx. Type: vascular length 3, width 3, and depth 1. Comments: Has area to L inner buttock, noted with bruising all extremities. Resident #63's Weekly Wound Evaluation Assessments were reviewed for dates 02/13/2024 through 06/05/2024. There was no documentation of a wound or pressure ulcer to the left or right lower extremity. The 06/05/2024, Vohora initial wound evaluation summary, revealed Patient presents with wounds on her right knee; left anterior medial foot; left medial heel. At the request of the referring provider, a thorough wound care assessment and evaluation was performed today. She has condition(s) as listed above. Details about current wound(s) and any skin conditions are outlined below. There is no indication of pain associated with this condition. SKIN Head/Face Normal Left lower extremity Wound present. See Focused Wound Exam below, right lower extremity Wound present. See Focused Wound Exam below SITE 1: SURGICAL EXCISIONAL DEBRIDEMENT PROCEDURE INDICATION FOR PROCEDURE Remove Necrotic Tissue and Establish the Margins of Viable Tissue consent for procedure Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 06/05/2024 to the health care surrogate; Max Fresquez; who indicated agreement to proceed with the procedure(s) procedure note The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise devitalized tissue and necrotic subcutaneous level tissues were removed at a depth of 0.2 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 10 percent to 0 percent. Hemostasis was achieved and a clean dressing was applied. Post-operative recommendations and updates to the plan of care are documented in the Assessment and Plan section below. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focused Wound Exam (Site 2) UNSTAGEABLE DTI OF THE LEFT, ANTERIOR, MEDIAL FOOT UNDETERMINED THICKNESS Etiology (quality) Pressure MDS 3.0 Stage Unstageable DTI with intact skin Duration > 1 days Objective Healing/Maintain Healing Wound Size (L x W x D): 3.1 x 2.1 x Not Measurable cm Surface Area: 6.51 cm² Exudate: None Skin: Intact with purple/maroon discoloration Blister: Blood Filled DRESSING TREATMENT PLAN Primary Dressing(s) Skin prep apply Q-shift (3xday) for 30 days PLAN OF CARE REVIEWED AND ADDRESSED Recommendations Off-Load Wound ; Reposition per facility protocol ; Float Heels in Bed Focused Wound Exam (Site 3) UNSTAGEABLE DTI OF THE LEFT, MEDIAL HEEL UNDETERMINED THICKNESS Etiology (quality) Pressure MDS 3.0 Stage Unstageable DTI with intact skin Duration > 1 days Objective Healing/Maintain Healing Wound Size (L x W x D): 1.2 x 1.5 x Not Measurable cm Surface Area: 1.80 cm² Exudate: None Skin: Intact with purple/maroon discoloration Blister: Blood Filled DRESSING TREATMENT PLAN Primary Dressing(s) Skin prep apply Q-shift (3xday) for 30 days PLAN OF CARE REVIEWED AND ADDRESSED Recommendations Off-Load Wound ; Reposition per facility protocol ; Float Heels in Bed A review of the Physician's orders, 02/13/2024-06/05/2024.No orders were found for wound care to Resident #63, left or right lower extremities. A review of the progress notes only included documentation regarding pressure ulcer to the right buttock. Resident #63 experienced an avoidable pressure ulcer injury which was not identified until a, VOHRA, initial wound evaluation was conducted on 06/05/2024. The Resident was at risk for skin breakdown. No orders or plan of care was implemented to protect the extremities from wounds. On 2/04/2025 at 3:00pm, the Administrator, Director of Nursing, and Corporate Nurse were notified that the survey team was considering a harm level deficiency. The facility staff was given the opportunity to provide any further information or explanation. No further information was provided prior to exit.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview and clinical record review and facility documentation review, the facility staff failed to ensure proper foot care was provided to one (1) resident (Resident # 83) in a survey sample of 63 residents. For Resident # 83, the facility staff failed to ensure proper nail care was provided. Resident # 83 was admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included but were not limited to: Chronic Obstructive Pulmonary Disease, Hypertension, Chronic Kidney Disease, Diabetes, Acute Respiratory Failure and Congestive Heart Failure. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 11/3/2024. Resident # 83's BIMS (Brief Interview for Mental Status) Score was a 15 out of 15, indicating no cognitive impairment. Resident # 83 required assistance with Activities of Daily Living. During the initial tour of the facility on 1/28/2025 at 1:30 p.m., Resident # 83 was observed lying in bed. The left foot was uncovered. Observation of the toenails on the left foot revealed the toenails were long, and dark in color. The left great toenail was approximately a half inch to 3/4 of an inch long, dark purple in color with jagged edges. The nail on the second toe was approximately a half inch long, discolored and pointed in shape. The skin on the feet looked very dry. On 1/28/2025 at approximately 2:30 p.m., an interview was conducted with Resident # 83 who stated she was embarrassed about her feet. She stated her toenails needed to be cut. Resident # 83 stated she did not want anybody to see her feet. She stated it had been a long time since she had foot care. Review of the clinical record was conducted 1/28/2025 -1/31/2025 and 2/3/2025- 2/5/2025. Review of the Podiatry records revealed that Resident # 83 was listed as one of the Residents to be seen in October 2024 and August 2024. Review of the clinical record revealed no documentation that the resident was treated by the Podiatrist during those months. On 1/29/2025 at 11:50 a.m., an interview was conducted with Registered Nurse-B who stated proper nail care should be provided to residents. Registered Nurse-B stated Resident # 83 should be seen by the Podiatrist for nail care. She stated Resident # 83 was a Diabetic and needed proper nail care to prevent complications. She stated she was unsure of the last time Resident # 83 was seen by the Podiatrist. Resident # 83 stated the Podiatrist usually came to the facility monthly on Saturdays and saw residents according to those placed on a list. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/2025 at 3:05 p.m., an interview was conducted with the Unit Secretary who stated she was the one who scheduled appointments for residents with the Podiatrist. She stated the Podiatrist came every two months on a Saturday. She stated the facility had a new Podiatrist who started approximately 5 months ago. The Unit Secretary stated she had documentation of the list of residents who had been scheduled to see the Podiatrist. Copies of all residents seen by the Podiatrist were requested. The Unit Secretary stated that sometimes the residents on the list were not seen if they refused or if they weren't available when the Podiatrist visited their room. Review of the clinical record revealed only one Podiatrist note that was written in June of 2023. Further review revealed no other documentation of foot care being provided by the Podiatrist. On 2/4/2025 during the end of day meeting, the Administrator, Corporate Nurse Consultants and Director of Nursing were made aware of the findings. No further information was provided.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, resident record review, and a review of facility documents, the facility staff failed to apply a Occupational Therapy (OT) recommended splitting/orthotic device for one (1) of 63 residents (Resident #50), in the survey sample. The findings included: Resident #50 was originally admitted to the facility 10/27/2016 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included a stroke with right hemiparesis and expressive aphasia. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/22/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were moderately impaired. Resident #50's Physician's Order Summary included an order dated 12/31/24 to start 1/1/25 for the following: Apply resting hand splint to Right Upper Arm (RUE) for up to four (4) hours as tolerated- daily with skin checks and hand hygiene per shift for contracture management every day shift. Resident #50 received OT services from 11/18/24 through 12/26/24. The discharge plan dated 12/31/24 stated OT recommended that Resident #50 wear an orthotic to his right upper extremity for 2-4 hours per day as tolerated for contracture management. Observations were made of Resident #50 daily from 1/31/25 through 2/5/25, but a right upper extremity was not witnessed. The resident was noted to have the right arm bent upwards at all time. An interview was conducted with the OT on 2/5/25 at approximately 3:37 PM. The OT stated the right upper extremity splinting/orthotic was to be applied by staff and worn daily during the day shift up to 4 hours as tolerated, beginning 1/1/25. No documentation of application or tolerance was identified in the resident's record. On 2/5/25 at approximately 4:20 PM, a final interview was conducted with the Administrator, Director of Nursing and four Corporate Consultants. The administrative team was informed of the above. No additional information was provided and no concerns were voiced.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and resident record review, the facility staff failed to provide incontinence care for one (1) of 63 residents (Resident #21), in the survey sample. The findings included: Resident #21 was originally admitted to the facility 05/27/2022 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included high blood pressure and bilateral lower extremity swelling. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/31/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #21's cognitive abilities for daily decision making were intact. In section H0300 the resident was coded as occasionally incontinent of urine. On 1/28/25 at approximately 4:07 PM, Resident #21 was observed in his room with a puddle of urine beneath his wheel chair and his pants were saturated. The resident propelled the wheel chair out in the corridor leaving a trail of urine on the floor. An interview was conducted with the resident. Resident #21 stated he washes himself up and changes his incontinence briefs as needed. The staff did not come to the resident's assistance to provide incontinence care. Resident #21 was observed again on 1/30/25 at approximately 1:45 PM in the Dayroom on Unit Four. The resident was again with urine saturated pants. The resident stated his bladder was weak and he could no longer hold his urine. He went into the linen closet and obtain washcloths and towels. No staff came to the resident's aid to provide incontinence care. The resident's person centered care plan dated 06/06/2022 had a problem which stated (name of the resident) has bladder incontinence related to new admission and Arthritis. The goals stated the resident will remain free from skin breakdown due to incontinence and brief use through the review date, 3/30/25 and the resident's risk for septicemia will be minimized through the review date, 3/30/25. The interventions included the resident uses disposable briefs. Change as needed and check as required for incontinence. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes, urinal at bedside when in bed. On 2/5/25 at approximately 4:20 PM, a final interview was conducted with the Administrator, Director of Nursing and four Corporate Consultants. The administrative team was informed of the the above information. No additional information was provided and no concerns were voiced.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure residents did not sustain significant unplanned weight loss for one (1) Resident (# 109) in a survey sample of 63 residents. The findings included: For Resident #109 the facility staff failed to ensure the Resident's food preferences were addressed and failed to act on a significant unplanned weight loss of 13.25% in 6 mos. On 1/28/25 at approximately 12:45 p.m., an interview was conducted with Resident #109 who stated the food was not good at the facility. When asked to elaborate the Resident complained that a lot of times the food was burnt or overcooked. The Resident stated that they did not have any seasoning in the food and it was bland. He stated that he has lost weight since being at the facility and it was not intential weight loss. When asked if he had seen the Registered Dietician, he stated that he had not. When asked if anyone had contacted him and asked him about food preferences, he stated that the nurse did when he was admitted and she asked about allergies and food he couldn't eat. When asked if anyone from the dietary department had spoken with him to get a list of his likes and dislikes, he stated that they had not. When asked how much weight he had lost he stated that he had lost at least 20 lbs. Resident #109 was admitted to the facility on [DATE] with diagnoses that included but were not limited to weakness unsteadiness on feet, difficulty in walking, abnormalities of gait and mobility, occlusion or stenosis of right middle cerebral artery, muscle spasms, chronic pain, insomnia, and attention deficit hyperactivity disorder. Resident #109's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/13/24 coded Resident #61 as having a BIMS (Brief Interview of Mental Status) score of 15/15 indicating no cognitive impairment. A review of the clinical record revealed that Resident #61 was weighed on 7/15/24 and he weighed in at 234 lbs. On 1/27/25 Resident #61 weighed in at 203 lbs. thus, indicating a 31 lb. (or 13. 25%) weight loss in 6 months. A review of the clinical record revealed the following entries for Resident's weight: 7/30/24 - 231.2 Lbs. 9/9/24 - 227.2 Lbs. 10/10/24 - 224.8 Lbs. 11/2/24 - 224.5 Lbs. 11/4/24 - 221 Lbs. 12/10/24 - 216.0 Lbs. 1/7/25 - 204.4 Lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/27/25 -203 Lbs. A review of the clinical record revealed that Resident #109 had a Nutritional at Risk Assessment completed and signed by the Registered Dietician on 12/19/24 excerpts are as follows: Diet and consistency: Regular Diet Regular Texture Fluid consistency: Thin Supplements / Snacks: HS snack / Large Portions Page 4 9. Weight History - Stable Page 7 9B. Weight loss over last 3 months? 3. No Weight Loss 9C. Mobility - able to get out of bed / chair but does not go out. 9E. Neuropsychological problem - Severe dementia or depression [Please note Resident has no dx of dementia and BIMS of 15] Page 8 10 - 1. Do you have preferred beverages for breakfast? [left unanswered] 2. Do you have preferred beverages for lunch? [left unanswered] 3. Do you have preferred beverages for dinner? [left unanswered] 4. Are your preferred mealtimes outside of the facility times? [left unanswered] 5. If yes specify . [left unanswered] 6. Food likes - obtained and noted by DM (Dietary Manager) 7. Food dislikes [left unanswered] Page 9 Comments [left unanswered] Plan of care - No nutrition problem Page 10 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goals [left unanswered] 3. Interventions / approaches - Will continue POC & follow up as indicated A review of the care plan for Resident #109 revealed the following: FOCUS: NUTRITIONAL STATUS: The resident is at risk for weight loss, malnutrition or poor hydration status related to cognitive impairment Date Initiated: 11/11/2024 GOALS: the resident will have optimal nutrition and hydration status thru review period Date Initiated: 11/11/2024 Target Date: 12/11/2024 INTERVENTIONS: Review dietary preferences with the resident as needed Date Initiated: 11/11/2024 On 2/4/25 at 12:50 PM., a telephone interview was conducted with the dietician she was asked how often she sees Residents and she stated that she only works remotely as she lives in Ohio. When asked how she gets her information she stated that she gets her information from the electronic health record. When asked how she would get the food preference data from Residents, she stated I wouldn't be doing food preferences because that's what the dietary manager should be doing. The dietician said that orders are given to the Director of Nursing (DON). On 2/5/25 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. ,

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. For Resident # 2, the facility staff failed to ensure several medications were available for administration as ordered by the physician. Resident #2 was admitted on [DATE] with diagnoses including but not limited to: Epilepsy, Seizures, Confirmed Physical Abuse, Confirmed Psychological Abuse, Major Depressive Disorder, Anxiety Disorder, and Neoplasm of the Brain. Resident #2's most recent MDS (Minimum Data Set) was a Quarterly Assessment with an ARD (Assessment Reference Date) of 12/27/2024 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 13 out of 15 indicating no cognitive impairment. Review of the clinical record was conducted on 1/28/2025 to 1/31/2025 and 2/3/2025 to 2/5/2025. Review of the Progress Notes and January 2025 Medication Administration Record (MAR) revealed documentation of medications being unavailable for administration including but not limited to: Effective Date: 01/22/2025 00:22 Type: Orders - Administration Note Note Text : Oxycodone Hydrochloride Tablet 5 milligrams Give 1 tablet by mouth every 6 hours for pain Not available. On order. Awaiting from pharmacy. Effective Date: 01/22/2025 05:08 Type: Orders - Administration Note Note Text : Oxycodone Hydrochloride Tablet 5 milligrams Give 1 tablet by mouth every 6 hours for pain Not available. On order. Awaiting from pharmacy. Effective Date: 01/28/2025 00:13 Type: Orders - Administration Note Note Text : Lorazepam Tablet 1 MG Give 1 tablet by mouth every 8 hours for anxiety for 14 Days awaiting arrival Effective Date: 01/27/2025 14:07 Type: Orders - Administration Note Note Text : Lorazepam Tablet 1 MG (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give 1 tablet by mouth every 8 hours for anxiety for 14 Days awaiting pharmacy, script was faxed and np (Nurse Practitioner) notified and aware Effective Date: 01/27/2025 07:39 Type: Orders - Administration Note Note Text : Lorazepam Tablet 1 MG Give 1 tablet by mouth every 8 hours for anxiety for 14 Days Medication on order from pharmacy per previous nurse Effective Date: 01/26/2025 14:30 Type: Orders - Administration Note Note Text : Lorazepam Tablet 1 MG Give 1 tablet by mouth every 8 hours for anxiety for 14 Days awaiting pharmacy Effective Date: 01/26/2025 05:48 Type: Orders - Administration Note Note Text : Lorazepam Tablet 1 MG Give 1 tablet by mouth every 8 hours for anxiety for 14 Days Not available. To soon to order. On 1/29/2025 at 3:05 p.m., an interview was conducted with LPN (Licensed Practical Nurse)-E who stated the medications from the Pharmacy for each resident. The blister pack should have the medications for each scheduled dose. LPN-E stated if the medication was not available, the nurse was expected to check the Omni Cell (in house Stat box) for an available supply of the medication and to notify the Pharmacy that the medication was not available. The nurse would order the medication from the Pharmacy so it would be available for the next scheduled dose. The nurse should notify the physician that the medication was not available for administration as ordered. On 2/4/2025 at 12:50 p.m., an interview was conducted with the Director of Nursing who stated medications should be available for administration as ordered by the physician. She stated the nurses should call the Pharmacy to inform them that the medication was not available in the medication cart, order the medication, check the Omnicell and notify the physician if the medication was not available to be administered. She stated the Pharmacy delivers twice a day at the facility. She also stated the expectation was for the Pharmacy to send medications on the next delivery after notification that a medication was not available as ordered. A copy of the Omnicell contents was requested and received on 2/5/2025. Review of the Omnicell contents revealed the medication, Oxycodone 5 milligrams, was available in the inventory. There were 10 tablets usually kept in the inventory. There was no documentation that the Omnicell was checked and the supply was not available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Five doses of Lorazepam 1 milligram were not available according to the documentation in the Progress notes. Review of the Omnicell contents revealed Lorazepam 0.5 milligrams tablets were available in the Omnicell. There was documentation that one dose of the Lorazepam was given from the Omnicell on 1/15/2025 as written: Effective Date: 01/25/2025 07:18 Type: Orders - Administration Note Note Text : Lorazepam Tablet 1 MG Give 1 tablet by mouth every 8 hours for anxiety for 14 Days. Late entry- Patient received one time order from omnicell for medication until pharmacy deliver medication. During the end of day debriefing on 12/18/2024, the Facility Administrator, Regional Nurse Consultant and and Director of Nursing were informed of the findings. They stated medications should be available for administration. No further information was provided. Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide routine medications to two (2) Residents (Residents #24, and #2) in a survey sample of 63 Residents. The findings included: 1. For Resident #24 the facility staff failed to ensure that the resident received the medications and treatments as ordered by the physician. Resident #24 was admitted to the facility on [DATE] with diagnoses that include but are not limited to paranoid schizophrenia, diabetes, chronic kidney disease, mild intellectual disabilities, hypertension, hypothyroidism, bipolar disorder, major depressive disorder, severe with psychotic features, and anxiety. A review of the clinical record revealed that Resident #24 had orders that included: [NAME] Moisture Barrier Cream (Skin Protectants, Misc.) Apply to Sacrum, buttocks topically every day and evening shift for protection/prevention -Start Date- 09/29/2020 0700 -Hold Date from 01/27/2025 to 01/30/2025 Cerave Lotion with Petroleum Jelly Apply to face & bilateral legs topically two times a day for scabs/ dry skin -Start Date-03/07/2024 1700 -Hold Date from 01/27/2025 to 01/30/2025 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Eucerin Advanced Repair External Cream (Emollient) Apply to bilateral heels topically every day and evening shift for dry Heels -Start Date- 08/02/2023 0700 -Hold Date from 01/27/2025 to 01/30/2025 A review of the clinical record revealed that the above ordered creams were documented in the progress notes as unavailable or awaiting from pharmacy on the following dates: [NAME] Moisture Barrier Cream [twice daily] - 1/4, 1/10, 1/22 - 1/31 and 2/1 - 2/5/2025 Cerave Lotion with Petroleum Jelly [twice daily] - 1/10, 1/22 - 1/31 and 2/1 - 2/5/2025 Eucerin Advanced Repair External Cream [twice daily] - 1/4, 1/10, 1/22 - 1/31 and 2/1 - 2/5/2025 On 2/5/25 at approximately 3 p.m. an interview was conducted with LPN C who was asked the procedure if a medication is unavailable, she stated that they are to the physician to see if they would like to substitute it with a different med that is available, notify the family or the Resident and then change the order and document the changes. On the afternoon of 2/5/25 the DON was asked what the expectation is for nurses when medications are unavailable and she stated, The nurse should call first check the stat box, then call the pharmacy to find out what is available, and when the medication can be obtained, then call the physician and make them aware of the issue, and see if they would like to change the order, or place it on hold until the medication arrives. Then they need to put in any new orders and discontinue any old ones if they were changed, phone the pharmacy and make them aware and notify the Resident and or Responsible Party. A review of the Policy # 6.10 entitled Unavailable Medications effective date 09/2018 revised on 8/2020, read: The nursing staff shall: 1. Notify the attending physician (or on-call physician when applicable) of the situation and explain the circumstances, expected availability, and the alternative therapies available. If the facility nurse is unable to obtain a response from the attending physician or on-call physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders and or direction. 2. Obtain a new order rand cancel / discontinue the order for the non-available medications. 3. Notify the pharmacy of the replacement order. On 2/5/25 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **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 ensure Residents were free from significant medication errors for two (2) Residents (Residents #24, and #139) in a survey sample of 63 Residents. The findings included: 1. For Resident #24 the facility staff failed to ensure that the Resident received the medications and treatments as ordered by the physician. Resident #24 was admitted to the facility on [DATE] with diagnoses that include but are not limited to paranoid schizophrenia, diabetes, chronic kidney disease, mild intellectual disabilities, hypertension, hypothyroidism, bipolar disorder, major depressive disorder, severe with psychotic features, and anxiety. A review of the clinical record revealed that Resident #24 had orders that included: Lisinopril Oral Tablet 20 MG - Give 1 tablet by mouth at bedtime related to essential (primary) hypertension -Start Date- 12/30/2024 Levothyroxine 25 mcg give 1 tablet by mouth in the morning for hypothyroidism -Start Date- 08/14/2023 Lorazepam 0.5 mg tablet give 1/2 tablet by mouth two times a day related to anxiety disorder -Start Date-12/20/20 On 2/5/25 a review of the progress notes revealed that Lisinopril 20 mg was documented as unavailable for Resident #24 on 12/17/24, 12/25/24, and 12/26/24, Levothyroxine 25 mcg. was documented at unavailable 1/15/25-1/17/25, and the Lorazepam was documented as unavailable from 1/3/25-1/5/25. A review of the MAR (Medication Administration Record) for Resident #24 revealed the following blood pressures: 12/17/24 - 128/69 12/18/24 - 136/86 12/25/24 - 158/91 12/26/24 - 160/80 On 2/5/25 at approximately 3 p.m., an interview was conducted with LPN C who was asked the procedure if a medication is unavailable, she stated that they are to be reported to the physician to see if they would like to substitute it with a different med that is available, notify the family or the resident and then change the order if necessary and document the changes. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the afternoon of 2/5/25, the Director of Nursing (DON) was asked what the expectation was for nurses when medications are unavailable and she stated, The nurse should call first check the stat box, then call the pharmacy to find out what is available, and when the medication can be obtained, then call the physician and make them aware of the issue, and see if they would like to change the order, or place it on hold until the medication arrives. Then they need to put in any new orders and discontinue any old ones if they were changed, phone the pharmacy and make them aware. The Resident and or Responsible Party should be notified of any changes. On 2/4/25 a review of the stat box contents revealed that the following medications were available for administration to Resident #24: Lisinopril 10 mg tabs Levothyroxine 25 mcg tabs Lorazepam 0.5 mg tabs A review of the Policy # 6.10 entitled Unavailable Medications effective date 09/2018 revised on 8/2020, read: The nursing staff shall: 1. Notify the attending physician (or on-call physician when applicable) of the situation and explain the circumstances, expected availability, and the alternative therapies available. If the facility nurse is unable to obtain a response from the attending physician or on-call physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders and or direction. 2. Obtain a new order rand cancel / discontinue the order for the non-available medications. 3. Notify the pharmacy of the replacement order. On 2/5/25 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 2. The facility staff failed to administer Resident #139, a significant medication, Methadone for 4 days, 11/28/24, 11/29/24, 11/30/24 and 12/01/24. Resident #139 was originally admitted to the facility 11/27/24 after an acute care hospital stay. The resident had an unplanned discharged from the facility on 12/01/24. The current diagnoses included; Chronic Pain Syndrome and Unspecified Fracture of the Lower end of Left Radius, Subsequent Encounter for Closed Fracture with Routine Healing. The 5-day, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/01/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #139 cognitive abilities for daily decision making were intact. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated on 11/27/24 read that Resident #139 is at risk for complications related to the use of opioid secondary. The Goal for Resident #139 was the resident will be free from complications related to opioid use thru review period. An intervention for Resident #139 was to administer medications as needed. The November 2024 Medication Administration Record (MAR) read: Methadone HCl Oral Solution, Give 80 mg by mouth one time a day for pain. Start Date 11/28/2024 9:00 AM., Coded as 9 meaning= no explanation given in the medical record. The Pain rating/level on 11/28/24 was documented a 2 out of 10. The November MAR read: Pain evaluation every day shift every day shift for Monitoring of patient's pain level-Start Date 11/28/2024 7:00 AM- discharge date [DATE] 10:03 PM. 11/28/24 pain level =4, 11/29/24 pain level = 0, 11/30/24 pain level =0 Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for mild pain for 10 Days (11/27/2024). The Pain Level on the following dates were : 11/27=5, 11/28=4, 11/29=4, 11/30=8. The December 24 MAR read: Methadone HCl Oral Solution 10 MG/5ML Give 80 mg by mouth one time a day for pain 11/28/24 9:00 AM. Pain=NA, Coded #5=Spoke to pharmacy regarding script. A review of an admission note dated on 11/27/2024 at 3:10 PM., read: Resident arrived via EMT for admission from local hospital. Cast to left forearm due to fracture. Both heels bruised. No IV lines noted. Medications entered into system. VS taken and entered. Resident asking about her Methadone. Prescription faxed to pharmacy. Paperwork placed in Nurse Practitioner (NP) communication book. The Physician Progress note dated 11/30/24 at 8:09 AM., read She is seen today lying in bed. She reports feeling ill due to not having had her methadone today. She reports having been on methadone for 15 years after being addicted to Oxycodone following a car accident. She is followed by a treatment center. A review of nursing note dated 12/1/2024 at 2:51 PM., read: Spoke with pharmacy regarding script for methadone, pharmacy states they are unable to fill dosage that has been put on script of 1200 ml due to resident has to have methadone clinic send medication for dosing, they are only able to do three 1 x doses until they are unable to send medication again. methadone clinic called and office is closed. resident is aware. Called third eye who says they are unable to call in script and methadone clinic needs to be contacted. called Nurse Practitioner (NP), NP faxed a 1 x script over to pharmacy. Resident notified and stated she would like to leave Against Medical Advice (AMA) when her roommate comes. Spoke with resident regarding AMA and informed her of the unsafe discharge. NP/MD made aware of resident wanting to leave AMA. Resident states she will decide when her roommate comes. Script faxed over for residents' methadone. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of nursing notes on 12/1/2024 9:59 PM., read: Writer was in and spoke with resident at approximately 3:30 PM., to address any issues. Resident adamite on leaving and returning to the community. Responsible Party (RP) and NP aware of discharge. A review of nursing notes on 12/1/2024 9:09 PM., read: Resident left AMA. NP aware. Resident advised of dangers/risks to health. AMA formed and signed by resident. Took all belongings with her. Resident is own RP. A review of the Delivery Manifest showed that the Methadone was delivered to the facility on [DATE] at 12:24 AM. The Methadone was delivered one (1) day after the resident had already left the facility Against Medical Advice (AMA). On 2/05/25 at approximately 10:30 AM., a phone call was made to speak to Resident #139. The Resident's daughter/Family Member (FM) #1, said that her mother was not staying with her but gave a phone number to reach the resident after 12:00 PM., today. FM #1 said that her mother wasn't getting her Methadone. The staff informed her that her medication shipment wasn't in yet due to the holiday. On 2/05/25 at approximately 3:15 PM., a phone call was made to Resident #139. A voice message was left. On 02/05/25 at approximately 3:05 PM., an interview was conducted with the Director of Nursing (DON) concerning Resident #139. The DON said that the resident left Against Medical Advice (AMA) was advised of the safety risk on leaving AMA. The DON also said that the residents' Methadone prescription was faxed to the pharmacy, but they (facility) were waiting on pharmacy to send it. The DON also mentioned that It's never acceptable because the resident was being treated for chronic pain. The DON said that she would check to see if pharmacy received the prescription from the facility. Methadone is used to treat moderate to severe pain when around-the-clock pain relief is needed for a long period of time. This medicine should not be used to treat pain that you only have once in a while or as needed. Methadone is also used together with medical supervision and counseling to treat opioid use disorder (eg, heroin or other morphine-like drugs). Methadone belongs to the group of medicines called opioid analgesics (pain medicines). It acts on the central nervous system (CNS) to relieve pain. The use of methadone to treat opioid use disorder in the US is only available through opioid treatment programs (methadone clinics). This medicine is available only with your doctor's prescription. https://www.mayoclinic.org/drugs-supplements/methadone-oral-route/description/drg-20075806. Missed methadone doses: If one of two doses are missed the patient can be maintained on the same methadone dose. If three doses are missed the next methadone dose should be reduced by 25% to adjust for the possible reduction in tolerance. If it is well tolerated, doses can return to previous dose levels. If four doses are missed the next dose should be reduced by 50% to adjust for the potential reduction in tolerance. If the dose is well tolerated doses can be increased over several days to previous levels. If more than four doses are missed, patients should resume induction from baseline. ttps://www.ncbi.nlm.nih.gov/books/NBK143167/ On 2/05/25 at approximately 7:00 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, resident record review, the facility staff failed to obtain dental services for two (2) of 63 residents (Resident #27 and 96), in the survey sample. The findings included: 1. Resident #27 was originally admitted to the facility 01/30/2015 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included COPD and a major depressive disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/2/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #27's cognitive abilities for daily decision making were intact. On 1/28/25 at approximately 3:25 PM an interview was conducted with Resident #27. Resident #27 stated his primary concern was obtaining dentures. He further stated he had made his dental concerns known to staff but no one had followed-up with him. A review of the resident's record revealed he had seen the dentist and completed a dental assessment on 11/22/24. The recommendation was for upper full denture for mastication, and to resubmit for approval of the upper full denture. An interview was conducted with Social Services members on 2/4/25 at 1:53 PM, neither was aware that the resident's desired dental services or the information in the previous dental assessment. On 2/5/25 at approximately 12:40 PM the Social Services Director stated the dentist would be returning to the facility in March 2025 and the resident would be seen. The resident's person centered care plan had a problem dated 3/3/23 which stated (name of resident) will have consults as ordered, Dental, audiology, podiatry, optometry/ophthalmologist, psychiatry/psychology, wound, and dietary. The goal stated Resident will have consults maintained and followed as ordered through the review date, 5/3/25. The intervention stated follow consults as ordered. On 2/5/25 at approximately 4:20 PM, a final interview was conducted with the Administrator, Director of Nursing and four Corporate Consultants. The administrative team was informed of the the above information. No additional information was provided and no concerns were voiced. 2. Resident #96 was originally admitted to the facility 07/21/2023 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included traumatic subdural hemorrhage and high blood pressure. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/6/2024 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #96's cognitive abilities for daily decision making were intact. On 1/28/25 at approximately 2:50 PM an interview was conducted with Resident #96. Resident #96 stated he had dental concerns and is very self-conscious of his dental status. No documentation regarding the resident's oral status was documented in the resident's record. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The person centered care plan had a problem dated 08/09/2023 which stated the resident had oral/dental health problems related to poor oral hygiene. The goal stated The resident will comply with mouth care at least daily through review date, 2/20/25. The interventions included monitor/document/report as needed any signs/symptoms of of oral/dental problems needing attention: pain (gums, toothache, palate), abscess, debris in mouth, lips cracked or bleeding, teeth missing, loose, broken, eroded, decayed, tongue (black, coated, inflamed, white, smooth), ulcers in mouth, or lesions. An interview was conducted with Social Services members on 2/4/25 at 1:53 PM, neither was aware that the resident's desired dental services. On 2/5/25 at approximately 12:40 PM the Social Services Director stated the dentist would be returning to the facility in March 2025 and the resident was scheduled to be evaluated. On 2/5/25 at approximately 4:20 PM, a final interview was conducted with the Administrator, Director of Nursing and four Corporate Consultants. The administrative team was informed of the the above information. No additional information was provided and no concerns were voiced.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to reflect resident's cultural and ethnic needs of the resident by not providing meal preferences for one (1) of 63 residents (Resident #36), in the survey sample. The findings included: Resident #36 was originally admitted to the facility on [DATE]. The resident has never been discharged from the facility. The current diagnoses included; Magnesium and Vitamin D Deficiency. The Annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/21/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 8 out of a possible 15. This indicated Resident #36 cognitive abilities for daily decision making were moderately impaired. On 1/30/25 at approximately 12:00 PM., an interview was conducted with Resident #36. Resident #36 was asked if she had concerns with the food. The resident mentioned that she was from Ghana and would like to eat red beans and rice but it is never served to her. On 2/03/25 at approximately 3:25 PM., an interview was conducted with the dietary manager concerning Resident #36. The dietary manager said that she will try to accommodate the residents by providing food preferences but Resident #36 never said anything about the food that she was eating. The Physician's Order Summary (POS) dated 4/05/21 read: Regular diet, Regular texture, Regular/Thin consistency. Dietary profile was not completed on 4/7/2021. The Nutritional Evaluation Initial and Annual RD only, was Completed on 4/07/21. Diet History and Food Preference document was left blank. On 2/04/25 at the dietary manager approached the surveyor and resident in the dining room. The dietary manager showed the surveyor pictures of the resident eating Red Beans and [NAME] and chicken on 2/2/25. The resident said that it tasted okay, but it was the first time she received a preferenced meal since her admission. 02/05/25 10:25 AM Received dietary timeline from the Regional Nurse Consultant. The list of remote dieticians was reviewed, no gap services was noted. The care plan dated 10/23/24 for Resident #36 read that resident is at risk for alteration in nutritional status. The Goal is for the resident to maintain stable weight. The interventions for Resident #36 are to weigh the resident per protocol and to identify and honor preferences. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/04/25 at approximately 12:50 PM., a telephone interview was conducted with the dietician concerning Resident #36 cultural food preferences. The dietician said that she worked remotely as she lives in Ohio. The dietician also said that she does not review food preferences because it was the role of the dietary manager. The dietician also mentioned that she can make recommendations, but the dietary manager needed to ensure food preferences are updated. The dietician said that orders are given to the Director of Nursing (DON). The Policy Read: A Dietician is a qualified, competent, and skilled Dietician will help oversee the food and nutrition services in the facility. Specific Procedures: Developing and implementing person centered education programs involving food and nutrition services for all facility staff. On 2/05/25 at approximately 7:00 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure that a resident's lunch was palatable and attractive for one (1) of 63 residents (Resident #129), in the survey sample. The findings included: Resident #129 was originally admitted to the facility 8/20/24. The resident has never been discharged from the facility. The current diagnoses included; Unspecified Protein Calorie Malnutrition. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/23/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #129 cognitive abilities for daily decision making were intact. The care plan dated on 1/16/25 read that Resident #129 was at risk for weight loss, malnutrition or poor hydration status related to chronic disease. The goal for Resident #129 was for the resident to have optimal nutrition and hydration status. The intervention for Resident #129 was to record the meal percentage intake. The Physicians Order Summary (POS) for February 2025 read: Regular diet, Regular texture, Regular/Thin consistency for double portions as of 8/20/24. On 1/30/25 at approximately 1:15 PM., Surveyor G, entered Unit 4 with the dietary manager to sample a test tray due to facility staff saying food is cold and unpalatable. Resident #129 was heard complaining about his lunch while sitting in the dining room. This surveyor (G), assured resident that she will speak to him in shortly as she was getting ready to sample her test tray with the dietary manager present. The lunch Test Tray Meal consisted of Salsbury Steak (145 F), Mashed Pot & Gravy (150 F)., Peas (136.4 F), roll (dark brown on top, appears burnt) and a brownie. The meal presentation was good except the dark brown roll, the taste was ok. On 1/30/25 at approximately, 1:20 PM., an observation was made to Resident #129's tray. Two brown beef patties appeared dark brown around the edges, the roll was dark brown on the top, with an appearance of being burnt, peas and mashed potatoes appeared to be ok. Resident #129 asked surveyor G, You from the government? This is what they feed me; would you serve this to anybody? You got the nerve to serve this to me (looking at the dietary manager), this bread (Roll) is black, burned and I am a baker. The patties are burnt, and overly cooked. Look at this, the food is criminal here. The dietary manager offered several times to bring the resident another plate food or to fix something else, but the resident declined and said she was just upset. The resident then asked the dietary manager if she was ashamed, The food is like this all of the time. On 2/03/25 an interview was conducted with the dietary manager at approximately 3:27 PM., concerning Resident #129. The dietary manager said that the resident's food tray is checked everyday by her and or the staff to ensure the meal is okay. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/05/25 at approximately 7:00 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure the facility maintained a safe, sanitary, and comfortable environment to prevent the transmission of communicable diseases and infections for the facility in general, and for two (2) residents (Residents #3, and #130) in a survey sample of 63 residents The findings included: 1. On 1-28-25 during resident room observations, the room of Resident #3 was noted to have a sticky, tape style insect trap, hanging from the ceiling in the bathroom. The 2 inch wide by 24 inch long tape was so covered in insects that it had the appearance of fur covering it. A nurse was coming down the hall at that time and was asked to view the area. When asked if he thought it was safe and sanitary for the Resident, he stated no. Resident #3 stated yes, they have pest control bug people come and spray, however, she stated they only spray the halls, not the rooms, because they don't want to move things around in the room. During the entire survey there were fruit flies as well as large flies, and cock roaches noted on all 4 living units, and in the common areas as well. A review of the pest control logs revealed that the facility is having pest control services come to the building monthly, however, the pests continue to be in the facility. On 2-5-25 at the time of survey exit the facility Administrator, and Director of Nursing stated that pest control services had been in and treated rooms on unit #2, and that they had nothing further to provide. 2. On 1-28-25 during resident room observations, the room of Resident #130 was noted to have small red bugs on the floor under the bed of the Resident's room mate. The room mate was wearing stained dirty clothing with wet spots noted in his lap while he sat in a wheel chair. A nurse was coming down the hall at that time and was asked to view the area. When asked if he thought it was safe and sanitary for the Resident, he stated no. He further stated he would get the Maintenance Director to have pest control come and treat the room. Resident #130 also stated yes, they have pest control bug people come and spray, however, they only spray the halls, not the rooms, because they don't want to move things around in the room. During the entire survey there were fruit flies as well as large flies, and cock roaches noted on all 4 living units, and in the common areas as well. A review of the pest control logs revealed that the facility is having pest control services come to the building monthly, however, the pests continue to be in the facility. On 2-5-25 at the time of survey exit the facility Administrator, and Director of Nursing stated that pest control services had been in and treated rooms on Unit #2, and had eradicated the bed bugs in Resident #130's room, and that they had nothing further to provide. 3. The facility staff failed to prevent contamination of the clean linens in the closet on Unit Four. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at approximately 1:45 PM in the Dayroom on Unit Four Resident #21 was observed wearing urine saturated pants. The resident stated his bladder was weak and he could no longer hold his urine. He was observed opening the linen closet and obtain washcloths and towels. Also on 1/30/25 at approximately 1:55 PM in the Dayroom on Unit Four Resident #33 was observed removing linen from the linen closet. The resident stated most of the time she comes to the linen closet to obtain her needed linens. She further stated if staff is on their break when she enters the Dayroom they would obtain the linens for her. An interview was conducted with the Environmental Services Director (EVSD) on 1/31/25 at approximately 11:00 AM. The EVSD stated she was aware that some residents on Unit Four was helping themselves to the linen, but it was not preferable due to any cross contamination going in and out of the cart. He stated the linen has been assessable to the residents because the staff had misplaced the lock to the linen closet again. She stated the lock had been missing for approximately one month. The EVSD also stated the missing lock had been reported to the Maintenance Director but it had not been acted upon yet. An interview was conducted with the Maintenance Director on 2/5/25 at 12:56 PM. The Maintenance Director stated keeping a lock on the linen closet is an ongoing concern and he has purchased numerous locks and applied them but the key or the lock is soon misplaced, never to be found again. The Maintenance Director stated provided an invoice for a new lock and stated it was added to the Unit Four linen closet on 1/31/25. On 2/5/25 at approximately 4:20 PM, a final interview was conducted with the Administrator, Director of Nursing and four Corporate Consultants. The administrative team was informed of the the above information. No additional information was provided and no concerns were voiced.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, the facility staff failed to ensure rooms had visual privacy for five (5) Residents (Residents # 123, # 2, # 128, # 132 and #46) in a survey sample of 63 residents. Findings included: 1. For Resident # 123, the facility staff failed to ensure the room was equipped with curtains that would extend around the bed. Resident # 123 was admitted to the facility on [DATE] with the diagnoses of, but not limited to: Dementia with Agitation, Diabetes, Hypertension, and Legal blindness. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 1/7/2025. Resident # 123's BIMS (Brief Interview for Mental Status) Score was a 13 out of 15, indicating no cognitive impairment. Review of the clinical record was conducted on 1/28/2025 to 1/31/2025 and 2/3/2025 to 2/5/2025. On 1/29/2025 at 10:20 a.m., the surveyor observed a Certified Nursing Assistant providing ADL (Activities of Daily Living) care to Resident # 123. There was no privacy curtain around the bed. Interviews were conducted with the Director of Housekeeping who stated she had been trying to obtain replacement curtains and curtain hooks for several rooms. The Director of Housekeeping stated due to the fact that there were not enough curtains, the housekeeping staff would remove the curtains when soiled, wash them and re-hang them when taken out of the laundry. The Director of Housekeeping stated she realized the importance of the residents having privacy. On 2/4/2025 during the end of day meeting, the Administrator, Corporate Nurse Consultants and Director of Nursing were made aware of the findings. No further information was provided. 2. For Resident # 2, the facility staff failed to ensure the room was equipped with curtains that would extend around the bed. Resident # 2 was admitted on [DATE] with diagnoses including but not limited to: Epilepsy, Seizures, Confirmed Physical Abuse, Confirmed Psychological Abuse, Major Depressive Disorder, Anxiety Disorder, and Neoplasm of the Brain. Resident #2's most recent MDS (Minimum Data Set) was a Quarterly Assessment with an ARD (Assessment Reference Date) of 12/27/2024 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 13 out of 15 indicating no cognitive impairment. Review of the clinical record was conducted on 1/28/2025 to 1/31/2025 and 2/3/2025 to 2/5/2025. Observations were made of there being one quarter panel curtain suspended above Resident # 2's bed. The curtain did not extend around the bed to completely provide visual privacy while ADL care was being provided. (continued on next page)

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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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 2 had a roommate in the room. The roommate (Resident # 123) was in the room while ADL care was being provided for Resident # 2. The Certified Nursing Assistant stated she was an agency employee. The Certified Nursing Assistant stated she pulled the curtain as far as she could and tried to shield the resident while providing care. There was no privacy curtain pulled around Resident # 2's bed. The privacy curtain was a quarter panel, covering only a portion of the resident and the bed. The panel was not wide enough to cover the entire bed but only approximately one fourth of the area around the bed.o Interviews were conducted with the Director of Housekeeping who stated she had been trying to obtain replacement curtains and curtain hooks for several rooms. The Director of Housekeeping stated due to the fact that there were not enough curtains, the housekeeping staff would remove the curtains when soiled, wash them and re-hang them when taken out of the laundry. The Director of Housekeeping stated she realized the importance of the residents having privacy. On 2/4/2025 at approximately 3:24 p.m., the Housekeeping Director was observed in the hallway near Resident # 2's room. The Housekeeping Director went into the room with the surveyor. She was interviewed and stated she knew the curtain was not large enough to completely cover the bed. The Housekeeping Director stated she was trying to get more curtains for all of the rooms. On 2/4/2025 during the end of day meeting, the Administrator, Corporate Nurse Consultants and Director of Nursing were made aware of the findings. No further information was provided. 3. For Resident # 128 , the facility staff failed to ensure the room was equipped with curtains that would extend around the bed. During rounds on 2/4/2025, the surveyor observed Resident # 128 was lying in bed. Resident # 128 quickly pulled the covers up when the surveyor entered the room. Resident # 128 stated the curtains could not completely protect him when he was trying to use the urinal. He stated the curtains did not fit completely. When you pull one side, the other is exposed. Resident # 128 asked the surveyor to try to pull the curtain so he could use the urinal privately. The curtain did not fit around the bed. Resident # 128 stated he always had to make sure the door to the room was closed so he could quickly try to void before someone came into the room. Interviews were conducted with the Director of Housekeeping who stated she had been trying to obtain replacement curtains and curtain hooks for several rooms. The Director of Housekeeping stated due to the fact that there were not enough curtains, the housekeeping staff would remove the curtains when soiled, wash them and re-hang them when taken out of the laundry. The Director of Housekeeping stated she realized the importance of the residents having privacy. On 2/4/2025 during the end of day meeting, the Administrator, Corporate Nurse Consultants and Director of Nursing were made aware of the findings. No further information was provided.5. The facility staff failed to ensure that Resident # 46 had a privacy curtain large enough to maintain privacy while the resident was receiving incontinence and Activity of Daily Living (ADL) care. (continued on next page)

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	495327	A. Building B. Wing	02/05/2025

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #46 was originally admitted to the facility 1/04/22 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Chronic Kidney Disease. The annual, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/28/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #46 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities Goals) the resident was coded as requiring supervision with eating, upper body dressing, requires substantial/maximal assistance with toileting hygiene, showers/bathing, lower body dressing and personal hygiene. The care plan dated 7/11/23 read that resident has an ADL self-care performance deficit r/t Weakness, Acute Kidney Failure, history of Falling, Epilepsy and Bipolar Disorder, history of falls. The Goal is the resident will improve current level of function in through the review date (11/21/23). The intervention: Monitor/document/report as needed any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. On 01/29/25 at approximately 11:30 AM., while rounding in the hallway on unit 4, Resident #46 was heard yelling for his Certified Nurse's Assistant (CNA) B, by her first name several times. On 01/29/25 at approximately 11:39 AM., CNA B entered Resident #46 room (403B unit 4). The resident had informed her that he had a Bowel Movement (BM). After receiving permission from Resident #46 to observe his care, CNA B began incontinent and ADL care on the resident. There was a partial privacy curtain preventing the resident across from him to seeing the ADL care, the door to room [ROOM NUMBER] B was closed. Visibly from the door the resident could be seen receiving care. A timeline of events: 11:51 AM., there was a knock at the door, two staff quickly entered the room while the resident was exposed, receiving Activities of Daily Living (ADL), incontinent care. 11:54 AM., there was a knock at the door, then quickly, the door opened, entered one staff, resident still exposed, while receiving ADL care. 11:56 AM., there was a knock at the door, the Assistant Director of Nursing (ADON) quickly entered the room and said I'm just rounding. CNA B, said I'm ok. On 02/05/25 at approximately 1:56 PM., an interview was conducted with CNA F concerning the above incident. CNA F said that She shouldn't have walked into the residents' room while he was receiving care. CNA F also said that months ago that she informed a nurse that some of the rooms didn't have privacy curtains. CNA F also said that if the rooms don't have privacy curtains, she will just make sure the door is closed. On 2/03/25 at approximately 4:21 PM., an interview was conducted with the Director of Nursing (DON) concerning the privacy curtains. The DON said after knocking on a resident's closed-door staff should wait to hear what the CNA is saying first before entering. On 02/03/25 at approximately 3:19 PM., an interview was conducted with CNA B concerning Resident #46. CNA B said that no one should walk in the room while care is being provided. CNA B also said that the resident only had a portion of a privacy curtain when care was being rendered. On 2/05/25 at approximately 7:00 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided. (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. The facility failed to provide a window blind to provide full visual privacy for Resident #132 in a resident room (room [ROOM NUMBER]-Unit two (2). Resident #132 was originally admitted to the facility 9/23/24. The resident's diagnoses included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, schizoaffective disorder, and essential hypertension. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/30/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #132's cognitive abilities for daily decision making were moderately impaired. During an observation on 12/29/25 at 11:30 AM the window blind in the window of room [ROOM NUMBER] was severely damage, allowing individuals to look into the window from the outside. On 12/29/25 at 11:40 AM an interview was conducted with Licensed Practical Nurse (LPN) (E). LPN (E) stated that the window blind in room [ROOM NUMBER] should have been fixed and this is a privacy issue due to individuals being able to see in the window from the outside. During an observation on 2/3/25 at 2:15 PM the window blind in room [ROOM NUMBER] was still not repaired or replaced, continuing to allow individuals to look into the window from the outside. On 2/3/25 at 2:25 PM an interview was conducted with the Regional Director of Maintenance. The Regional Director of Maintenance stated that due to the window blind in room [ROOM NUMBER] missing slates and individuals being able to look in the room from the outside, this is a privacy issue. On 2/5/25 at 6:55 PM a final interview was conducted with the Administrator, Director of Nursing, Regional MDS, Regional Nursing Consultant, Regional Maintenance Director, [NAME] President of Clinical Services, Regional Risk Management, and Regional Director of Operations. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to maintain an effective pest control program in the rooms of Resident # 3 and #130 and throughout the entire facility. The findings include: 1. On 1-28-25 during resident room observations, the room of Resident #3 was noted to have a sticky, tape style insect trap, hanging from the ceiling in the bathroom. The 2 inch wide by 24 inch long tape was so covered in insects that it had the appearance of fur covering it. A nurse was coming down the hall at that time and was asked to view the area. When asked if he thought it was safe and sanitary for the Resident, he stated no. Resident #3 stated yes, they have pest control bug people come and spray, however, she stated they only spray the halls, not the rooms, because they don't want to move things around in the room. During the entire survey there were fruit flies as well as large flies, and cock roaches noted on all 4 living units, and in the common areas as well. A review of the pest control logs revealed that the facility is having pest control services come to the building monthly, however, the pests continue to be in the facility. On 2-5-25 at the time of survey exit the facility Administrator, and Director of Nursing stated that pest control services had been in and treated rooms on unit #2, and that they had nothing further to provide. 2. On 1-28-25 during resident room observations, the room of Resident #130 was noted to have small red bugs on the floor under the bed of the Resident's room mate. The room mate was wearing stained dirty clothing with wet spots noted in his lap while he sat in a wheel chair. A nurse was coming down the hall at that time and was asked to view the area. When asked if he thought it was safe and sanitary for the Resident, he stated no. He further stated he would get the Maintenance Director to have pest control come and treat the room. Resident #130 also stated yes, they have pest control bug people come and spray, however, they only spray the halls, not the rooms, because they don't want to move things around in the room. During the entire survey there were fruit flies as well as large flies, and cock roaches noted on all 4 living units, and in the common areas as well. A review of the pest control logs revealed that the facility is having pest control services come to the building monthly, however, the pests continue to be in the facility. On 2-5-25 at the time of survey exit the facility Administrator, and Director of Nursing stated that pest control services had been in and treated rooms on Unit #2, and had eradicated the bed bugs in Resident #130's room, and that they had nothing further to provide. 3. Throughout the facility during the course of the survey, there was evidence of live pests including cock roaches and bed bugs. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the initial tour of the facility on 1/28/2025 at 1:30 p.m., the surveyor was touring the rooms of residents on Unit 2. As the surveyor walked in the hallway in front of the nurses station, one Certified Nursing Assistant-G stopped the surveyor and said Excuse me, there is a bug on your back. He knocked the bug off of the surveyor's back and killed it once it fell on the floor. The bug was medium brown in color (cock roach) and approximately an inch long. The surveyor thanked the Certified Nursing Assistant for observing and removing the bug. The surveyor asked if that was a frequent problem in the facility. Certified Nursing Assistant-G stated, yes. There were residents standing in the hallway and in the doorways of their rooms. One Resident, who was standing in the doorway of the room that the surveyor was about to enter, laughed and stated there were lots of bugs in the facility. The Resident stated, bugs are everywhere. During the Resident Council meeting conducted on 1/29/2025, residents complained about roaches in the facility. There were more than four staff members at the nurses station and in the hallway. When the surveyor asked if they saw bugs in the facility, the staff members stated there were bugs seen in the facility. Throughout the days of survey, flying and crawling bugs were observed in several areas of the facility including residents' rooms, in hallways, in shower rooms, on the elevator and in the stairwell. The Maintenance Director stated (the following day after the observation of the bed bugs) that We had the pest control company come in and erradicate the bed bugs. During the end of day debriefings on 2/3/2025 and 2/4/2025, the Administrator, Director of Nursing and Corporate Consultants were informed of the findings. No further information was provided.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and staff interview, the facility failed to ensure the required in-service training for nurses' aides be sufficient and no less than 12 hours per year for 4 of 6 Certified Nursing Assistant's (CNA's) reviewed during the survey. The findings included: An interview was conducted on 2/5/25 at 11:35 AM with the Human Resources Manager. The Human Resources Manager stated that the required 12 hours of nurses' aide training was not completed for CNA(C), CNA(D), and CNA(E). The Human Resources Manager also stated that the facility has not had a full-time Human Resources Manager, and she works at various facilities and has been filling in at the position until the facility hires a new Human Resources Manager. A review of the facility's records revealed that CNA(C), CNA(D), and CNA(E) did not complete the required 12 hours per year of in-service training for nurses' aides. On 2/5/25 at 6:55 PM a final interview was conducted with the Administrator, Director of Nursing, Regional MDS, Regional Nursing Consultant, Regional Maintenance Director, [NAME] President of Clinical Services, Regional Risk Management, and Regional Director of Operations. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.