STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Ridge Rehab Center	5872 Hanks Street Dublin, VA 24084

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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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, resident interview, staff interview, and facility document review, the facility staff failed to meet the daily nutritional and dietary needs of all residents that receive nutrition by oral means and the facility staff failed to maintain an overall system to manage and execute its food and nutritional services during a lapse in food service management. The findings included:Tray line was observed on 2/25/26 at 11:45 AM. The menu consisted of Swedish meatballs, egg noodles, and pacific blend vegetables. During observations of the tray-line, no special diets were noted to be called out other than regular diets, ground consistencies, and/or puree consistencies. When asked why no carbohydrate-controlled diets had been called out, other staff #1 stated, they only have one resident on a carb-controlled diet and that resident's spouse calls the kitchen to determine the resident's meal choice for that service. When asked who was cooking the evening meal, other staff #2 stated either the administrator or the human resource director, as they did not have another cook and the administrator and human resource director had been cooking since the dietary manager and other dietary staff had quit. On 2/25/26 at 12:38 PM, the registered dietician (RD) was interviewed about a carb-controlled diet for Resident #126 and informed the resident's tray ticket stated CCD (carbohydrate-controlled diet) but a medical provider order was for a regular diet. The RD was also asked about special dietary needs and/or diet orders other than regular diets. The RD stated they would do an audit and provide the audit with any corrections. On 2/25/26 at approximately 1:12 PM, the administrator stated that the human resource director had a ServSafe certification. On 2/25/26 at 1:19 PM, the administrator stated a fill-in cook was coming from within the company to prepare the dinner meal and the cook had a ServSafe certification. The administrator was asked to provide the certification. These concerns were discussed at the end of day meeting on 2/25/26 at 3:05 PM with the administrator, director of nursing, regional director of clinical services, unit manager #1, unit manager #2, unit manager #3, and assistant director of nursing. The RD provided the diet audit and stated there were 2 errors and the tray ticket system was updated. A review of the diet audit disclosed that 34 residents had a medical provider order for consistent carbohydrate diets and one resident had a medical provider order for a renal diet. On 2/25/26 at 4:13 PM, the administrator provided a ServSafe certification for the fill-in cook that was to prepare the evening meal. No further information was provided to the survey team prior to exit on 2/26/26.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview, and facility document review, the facility staff failed to prepare, store, distribute, and serve food in accordance with professional standards for food service safety in the facility kitchen and in 4 of 4 unit pantries/nutrition rooms.The findings included:For the facility, the facility staff failed to discard out-of-date food items, failed to date and label perishable food items, failed to maintain clean dietary equipment, failed to store food under sanitary conditions, failed to utilize hair and beard restraints for dietary personnel, and failed to practice proper hand hygiene.An initial tour of the kitchen on 2/24/2026 at 10:51 AM was completed with the Registered Dietician (RD).Observation of the dry storage area revealed the following items:7 boxes of Quaker barley with a best by (BB) date of 8/30/251 large bag of Hershey's chocolate chips with a BB date of 9/3/25 that was open to air and not sealed1 bag of French-fried onions with a BB date of 12/16/241 large bag of graham cracker crumbs open to air and not sealed5 boxes of thickened sweet tea lemon flavor with a BB date of 1/28/266 boxes of thickened sweet tea lemon flavor with a BB date of 2/19/261 box of thickened apple juice with a BB date of 1/26/261 open container of Folgers coffee without an open date1 container of ground oregano with a BB date of 8/26/25 The RD was made aware of the items and removed them. On 2/24/26 at 11:20 AM, the walk-in refrigerator was observed.The following observations were made in the walk-in refrigerator:1 pan of prepared food in a deep tray was resting on a plastic crate on the floor without a label or date. A large silver tray was observed to have several dried brown liquid spots and multiple pieces of dried, loose, shredded cheese resting on the bottom of the tray. The tray contained the following items: 1 large ziplock bag of cubed ham without a label or date1 small ziplock bag of small dices of ham and 1 slice of ham without a label or date.2 chef salads in Styrofoam containers1 ziplock with a slab of ham1 ziploc bag of coleslaw1 bag of shredded mozzarella cheese3 containers of salad that were not labeled Continued observations of the walk-in refrigerator revealed: 4 meat and cheese sandwiches in ziploc bags without dates were noted on top of the second shelf on the right1 covered container of yellow cheese slices labeled Use by 2/16/26 was observed to have multiple brown crumbs on the cheese and in the bottom of the container2 large, uncovered trays of prepared crumbled cake-like white food with a red sauce were resting on a tray rack towards the back of the refrigerator45 uncovered plastic Jell-O cups without dates or lids18 covered cups of pudding without dates1 box on the bottom shelf on the left-side contained 2 large rounds of ground beef with use or freeze by dates 2/19/261 box containing (2) smoked turkey meat was noted to be sitting on a box fresh apples2 large trays of turkey sandwiches without a label The RD was made aware and removed the items.Other staff #2 was interviewed and reported that cooks are trained on first in - first out when stock comes in and that things have been getting missed for about 2 weeks since they lost most of their staff.On 2/25/26 at 12:00 PM, other staff #4 (OS#4), other staff #5 (OS#5), and other staff #6 (OS#6) entered the facility kitchen to begin their scheduled shift and proceeded to the hand-washing sink. None of the dietary employees wore a hair restraint. OS#6 had visible facial hair and a beard net was not visible.When asked about the protocol for hair restraints and beard nets, OS#4 stated there are no hair restraints outside of the kitchen door for them to use. OS#5 stated this is how they have been entering the kitchen. OS#6 stated he was never educated on hair nets or beard restraints and he had started in the kitchen in February 2026.On 2/25/26 at 12:06 PM, the regional director of dining services (RDDS) stated he was going to put in a work order to have a holder for hair and beard restraints to be provided outside of the facility kitchen entrance for the dietary employees to utilize prior to entering the facility kitchen. RDDS also stated he would provide education for the dietary staff, as they had not had a dietary manager for a few weeks.On 2/25/26 at 12:14 PM, other staff #2 (OS#2) who was the cook, was observed to put oven mitts over her gloves to remove a pan of egg noodles from the steamer to add to the serving station. OS#2 replaced the pan of egg noodles and then removed the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	oven mitts. The RDDS reminded OS#2 to change gloves. OS#2 was not observed to practice hand hygiene and put on new gloves.On 2/25/26 at 12:26 PM, OS#2 was observed to take a break for a drink of water. OS#2 changed gloves and did not practice hand hygiene. The RDDS asked OS#2 to wash hands and OS#2 washed her hands and put on new gloves.On 2/25/26 at 12:44 PM, OS#2 was observed to put oven mitts over her gloves to add more egg noodles to the serving station. OS#2 removed the oven mitts and changed gloves but did not practice hand hygiene.These concerns were discussed at the end of day meeting on 2/25/26 at 3:05 PM with the administrator, director of nursing, regional director of clinical services, unit manager #1, unit manager #2, unit manager #3, and assistant director of nursing.On 02/26/2026 at 8:30 AM, the D-Wing nutrition room was observed to contain the following items in the refrigerator:5 half meat and cheese sandwiches in individual baggies without dates or labels21 various food items in styrofoam bowls with lids without dates or labels5 various food items in styrofoam bowls with lids without dates or labels2 cups of covered puddings without datesCertified nursing assistant #6 made aware and disposed of items.On 02/26/2026 at 8:40 AM, the B-Wing nutrition room was observed to contain the following items:The sink was covered and out of order1 large tub of peanut butter with a BB date of 1/19/26 without an open date1 small tub of peanut butter without an open dateMultiple dried, red liquid splatters on the shelves and bottom of refrigerator were noted. Certified nursing assistant #7 made aware and disposed of items and stated that they would clean the refrigerator.On 02/26/2026 at 8:45 AM, the C-Wing nutrition room was observed to contain the following items in the refrigerator:15 food items in styrofoam bowls with lids without a date or label7 covered pudding bowls without a date1 box of thickened apple juice with a BB date of 1/27/264 half meat and cheese sandwiches in baggies were observed in the bottom drawer without dates or labelsThe freezer was observed to contain a box of Outshine Bars with a BB date of 3/31/25 with a resident's name on the box. An observation of the food cabinet revealed the following items: 1 large tub of peanut butter with a BB date of 1/19/261 container of homestyle chicken noodle soup with a BB date of 12/3/251 opened jug of Hawaiian Punch Berry Blue Typhoon Juice without an open date1 opened two liter of Dr Thunder soda labeled residents without an open date1 bottle of yellow mustard with a BB date of 7/11/251 opened container of instant coffee without an open date1 container of Folgers decaf coffee without an open date On 02/26/2026 at 8:46 AM, the A Wing nutrition room was observed to contain the following items:1 Apple pie on top of the refrigerator without a date1 dirty storage container on top of the refrigerator1 opened jar of peanut butter in the cabinet without an open date Registered nurse #1 (RN#1) made aware and stated that the apple pie was given to employees yesterday and was not for residents. RN#1 stated the dirty storage container most likely belonged to a staff member.On 2/26/2026 at 9:06 AM, licensed practical nurse #8 (LPN#8) was interviewed and stated the kitchen staff are supposed to bring carts of snacks to stock the pantries, but they do not do this very often.Requested and received a facility policy titled Food Storage which read in part, .7. All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods. A. Old stock is always used first (first in - first out method.).b. food should be dated as it is placed on the shelves.Date marking should be visible on all high-risk food to indicate the date by which a ready to eat.food should be consumed.or discarded.8. Plastic containers with tight fitting covers or sealable plastic bags must be used for storing.opened packages. All containers or storage bins must be legible and accurately labeled and dated.13. Refrigerated food storage.f. all foods should be covered, labeled and dated and routinely monitored to assure that foods.will be consumed by their use by dates, or frozen or discarded.Requested and received a facility policy titled Food Safety and Sanitation which read in part, .2. Employees.c. Employees.Hair restraints are required and should cover all hair on the head. [NAME] nets are required when facial hair is visible.No further information was provided to the survey team prior to exit on 2/26/26.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide and/or review a baseline care plan (BCP) for 5 of 25 residents, Residents #6, #2, #13, #126, and #134 and failed to complete a BCP for 1 of 25 residents, Resident #84. The findings included:1. For Resident #6, the facility staff failed to provide the resident with a copy of their BCP. Resident #6's clinical record listed the resident as being their own responsible party. Diagnoses included sepsis and chronic pulmonary edema. Section C (cognitive patterns) of Resident #6's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/30/26 included a brief interview for mental status (BIMS) score of 8, indicating Resident #6 was moderately impaired in cognitive skills for daily decision making. During the clinical record review, the surveyor was unable to find evidence that Resident #6 was provided with a copy of their BCP. On 02/25/26 at 5:10 p.m., during an interview with Licensed Practical Nurse (LPN) #5 this nurse stated Resident #6's BCP was initiated on 01/27/26 and she had no proof anyone was provided with a copy. LPN #5 stated Resident #6's admission collection tool was closed, and she had no idea why. On 02/26/2026 at 2:55 p.m., Resident #6 was asked if the facility staff provided him with a copy of his BCP. Resident #6 stated not that I am aware of. On 02/26/26 at 3:40 p.m., during a meeting with the Administrator, Director of Nursing, Nurse Consultants #1 and #2, Assistant Director of Nursing, and Licensed Practical Nurses #8 and #9 the issue regarding the BCP not being provided to Resident #6 was reviewed. No further information regarding this issue was provided prior to the exit conference. 2. For Resident #2 the facility staff failed to provide the resident and/or resident representative with a summary and/or copy of a baseline care plan that was effective on 2/20/26. Resident #2's diagnosis list indicated diagnoses that included, but were not limited to, acute on chronic respiratory failure with hypoxia, atrial fibrillation, congestive heart failure, anxiety disorder, depression, intervertebral disc degeneration-lumbar region, obsessive-compulsive personality disorder, and chronic obstructive pulmonary disease. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 1/27/26 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities indicating the resident was cognitively intact. On 2/24/26 at 2:39 PM, during an interview with Resident #2, the resident did not recall getting a copy of the baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #2's clinical record disclosed an admission Nursing Collection Tool dated 2/20/26. In Section Q Baseline Care Plan, section c. read in part, .Copy of baseline care plan and copy of medications have been given to the resident and/or responsible party. This section was not marked as being completed and was blank. This concern was discussed at the pre-exit meeting on 1/26/26 at 4:30 PM with the administrator, director of nursing, regional director of clinical services #1, regional director of clinical services #2, unit manager #1, assistant director of nursing, and unit manager #2. Requested and received a facility policy titled, Baseline Care Plans which read in part, .4. The resident and their representative will be provided with a summary of the baseline care plan. No further information was provided to the survey team prior to exit on 2/26/26. 3. For Resident #13 the facility staff failed to review the baseline care plan with the resident and/or resident representative and the facility staff failed to provide the resident and/or resident representative with a summary and/or copy of a baseline care plan that was effective on 1/28/26. Resident #13's diagnosis list indicated diagnoses that included, but were not limited to, psoas muscle abscess, sepsis due to streptococcus, atrial fibrillation, chronic kidney disease-stage 3, infrarenal abdominal aortic aneurysm, muscle weakness, and malnutrition. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 1/31/26, assigned the resident a brief interview for mental status (BIMS) summary score of 8 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A review of Resident #13's clinical record disclosed an admission Nursing Collection Tool dated 1/28/26. In Section Q Baseline Care Plan, section b. read in part, .Baseline care plan has been reviewed with resident and/or responsible party. and section c. read in part, .Copy of baseline care plan and copy of medications have been given to the resident and/or responsible party. These sections were not marked as completed and were blank. This concern was discussed at the end of day meeting on 2/25/26 at 3:05 PM with the administrator, director of nursing, regional director of clinical services, unit manager #1, unit manager #2, unit manager #3, and assistant director of nursing. Requested and received a facility policy titled, Baseline Care Plans which read in part, .4. The resident and their representative will be provided with a summary of the baseline care plan. No further information was provided to the survey team prior to exit on 2/26/26. 4. For Resident #126, the facility staff failed to review the baseline care plan with the resident and/or resident representative and the facility staff failed to provide the resident and/or resident representative with a summary and/or copy of a baseline care plan that was effective on 2/5/26. Resident #126's diagnosis list indicated diagnoses that included, but were not limited to, surgical aftercare following surgery on the circulatory system, infection and inflammatory reaction due to cardiac valve prosthesis, presence of prosthetic heart valve, diabetes mellitus with hyperglycemia, chronic kidney disease, gastroparesis, and pleural effusion. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 2/9/26, assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. On 2/24/26 at 12:54 PM, Resident #126 and [family member #1] were interviewed. Both concluded that 2-3 days after the resident's admission the social worker and physical therapist met with them and [family member #1] stated they gave these two facility staff members a list of goals. Resident #126 and [family member #1] stated the physical therapist and the social worker did not give them a copy of a baseline care plan. A review of Resident #126's clinical record disclosed an admission Nursing Collection Tool dated 2/5/26. In Section Q Baseline Care Plan, section b. read in part, .Baseline care plan has been reviewed with resident and/or responsible party. and section c. read in part, .Copy of baseline care plan and copy of medications have been given to the resident and/or responsible party. These sections were not marked as completed and were blank. This concern was discussed at the end of day meeting on 2/25/26 at 3:05 PM with the administrator, director of nursing, regional director of clinical services, unit manager #1, unit manager #2, unit manager #3, and assistant director of nursing. Requested and received a facility policy titled, Baseline Care Plans which read in part, .4. The resident and their representative will be provided with a summary of the baseline care plan. No further information was provided to the survey team prior to exit on 2/26/26. 5. For Resident #134, the facility staff failed to review the baseline care plan with the resident and/or resident representative and the facility staff failed to provide the resident and/or resident representative with a summary and/or copy of a baseline care plan that was effective on 2/20/26. Resident #134's diagnosis list indicated diagnoses that included, but were not limited to, wedge compression fracture of first lumbar vertebra, displaced intertrochanteric fracture of right femur, congestive heart failure, chronic kidney disease-stage 3, atrial fibrillation, osteoarthritis, spondylosis of lumbar region, and muscle weakness. Resident #134's admission minimum data set (MDS) had not been completed during the time of the survey. A review of the resident's brief interview for mental status (BIMS) dated 2/24/26, disclosed a summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. On 2/24/26 at 12:33 PM, during an interview with Resident #134, the resident stated that facility staff had not reviewed or given a copy of a baseline care plan to the resident and/or the resident's representative. [Family member #2] stated some type of orientation would have been nice. On 2/25/26 at 5:01 PM, licensed practical nurse #5 (LPN#5) reviewed an admission Nursing Collection Tool dated 2/20/26 on the electronic clinical record. LPN#5 agreed Section Q-Baseline Care Plan containing section b. which read in part, .Baseline care plan has been reviewed with resident and/or responsible party. and section c. which read in part, .Copy of baseline care plan and copy of medications have been given to the resident and/or responsible party. were not completed and were blank. LPN#5 agreed the baseline care plan was not reviewed with, nor provided to the resident and/or the resident's representative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This concern was discussed at the pre-exit meeting on 1/26/26 at 4:30 PM with the administrator, director of nursing, regional director of clinical services #1, regional director of clinical services #2, unit manager #1, assistant director of nursing, and unit manager #2. Requested and received a facility policy titled, Baseline Care Plans which read in part, .4. The resident and their representative will be provided with a summary of the baseline care plan. No further information was provided to the survey team prior to exit on 2/26/26. 6. For Resident #84, the facility staff failed to develop a baseline care plan. Resident #84's diagnosis list indicated diagnoses that included, but were not limited to, chronic respiratory failure with hypoxia, atherosclerotic heart disease, history of transient ischemic attack, congestive heart failure, chronic obstructive pulmonary disease, morbid obesity, bilateral primary osteoarthritis of hips, shortness of breath, and muscle weakness. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 2/4/26 assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 for cognitive abilities indicating the resident was severely impaired in cognition. On 2/24/26 at 2:15 PM, Resident #84 was interviewed and did not recall reviewing and/or receiving a copy of a baseline care plan. A review of Resident #84's clinical record did not disclose any evidence of an admission Nursing Collection Tool that would include a baseline care plan. This concern was discussed at the pre-exit meeting on 1/26/26 at 4:30 PM with the administrator, director of nursing, regional director of clinical services #1, regional director of clinical services #2, unit manager #1, assistant director of nursing, and unit manager #2. Requested and received a facility policy titled, Baseline Care Plans which read in part, .Procedures.1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission.4. The resident and their representative will be provided with a summary of the baseline care plan. No further information was provided to the survey team prior to exit on 2/26/26.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to include the resident and/or resident representative in reviews and/or revisions of the comprehensive person-centered care plan for (1) one of (25) twenty-five sample residents, Resident #50 and the facility staff failed to develop and implement a comprehensive person-centered care plan for (3) three of (25) sampled residents, Resident #116, Resident #11, and Resident #32. The findings included: 1. For Resident #50 the facility staff failed to include the resident and/or resident representative in reviews and/or revisions of the comprehensive person-centered care plan. Resident #50's diagnosis list indicated diagnoses that included, but were not limited to, depression, obstructive and reflux uropathy, chronic obstructive pulmonary disease, cardiomegaly, tachycardia, metabolic encephalopathy, weakness, and chronic respiratory failure with hypoxia. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 2/14/26 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities indicating the resident was cognitively intact. On 2/25/26 at 9:29 AM, during an interview with Resident #50, the resident could not recall being invited to care plan meetings. A review of Resident #50's clinical record did not disclose any evidence of the resident and/or resident's representative being invited to participate in care plan reviews. This concern was discussed at the end of day meeting on 2/25/26 at 3:05 PM with the administrator, director of nursing, regional director of clinical services, unit manager #1, unit manager #2, unit manager #3, and assistant director of nursing. On 2/26/26 at 11:03 AM, social worker #2 (SW#2) was interviewed and stated a care plan meeting had been scheduled for 3/3/26 with Resident #50. SW#2 agreed there was no evidence Resident #50 had been invited to attend a care plan meeting and stated the last documented evidence of the resident being invited to a care plan meeting was in May 2025. A review of a social services progress note dated 2/26/26 read in part, .Care Plan meeting scheduled for 3/3 (3/3/26) at 3:00 (3:00 PM) with resident and [family member relationship identification omitted]. Requested and received a facility policy titled, Care Planning – Comprehensive Person-Centered which read in part, .POLICY.To the extent practicable, the resident/resident representative will be provided with opportunities to participate in the care planning process.PROCEDURES.6. The resident/representative [s] is encouraged to participate in the development of and revisions to the resident's care plan.7. The resident/resident representative will be encouraged to: i. Participate in establishing the expected goals and outcomes of care.ii. Participate in the care planning process.10. Every effort will be made to schedule care plan discussions at the best time of the day for the resident/resident representative. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided to the survey team prior to exit on 1/26/26. 2. For Resident #116 the facility staff failed to develop and implement a care plan for self-administration of medications. Resident #116's clinical record listed diagnoses which included but not limited to respiratory conditions due to unspecified external agent. Resident #116's most recent minimum data set with an assessment reference date of 11/24/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #116's clinical record was reviewed and contained a physician's order summary which read in part, May keep Flonase and Chloroseptic at bedside. Resident #116's comprehensive care plan was reviewed, and no self-administration of medications care plan was located. Resident #116 was interviewed on 02/26/26 at 10:40 am and stated that she keeps her Flonase and Chloraseptic in the top drawer of her nightstand. Requested and was provided with a facility policy entitled, Care-Planning-Comprehensive and Person-Centered which read in part, A person-centered comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs shall be developed for each resident. 2. The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process. The concern of not developing and implementing a care plan for self-administration of medications for Resident #116 was discussed with the administrator, Director of Nursing (DON), assistant DON, regional director of clinical services, two (2) unit managers on 02/26/26 at 4:30 pm. No further information was provided prior to exit. 3. For Resident #11, the facility staff failed to develop a comprehensive care plan (CCP) for post-traumatic stress disorder (PTSD). Resident #11's diagnoses included PTSD, anxiety disorder, and depression. Section C (cognitive patterns) of Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/09/26 included a brief interview for mental status (BIMS) score of 14, indicating Resident #11 was cognitively intact. A review of Resident #11's CCP revealed the facility staff had failed to develop a focus area for the diagnosis of PTSD. On 02/25/2026 at 11:42 a.m., Licensed Practical Nurse (LPN) #5 was interviewed regarding PTSD not being included on Resident #11's CCP. LPN #5 referred the surveyor to the social services (continued on next page)

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Highland Ridge Rehab Center	5872 Hanks Street Dublin, VA 24084

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	department. On 02/25/2026 at 11:57 a.m., during an interview with the Assistant Social Worker this staff stated PTSD should have been on Resident #11's CCP. On 02/26/26 at 3:40 p.m., during a meeting with the Administrator, Director of Nursing, Nurse Consultants #1 and #2, Assistant Director of Nursing and Licensed Practical Nurses #8 and #9 the issue with the CCP not including PTSD was reviewed. Prior to the exit conference the facility staff provided the surveyor with an updated CCP that included PTSD. No further information regarding this issue was provided prior to the exit conference. 4. For Resident #32, the facility staff failed to develop a comprehensive care plan (CCP) for self-administration of medications. Resident #32's diagnoses included acute and chronic respiratory failure, chronic diastolic congestive heart failure, and diabetes. Section C (cognitive patterns) of Resident #32's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/06/26 included a brief interview for mental status (BIMS) score of 12 out of a possible 15 points, indicating Resident #32 was moderately impaired in cognitive skills for daily decision making. On 02/24/26 at 12:35 p.m., during an interview with Resident #32 an observation was made of a bottle of Systane eye drops on the top of Resident #32's over the bed table. Resident #32's clinical record included a provider order dated 10/22/25 for Systane eye drops instill one drop in both eyes two times a day for dry eye may leave at bedside. The surveyor was unable to find any evidence that the resident had been assessed for self-administration of medications or that this had been included in their CCP. No further information regarding this issue was provided prior to the exit conference.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide activities of daily living care for 7 of 25 resident's, Resident #6, #84, #42, #51, #62, #67, and #116.The findings included:1. For Resident #6, the facility staff failed to provide nail care. Resident #6 was observed to have long, jagged fingernails with debris present under the nails. Resident #6's diagnoses included sepsis, and chronic pulmonary edema. Section C (cognitive patterns) of Resident #6's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/30/26 included a brief interview for mental status (BIMS) score of 8, indicating Resident #6 was moderately impaired in cognitive skills for daily decision making. Section GG (functional abilities) was coded to indicate this resident required substantial/maximal assistance for personal hygiene. Resident #6's comprehensive care plan included the intervention remind the resident to use their call light to ask for assistance with activities of daily living. On 02/24/26 at 12:21 p.m., during an interview with Resident #6 their fingernails were observed to be long, jagged, with debris present. Resident #6 stated he did not like them that long and he had asked the staff to cut them and they said they would, but that time never comes. On 02/25/2026 at 8:45 a.m., Resident #6's fingernails were observed to be long with debris present under the nails. On 02/25/26 at 3:05 p.m., during an end of the day meeting with the Administrator, Director of Nursing, Regional Nurse, Assistant Director of Nursing (ADON), and Licensed Practical Nurses #7, #8, and #9 the issue regarding resident #6's nail care was reviewed. On 02/25/26 at 4:56 p.m., the ADON documented Nails trimmed and cleaned by ADON, per rsd [resident] request. On 02/25/26 the facility staff provided the survey team with a copy of their policy titled, Fingernails/Toenails. This policy read in part, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections .Nail care includes daily cleaning and regular trimming . On 02/26/2026 at 2:55 p.m., during an interview with Resident #6 this resident stated the facility staff had trimmed their nails. No further information regarding this issue was provided prior to the exit conference. 2. For Resident #84, the facility staff failed to ensure the resident was offered a shower and/or full bath at least twice per week. Resident #84's diagnosis list indicated diagnoses that included, but were not limited to, chronic respiratory failure with hypoxia, atherosclerotic heart disease, history of transient ischemic attack, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	congestive heart failure, chronic obstructive pulmonary disease, morbid obesity, bilateral primary osteoarthritis of hips, shortness of breath, and muscle weakness. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 2/4/26 assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 for cognitive abilities indicating the resident was severely impaired in cognition. On 2/24/26 at 2:15 PM during an interview with Resident #84, the resident stated they missed their shower yesterday (2/23/26) due to having a room change and they would like to have a shower. A review of Resident #84's comprehensive person-centered care plan disclosed a focus which read in part, .Personal Hygiene.the resident requires assistance with their.personal hygiene. An intervention associated with the focus read in part, .Provide assistance with personal hygiene and grooming as needed. On 2/24/26 at 3:51 PM, licensed practical nurse #9 (LPN#9) was interviewed. LPN#9 was informed Resident #84 did not receive a shower on 2/23/26 and wanted a shower. LPN#9 stated they would take care of this. On 2/25/26 at approximately 9:30 AM, LPN#9 stated Resident #84 received a shower yesterday (2/24/26). Requested and received shower/bathing records for Resident #84. Resident #84 was admitted to the facility on [DATE]. A review of the shower/bathing records disclosed the resident received a shower on 2/12/26 and 2/24/26. The shower records contained no indications of refusals of showers, receiving bed baths, or receiving partial bed baths. On 2/26/26 at 2:35 PM, LPN#9 provided an email dated 2/26/26 from certified nursing assistant #5 (CNA#5) which read in part, .I forgot to document bath for [Resident #84] on 2/4/26 and 2/14/26.I had asked her a couple of those days and she stated she didn't feel up to it. It was usual for her to refuse to get in the shower at that point, so when taking her to the bedside commode, I'd wipe her down with a wet soapy rag.I tried to get her a little freshened up, even if it isn't a full shower.charting last minute baths slip {sic} my mind. This concern was discussed at the pre-exit meeting on 1/26/26 at 4:30 PM with the administrator, director of nursing, regional director of clinical services #1, regional director of clinical services #2, unit manager #1, assistant director of nursing, and unit manager #2. Requested and received a facility policy titled, Shower/Tub Bath which read in part, .Procedures.1. Qualified nursing staff will provide a bed bath to the resident as needed. At a minimum, the resident will be offered at least 2 full baths or showers per week.Documentation – 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath.5. If the resident refused the shower/tub bath, the reason(s) why and interventions taken.Reporting – 1. Notify the licensed nurse if the resident refuses the shower/tub bath. No further information was provided to the survey team prior to exit on 2/26/26. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. For Resident #42 the facility staff failed to provide nail care and showers. Resident #42's clinical record listed diagnoses which included but not limited to need for assistance with personal care. Resident #42's most recent minimum data set with an assessment reference date of 02/03/26 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section GG, functional abilities, coded the resident as needing substantial/maximal assistance with shower/bathe self, and as needing partial/moderate assistance with personal hygiene. Resident #42's comprehensive care plan was reviewed and contained a plan for Personal Hygiene/Dental: the resident requires assistance with their dental care and personal hygiene. Interventions for this care plan include Provide assistance with personal hygiene and grooming as needed. Resident #42 was interviewed on 02/24/26 at 4:40 pm. Resident stated she doesn't get her showers on time, sometimes doesn't get one for a week at a time. Resident stated, Not getting a shower aggravates me, I like to be clean. They have a shower girl here, but they use her for other things so she don't get to our showers. Resident's toenails were observed to be long and curling over the end of her toes. Resident stated, My toenails need to be cut now, but that doesn't bother me as much as not getting a shower. During an end of day meeting on 02/25/26 at 3:05 pm, director of nursing (DON) was asked who is responsible for nail care, and DON responded the assistant director of nursing. On 02/26/26 at 9:10 am, DON was again asked who is responsible for providing toenail care, and DON stated the certified nurse's aide's or shower team can clean and file, nurse's do the trimming. DON was asked how often this should be done, and DON stated nails should be cleaned and filed with every shower and trimmed as needed. Requested and provided with Resident #42's shower/bath records for the months of January and February 2026. These records indicated that the resident had received three showers and one bed bath in January, and three showers and three bed baths in February. Shower records indicate that resident went from 01/26/26 until 02/12/26 without a full shower. During this time, records indicate that resident received two bed baths. Requested and was provided with facility policies entitled Shower/Tub Bath and Fingernails/Toenails. The shower policy read in part, 1. Qualified nursing staff will provide a bed bath to the resident as needed. At a minimum, the resident will be offered at least 2 full baths or showers per week. The fingernail/toenail policy read in part, The purpose of this procedure are to clean the nail bed, to keep the nails trimmed, and to prevent infections. 1. Routine nail care may be performed by nursing staff and/or qualified activity team members. 3. Nail care includes daily cleaning and regular trimming. The concern of not providing showers and nail care for Resident #42 was discussed with the administrator, DON, assistant DON, regional director of clinical services and two (2) unit managers on 02/26/26 at 4:30 pm. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit. 4. For Resident #51 the facility staff failed to provide nail care. Resident #51's clinical record listed diagnoses which included but not limited to type 2 diabetes mellitus without complications and need for assistance with personal care. Resident #51's most recent minimum data set with an assessment reference date of 12/18/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #51's comprehensive care plan was reviewed and contained a plan for Maintenance: the resident is a long-term care and requires assistance with their ADL's (activities of daily living) related to CVA (cerebrovascular accident) with left sided weakness. Resident #51 was interviewed on 02/25/26 at 1:30 pm. Resident stated that podiatry hasn't been in since June of 2025. Resident's toenails observed to be long. Resident stated that her mother will trim her toenails when she visits. Resident stated, My toenails sometimes start cutting into the toe next to them. During an end of day meeting on 02/25/26 at 3:05 pm, director of nursing (DON) was asked who is responsible for nail care, and DON responded the assistant director of nursing. On 02/26/26 at 9:10 am, DON was again asked who is responsible for providing toenail care, and DON stated the certified nurse's aide's or shower team can clean and file, nurse's do the trimming. DON was asked how often this should be done, and DON stated nails should be cleaned and filed with every shower and trimmed as needed. Requested and was provided with a facility policy entitled Fingernails/Toenails which read in part, The purpose of this procedure are to clean the nail bed, to keep the nails trimmed, and to prevent infections. 1. Routine nail care may be performed by nursing staff and/or qualified activity team members. 3. Nail care includes daily cleaning and regular trimming. The concern of not providing showers and nail care for Resident #51 was discussed with the administrator, DON, assistant DON, regional director of clinical services and two (2) unit managers on 02/26/26 at 4:30 pm. No further information was provided prior to exit. 5. For Resident #62 the facility staff failed to provide nail care. Resident #62's clinical record listed diagnoses which included but not limited to unspecified dementia. Resident #62's most recent minimum data set with an assessment reference date of 12/30/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #62's comprehensive care plan was reviewed and contained a plan for Personal Hygiene/Dental: the resident requires assistance with their dental care and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions for this plan include Provide assistance with personal hygiene and grooming as needed. Resident #62 was observed at the nurse's station on 02/25/26 at 8:00 am. Resident was asking about having her toenails trimmed, stating they were long and hurting her. Resident's toenails were observed on 02/25/26 at 1:15 pm. Resident's nails were observed to be long, thick and ragged. Resident #62 stated, My toenails haven't been cut in pretty close to a year. They are too long and the strings on my pajamas get stuck in them and it hurts. I'm tired of everybody telling me they will do something, but nobody ever does. During an end of day meeting on 02/25/26 at 3:05 pm, director of nursing (DON) was asked who is responsible for nail care, and DON responded the assistant director of nursing. On 02/26/26 at 9:10 am, DON was again asked who is responsible for providing toenail care, and DON stated the certified nurse's aide's or shower team can clean and file, nurse's do the trimming. DON was asked how often this should be done, and DON stated nails should be cleaned and filed with every shower and trimmed as needed. Requested and was provided with a facility policy entitled Fingernails/Toenails which read in part, The purpose of this procedure are to clean the nail bed, to keep the nails trimmed, and to prevent infections. 1. Routine nail care may be performed by nursing staff and/or qualified activity team members. 3. Nail care includes daily cleaning and regular trimming. The concern of not providing showers and nail care for Resident #62 was discussed with the administrator, DON, assistant DON, regional director of clinical services and two (2) unit managers on 02/26/26 at 4:30 pm. No further information was provided prior to exit. 6. For Resident #67 the facility staff failed to provide nail care. Resident #67's clinical record listed diagnoses which included but not limited to unspecified dementia, unspecified severity, with mood disturbance. Resident #67's most recent minimum data set with an assessment reference date of 12/19/25 assigned the resident a brief interview for mental status score of 11 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Section GG, functional abilities, coded the resident as needing substantial/maximal assistance with personal hygiene. Resident #67's comprehensive care plan was reviewed and contained a plan for Maintenance: the resident is a long-term care or respite resident and requires assistance with their ADL's (activities of daily living) related to decline in status. Resident #67 was observed on 02/25/26 at 8:40 am. Resident was resting in bed. Resident's toenails were observed to be extremely long and ragged. Resident #67 was interviewed on 02/25/26 at 1:25 pm. Resident #67's toenails were observed to be very long, ragged, with dark debris observed under and around the nail bed of the left great toe. Resident stated her toe nails needed to be cut. Resident #67's fingernails were also observed to be long and ragged. Resident was asked if this bothers her, and resident stated, It don't bother me, but they are too long. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an end of day meeting on 02/25/26 at 3:05 pm, director of nursing (DON) was asked who is responsible for nail care, and DON responded the assistant director of nursing. On 02/26/26 at 9:10 am, DON was again asked who is responsible for providing toenail care, and DON stated the certified nurse's aide's or shower team can clean and file, nurse's do the trimming. DON was asked how often this should be done, and DON stated nails should be cleaned and filed with every shower and trimmed as needed. Requested and was provided with a facility policy entitled Fingernails/Toenails which read in part, The purpose of this procedure are to clean the nail bed, to keep the nails trimmed, and to prevent infections. 1. Routine nail care may be performed by nursing staff and/or qualified activity team members. 3. Nail care includes daily cleaning and regular trimming. The concern of not providing nail care for Resident #67 was discussed with the administrator, DON, assistant DON, regional director of clinical services and two (2) unit managers on 02/26/26 at 4:30 pm. No further information was provided prior to exit. 7. For Resident #116 the facility staff failed to provide nail care. Resident #116's clinical record listed diagnoses which included but not limited to respiratory conditions due to unspecified external agent. Resident #116's most recent minimum data set with an assessment reference date of 11/24/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #116's comprehensive care plan was reviewed and contained a plan for Personal Hygiene/Dental: the resident requires assistance with their dental care and personal hygiene. Resident #116 was interviewed on 02/25/26 at 1:10 pm. Resident #116's toenails were observed to be long, and resident stated, I usually go to podiatry, but I was in the hospital the last time I had an appointment, so I missed it. My daughter is checking on getting me another appointment. She is also checking to see if the facility will transport me, or if she has to. During an end of day meeting on 02/25/26 at 3:05 pm, director of nursing (DON) was asked who is responsible for nail care, and DON responded the assistant director of nursing. On 02/26/26 at 9:10 am, DON was again asked who is responsible for providing toenail care, and DON stated the certified nurse's aide's or shower team can clean and file, nurse's do the trimming. DON was asked how often this should be done, and DON stated nails should be cleaned and filed with every shower and trimmed as needed. Requested and was provided with a facility policy entitled Fingernails/Toenails which read in part, The purpose of this procedure are to clean the nail bed, to keep the nails trimmed, and to prevent infections. 1. Routine nail care may be performed by nursing staff and/or qualified activity team members. 3. Nail care includes daily cleaning and regular trimming. The concern of not providing nail care for Resident #116 was discussed with the administrator, DON, assistant DON, regional director of clinical services and two (2) unit managers on 02/26/26 at 4:30 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pm. No further information was provided prior to exit.

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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. Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to assess 2 of 25 residents for self-administration of medications, Residents #32 and #116.The findings included:1. For Resident #32, the facility staff failed to assess the resident for self-administration of medications. Resident #32 had a provider order for Systane eye drops two times a day for dry eye may leave at bedside. Resident #32's diagnoses included acute and chronic respiratory failure, chronic diastolic congestive heart failure, and diabetes. Section C (cognitive patterns) of Resident #32's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/06/26 included a brief interview for mental status (BIMS) score of 12 out of a possible 15 points, indicating Resident #32 was moderately impaired in cognitive skills for daily decision making. On 02/24/26 at 12:35 p.m., during an interview with Resident #32 an observation was made of Systane eye drops, Voltaren cream, and Neosporin ointment on the residents over the bed table. Resident #32 stated she had to order the medications herself and the Voltaren was for her hip. Resident #32's clinical record included a provider order dated 10/23/25 for Systane eye drops instill one drop in both eyes two times a day for dry eye may leave at bedside. Resident #32's clinical record did not include orders for Voltaren or Neosporin ointment. Resident #32's clinical record did not include any evidence to indicate the resident had been assessed for self-administration of medications. On 02/25/26 at 3:05 p.m., during an end of the day meeting with the Administrator, Director of Nursing, Regional Nurse, Assistant Director of Nursing, and Licensed Practical Nurses #7, #8, and #9 the above issue was reviewed. On 02/25/26, the facility staff provided the survey team with a copy of their policy titled, Self-Administration of Medications and Treatments. This policy read in part, .As part of the overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities and choice to determine whether self-administering medications and/or treatments is clinically appropriate for the resident. On 02/26/26 the facility staff provided the surveyor with a document titled, Self Administration of Medications Safety Evaluation indicating the resident would like to self-administer Systane Ophthalmic Solution and indicated Resident #32 was appropriate to self-administer medications and/or treatments. This document was dated 02/25/26. No further information regarding this issue was provided to the survey team prior to exit conference. 2. For Resident #116 the facility staff failed to complete a self-administration of medication assessment prior to allowing resident to self-administer the medications Flonase nasal spray and Chloraseptic throat spray Resident #116's clinical record listed diagnoses which included but not limited to respiratory (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conditions due to unspecified external agent. Resident #116's most recent minimum data set with an assessment reference date of 11/24/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #116's clinical record was reviewed and contained a physician's order summary which read in part, May keep Flonase and Chloraseptic at bedside. Resident #116's electronic medication administration record for the month of February 2026 was reviewed and there was no documentation related to resident's Flonase or Chloraseptic. Resident #116's clinical record was reviewed on 02/25/26 and a self-administration of medications assessment was not located. On 02/26/26 at 8:15 am the director of nursing (DON) was asked to provide a self-administration of medication assessment for Resident #116. The self-administration of medication assessment was provided by the DON on 02/26/26 at 9:45 am and was dated 02/26/26 at 9:17 am. Resident #116 was interviewed on 02/26/26 at 10:40 am and stated that she keeps her Flonase and Chloraseptic in the top drawer of her nightstand. Requested and was provided with a facility policy entitled, Self-Administration of Medications and Treatments which read in part, 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities and choice to determine whether self-administering medications and/or treatments is clinically appropriate for the resident. 3. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, which may include (but not limited to) the resident's: a. Ability to read and understand medication labels/treatment instructions; b. Comprehension of the purpose and proper administration for his or her medication/treatments. c. Ability to remove medications and/or treatment supplies from a container d. Ability to recognize risks and major adverse consequences of his or her medications/treatments. 6. For self-administering residents, the nursing staff will determine who will be responsible for (the resident or the nursing staff) for documenting those medications were taken and/or that treatments were administered. 12. Nursing staff will review the self-administered medication/treatment record on each nursing shift, and they will transfer pertinent information to the medication/treatment administration record (MAR/TAR) appropriately noting that the doses were self-administered. The concern of not completing a self-administration of medications assessment prior to allowing Resident #116 to self-administer medications was discussed with the administrator, DON, assistant DON, regional director of clinical services, two (2) unit managers on 02/26/26 at 4:30 pm. No further information was provided prior to exit.

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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 and facility document review the facility staff failed to provide 2 of 3 residents with the appropriate beneficiary notices, Residents #36 and #42. The findings included: The facility staff failed to provide Resident #36 with an Advance Beneficiary Notice of Non-Coverage (ABN) and failed to provide Resident #42 with a Notice of Medicare Non-coverage (NOMNC). Resident #36's diagnoses included sepsis and acute respiratory failure. Section C (cognitive patterns) of Resident #36's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/19/26 included a brief interview for mental status (BIMS) score of 15, indicating Resident #36 was cognitively intact. Resident #42's diagnoses included chronic systolic congestive heart failure and diabetes. Section C of Resident #42's quarterly MDS assessment with an ARD of 02/03/26 included a BIMS score of 15, indicating Resident #42 was cognitively intact. On 02/25/26, the surveyor requested from the Social Worker Assistant notices that were provided to Resident #36 and Resident #42 regarding their discharge from Medicare part A. On 02/26/26 at 9:10 a.m., during an interview with the Social Worker, this staff stated Resident's #36 and #42 were not given the appropriate notices. Resident #36 should have received an ABN and Resident #42 should have received a NOMNC. The Social Worker stated Resident #36 was provided with an ABN today. On 02/26/26 at 3:40 p.m., during a meeting with the Administrator, Director of Nursing, Nurse Consultants #1 and #2, Assistant Director of Nursing and Licensed Practical Nurses #8 and #9 the issue with the beneficiary notices not being provided to Residents #36 and #42 were reviewed. No further information regarding this issue was provided prior to the exit conference.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify the office of the state long-term care ombudsman of a resident transfer/discharge for (1) one of (25) twenty-five sampled residents, Resident #13. The findings included:For Resident #13, the facility staff failed to notify the office of the state long-term care ombudsman of a transfer/discharge to a higher level of care on 1/30/26. Resident #13's diagnosis list indicated diagnoses that included, but were not limited to, psoas muscle abscess, sepsis due to streptococcus, atrial fibrillation, chronic kidney disease-stage 3, infrarenal abdominal aortic aneurysm, muscle weakness, and malnutrition. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 131/26, assigned the resident a brief interview for mental status (BIMS) summary score of 8 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. An order progress note dated 1/30/26 read in part, .May send to ER (emergency room at hospital) for evaluation/treatment related to Hgb 7 (A hemoglobin level of 7 g/dL (grams per deciliter) is a, medically significant, severe level of anemia indicating a critically low concentration of oxygen-carrying protein in the red blood cells) and severe left sided abdominal pain. Requested evidence that the office of the state long-term care ombudsman was notified of the transfer/discharge for Resident #13 on 1/30/26. On 2/26/26 at 12:27 PM, social worker #2 (SW#2) was interviewed and provided a transfer/discharge list of residents for the month of January 2026 and stated the list was printed today (1/26/26). Resident #13 was on the list of transfers/discharges. SW#2 stated the fax confirmation form is not kept and agreed there was no evidence the list was sent to the state long-term care ombudsman. This concern was discussed at the pre-exit meeting on 1/26/26 at 4:30 PM with the administrator, director of nursing, regional director of clinical services #1, regional director of clinical services #2, unit manager #1, assistant director of nursing, and unit manager #2. Requested, but did not receive a facility policy for transfer/discharge. No further information regarding this concern was presented to the survey team prior to the exit on 2/26/26.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on staff interview, clinical record review and facility document review the facility staff failed to follow up on pharmacy recommendations for 2 of 25 residents, Resident #5 and Resident #72.The findings included:1. For Resident #5 the facility staff failed to follow up on pharmacist recommendations. Resident #5's clinical record listed diagnoses which included but not limited to personal history of traumatic brain injury, major depressive disorder, and metabolic encephalopathy.Resident #5's most recent minimum data set with an assessment reference date of 12/14/25 assigned the resident a brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Section N, medications, coded the resident as receiving antipsychotic, antidepressant, and antibiotic.Resident #5's clinical record was reviewed and contained a Pharmacy/Pharmacy Consultant Note dated 09/23/25 which read in part, Medication Regimen Review Completed (X) Recommendations written to provider, please see pharmacy report for detail. A pharmacy report related to this medication regimen review could not be located.The director of nursing (DON) was informed of the missing pharmacy report but could not locate it.Requested and received a facility policy entitled, Medication Regimen Review which read in part, Specific Procedures/Guidance 3. The Consultant Pharmacist will perform a medication regimen review (MRR) for every resident in the facility. 8. The pharmacist will report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.9. Any irregularities noted by the pharmacist during this review will be documented on a separate, written report that is sent to the attending physician and the facility's medical director and the director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. a) The consulting pharmacist will provide a copy of recommendations to the attending physician, medical director, and director of nursing within 5 working days of completion of the review. i) The attending physician and director of nursing will be contacted immediately if the pharmacist identifies an irregularity that requires urgent action to protect the resident. b) The director of nursing or designee will review the recommendations and the attending physician will be contacted for review and response. c)If the attending physician does not respond within 30 days, the medical director will be asked to review the recommendations and/or contact the attending physician. 10. The attending physician or medical director will document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.The concern of not following up on pharmacist recommendations was discussed with the administrator, DON, assistant DON, regional director of clinical services, two (2) unit managers on 02/26/26 at 4:30 pm.No further information was provided prior to exit. 2. For Resident #72 the facility staff failed to follow up on pharmacy recommendations.Resident #72's clinical record listed diagnoses which included but not limited to unspecified dementia, delusional disorders, psychotic disorder, and major depressive disorder.Resident #72's most recent minimum data set with an assessment reference date of 11/25/25 assigned the resident a brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Section N, medications, coded the resident as receiving antipsychotics, antianxiety, antidepressants, opioids, and anticonvulsants.Resident #72's comprehensive care plan was reviewed and contained a plan for Psychoactive medication: the resident is at risk for complications related to psychoactive (anxiolytic, antidepressant) medications used secondary to diagnoses of: anxiety disorder, depression, insomnia.Resident #72's clinical record was reviewed and contained Pharmacy/Pharmacy Consultant Note dated 09/22/25 which read in part, Medication Regimen Review Completed (X) Recommendations written to provider, please see pharmacy report for detail. A pharmacy report (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	related to this medication regimen review could not be located.The director of nursing (DON) was informed of the missing pharmacy report but could not locate it.Requested and received a facility policy entitled, Medication Regimen Review which read in part, Specific Procedures/Guidance 3. The Consultant Pharmacist will perform a medication regimen review (MRR) for every resident in the facility. 8. The pharmacist will report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.9. Any irregularities noted by the pharmacist during this review will be documented on a separate, written report that is sent to the attending physician and the facility's medical director and the director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. a) The consulting pharmacist will provide a copy of recommendations to the attending physician, medical director, and director of nursing within 5 working days of completion of the review. i) The attending physician and director of nursing will be contacted immediately if the pharmacist identifies an irregularity that requires urgent action to protect the resident. b) The director of nursing or designee will review the recommendations and the attending physician will be contacted for review and response. c)If the attending physician does not respond within 30 days, the medical director will be asked to review the recommendations and/or contact the attending physician. 10. The attending physician or medical director will document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.The concern of not following up on pharmacist recommendations was discussed with the administrator, DON, assistant DON, regional director of clinical services, two (2) unit managers on 02/26/26 at 4:30 pm.No further information was provided prior to exit.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to safely store drugs and/or biologicals in a locked and secure manner for 2 of 25 residents, Resident #4 and #32.Joy1. For Resident #4, the facility nursing staff left hydrocortisone in the resident's room unattended.Resident #4's diagnoses included, Parkinson's disease, respiratory failure, and epilepsy.Section C (cognitive patterns) of Resident #4's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/13/26 included a brief interview for mental status (BIMS) score of 10, indicating Resident #4 was moderately impaired in cognitive skills for daily decision making.On 02/24/2026, during initial tour, the surveyor observed a white cream in a clear plastic medicine cup sitting on the top of an extended outlet box. On 02/24/2026, during an interview with Licensed Practical Nurse (LPN) #1 this staff stated the cream was hydrocortisone and she had placed it there. Resident #4's clinical record included a provider order dated 02/21/26 for hydrocortisone cream apply to right lower leg topically two times a day for 5 days. On 02/25/26 at 3:05 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), Regional Nurse, Assistant Director of Nursing, and LPN's #7, #8, and #9 the above issue was reviewed. The DON stated the hydrocortisone should not have been left in the room.On 02/26/26, the facility staff provided the surveyor with evidence that they had provided LPN #1 with education regarding medications being left at the bedside.No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #32, the facility staff failed to safely store Voltaren and Neosporin ointment. Both medications were observed on the residents over the bed table unattended. Resident #32's diagnoses included acute and chronic respiratory failure, chronic diastolic congestive heart failure, and diabetes.Section C (cognitive patterns) of Resident #32's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/06/26 included a brief interview for mental status (BIMS) score of 12 out of a possible 15 points, indicating Resident #32 was moderately impaired in cognitive skills for daily decision making.On 02/24/26 at 12:35 p.m., Systane eye drops, Voltaren cream, and Neosporin ointment were observed on Resident #32's over the bed table. Resident #32 stated she had to order the medications herself and the Voltaren was for her hip. Resident #32's clinical record included a provider order for Systane eye drops two times a day for dry eye may leave at bedside. Resident #32's clinical record did not include orders for Voltaren or Neosporin ointment.On 02/25/26 at 8:58 a.m., the provider ordered Diclofenac (Voltaren) Sodium External Gel 1% apply to left hip topically four times a day for pain. On 02/25/26 at 3:05 p.m., during an end of the day meeting with the Administrator, Director of Nursing, Regional Nurse, Assistant Director of Nursing, and Licensed Practical Nurses #7, #8, and #9 the above issues were reviewed.On 02/26/26, the facility staff provided the survey team with a copy of their policy titled, Medication Storage. This policy read in part, .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.No further information regarding this issue was provided to the survey team prior to the exit conference.

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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 observations, resident interviews, staff interviews, and facility document review, the facility staff failed to address resident concerns regarding food services. The findings included:For the facility, the facility staff failed to adequately address resident complaints about the food. During the course of the survey, multiple resident interviews were conducted and multiple residents complained about the taste and temperature of the food and not having snacks available. A review of Resident Council Minutes dated 12/30/25 read in part, .Residents stated it is a waste of time to voice any concerns with dietary.nothing is getting done.still not receiving snacks A review of Resident Council Minutes dated 1/27/26 read in part, .Residents stated the eggs and vegetables are watery when served.Residents are stating the hot plates are not hot when meals arrive and their food is cold .will send an email to Dietary Manager to follow up with these concerns. A review of Resident Council Minutes dated 2/24/26 read in part, .All residents agree the food is cold when they receive it.All residents agree the trays are lacking condiments.All residents agree the food is hit or miss but mostly not good.All residents agree there are no snacks at night.stated phone is not being answered when they call for an alternate meal.Residents want to know when they will get soda back. A test tray was requested on 2/25/26 and was observed to be the last tray off the cart at 1:10 PM. The menu consisted of Swedish meatballs, egg noodles, and pacific blend vegetables. The meal was palatable and at a temperature that would have been enjoyed. These concerns were discussed at the end of day meeting on 2/25/26 at 3:05 PM with the administrator, director of nursing, regional director of clinical services, unit manager #1, unit manager #2, unit manager #3, and assistant director of nursing. On 2/26/26 the (4) four-unit pantries were observed and identified to have several out-of-date items with limited snacks available or for safe consumption by the residents. On 2/26/2026 at 9:06 AM, licensed practical nurse #8 (LPN#8) was interviewed and stated the kitchen staff are supposed to bring carts of snacks to stock the pantries, but they do not do this very often. The CNAs (certified nursing assistants) have to go to the kitchen to ask for snacks for the residents. LPN#8 stated the residents enjoy peanut butter and jelly sandwiches, oatmeal cream pies, and fudge rounds. LPN#8 agreed there is no bread or soup in the pantries for nursing staff to use for the residents. LPN#8 stated they (nursing staff) keep snacks in her office such as peanut butter crackers, cookies, and left-over fruit cups. LPN#8 stated at one point, nursing staff members were bringing in their own peanut butter, jelly, and bread to make the residents sandwiches. LPN#8 stated nursing staff also have to ask for Magic Cups for the residents that have an order for them, as they are not kept in the unit pantries. On 2/26/26 at 9:35 AM, the facility administrator (ADM) was interviewed and asked about the concerns of the residents and Resident Council regarding the food at the facility. The ADM agreed food had been mentioned in Resident Council and the previous dietary manager met with the Resident Council about the food, but he did not have any notes or documentation from the previous dietary manager regarding the response to the complaints. No further information was provided to the survey team prior to exit on 2/26/26.

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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, staff interview and facility document review the facility staff failed to follow established infection control procedures.The findings included:During a medication pass and pour observation, observed the nurse touching medications with her bare hands. For Resident # 42 observed an incentive spirometer under the resident's bed, and for Resident #92, failed to bag CPAP (continuous positive airway pressure) mask. Linens were observed on the floor in room B-6 and A-6, A-bed side.On 02/25/26 at 8:00 am, while preparing to observe a medication pass and pour, registered nurse (RN) #2 was observed dispensing medication from the medication card into her bare hand and placing them in the medication cup. During the medication pass and pour observations, RN #2 removed a capsule from the medication cup with her bare hand, opened it and poured the contents into a cup of pudding.Linens were observed laying on the floor of room B-6 on 02/25/26 at 8:40 am. A wet washcloth was observed laying on the floor of room A-6 on 02/25/26 at 1:20 pm.An incentive spirometer was observed under the head of Resident #42's bed on 02/25/26 at 10:50 am and 4:00 pm and on 02/26/26 at 10:40 am.Resident #92's CPAP (continuous positive airway pressure) mask was observed lying on the nightstand, uncovered on 02/25/26 at 9:15 am and 4:00 pm and on 02/26/26 at 8:30 am and 10:45 am.Assistant director of nursing (ADON) was interviewed on 02/26/26 at 10:50 am regarding infection control issues. ADON stated that linens should not be left on the floor, and respiratory equipment should be bagged when not in use.Requested and was provided with facility policies entitled Medication Administration General Guidelines, Prevention of Infection-Laundry and Linen, and Prevention of Infection While Providing Respiratory Care. The policy for medication administration read in part, If breaking tablets is necessary to administer the proper dose, hands are washed with soap and water and gloves applied prior to handling tablets. The policy for linens read in part, Bagging and Handling Soiled Linen. 1. All soiled linen must be placed directly into a covered laundry hamper which can contain the moisture. The policy for respiratory care read in part, 1. Respiratory equipment, when not in use by the assigned resident, will be stored in a safe manner to prevent injury and/or contamination. 5. CPAP/BiPAP or other Mechanical Respiratory Support Devices. C. Equipment will be cleaned and disinfected between resident use and will be stored in a clean environment.The concern of not following established infection control practices was discussed with the administrator, DON, assistant DON, regional director of clinical services, two (2) unit managers on 02/26/26 at 4:30 pm.No further information was provided prior to exit.

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F 0802 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations and staff interviews, the facility staff failed to provide adequate training and skill sets for dietary staff to carry out the functions of the food and nutrition services of the facility. The findings included: For the facility, the facility staff failed to ensure dietary employees received adequate training and skill sets to safely and effectively carry out meal preparation and other food and nutrition services of the facility. Entered the facility kitchen on 2/25/26 at 11:45 AM to observe the lunch meal tray line. Other staff #3 (OS#3) was observed to be preparing resident trays with visible facial hair. OS#3 was not observed to be wearing a beard net. When asked why a beard net was not utilized, the regional director of dining services (RDDS) requested OS#3 to utilize a beard net and OS#3 place a beard net over his facial hair. On 2/25/26 at 12:00 PM, other staff #4 (OS#4), other staff #5 (OS#5), and other staff #6 (OS#6) entered the facility kitchen to begin their scheduled shift and proceeded to the hand-washing sink. None of the dietary employees wore a hair restraint. OS#6 had visible facial hair and a beard net was not visible. When asked why they entered the facility kitchen without hair restraints and beard nets, OS#4 stated there are no hair restraints outside of the kitchen door for them to use. OS#5 stated this is how they have been entering the kitchen. OS#6 stated he was never educated on hair nets or beard restraints and he had started in the kitchen in February 2026. On 2/25/26 at 12:06 PM, the RDDS stated he was going to put in a work order to have hair and beard restraints provided outside of the facility kitchen entrance for the dietary employees to utilize prior to entering the facility kitchen. RDDS also stated he would provide education for the dietary staff, as they had not had a dietary manager for a few weeks. On 2/25/26 at 12:14 PM, other staff #2 (OS#2) who was the cook, was observed to put oven mitts over her gloves to remove a pan of egg noodles from the steamer to add to the serving station. OS#2 replaced the pan of egg noodles and then removed the oven mitts. The RDDS reminded OS#2 to change gloves. OS#2 was not observed to practice hand hygiene and put on new gloves. On 2/25/26 at 12:26 PM, OS#2 was observed to take a break for a drink of water. OS#2 changed gloves and did not practice hand hygiene. The RDDS asked OS#2 to wash hands and OS#2 washed her hands and put on new gloves. On 2/25/26 at 12:44 PM, OS#2 was observed to put oven mitts over her gloves to add more egg noodles to the serving station. OS#2 removed the oven mitts and changed gloves but did not practice hand hygiene. These concerns were discussed at the end of day meeting on 2/25/26 at 3:05 PM with the administrator, director of nursing, regional director of clinical services, unit manager #1, unit manager #2, unit manager #3, and assistant director of nursing. On 2/26/26 at 9:35AM the facility administrator (ADM) was interviewed. The ADM stated the dietary manager quit on 2/6/26 and 3-4 other dietary staff quit not long afterwards. The facility has hired new dietary staff and they just hired a new cook and dietary aide. The ADM stated an offer to a new dietary manager was about to be made. The ADM agreed that the RDDS was in the process of establishing training for the dietary employees. No further information was provided to the survey team prior to exit on 2/26/26.