

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026
NAME OF PROVIDER OR SUPPLIER Newport News Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 12997 Nettles Drive Newport News, VA 23602	
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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, staff interviews, and review of facility documentation, the facility staff failed to implement their abuse policy regarding the screening of employees and permitted a certified nursing assistant to work over 15 months, providing direct care to residents within the entire facility while having been convicted of a barrier crime, which barred employment within a nursing facility. This non-compliance placed all 93 residents residing in the facility at a significant and on-going risk for harm by allowing unrestricted access to a staff member convicted of a crime of moral turpitude. This resulted in the identification of Immediate Jeopardy and substandard quality of care on 3/6/26 at 8:10 PM. Following the removal of IJ on 3/9/26 at 12:30 PM, the scope and severity was lowered to a level two, pattern. The findings included: The facility staff failed to implement their abuse policy regarding the screening of employees by permitting Certified Nursing Assistant (CNA #3) to provide direct care to residents with unrestricted and unsupervised access despite the employee had a conviction for a barrier crime, which prohibits employment in a long-term care facility under regulatory requirements. The facility's Abuse, Neglect, Exploitation & Misappropriation policy with a revision date of 11/28/17 read in part: .1. Screening: Persons applying for employment with the center will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. This includes but not limited to: employment history, criminal background check, abuse check with appropriate licensing board and registries prior to hire, sworn disclosure statement prior to hire, Licensure or Registration verification prior to hire, Documentation of status of any disciplinary actions from licensing or registration boards and other registries, information from former employees. The center will ensure that all prospective consultants, contractors, volunteers, caregivers, and students are pre-screened as required by law . On 3/6/26 at 11:55 AM, while completing a review of employee records, it was noted that CNA #3's Commonwealth of Virginia Department of State Police criminal history and sex offender record read: 08/28/2023 Guilty - Felony 18.2 - 474.1 Jail: Delivery of Drugs to Prisoner. On 3/6/26 at 11:56 AM, an interview was conducted with the Administrator in Training (AIT) and the Human Resource Coordinator (HRC). The findings of CNA #3's criminal history and sex offender record was brought to the AIT's attention. The AIT said, Can we please take a break? and exited the room. The HRC then said, You do not understand what is going to happen to me. On 3/6/26 at 12:30 PM an interview was conducted with the Administrator. The Administrator stated that CNA #3 should not be working at the center due to the results of the employee's background check. A review of the facilities payroll documentation revealed that CNA #3 worked from 11:22 PM on 3/5/26 until 7:35 AM on 3/6/26. On 3/6/26 at 8:10 PM the facility's Administrator in Training, Director of Nursing, and an Administrator from another facility within the company were informed of the non-compliance which constituted Immediate Jeopardy and substandard quality of care. The IJ was determined to have began on 11/26/24, when CNA #3 was hired. On 3/6/26 at 10:45 PM an interview was conducted with the Administrator in Training. The Administrator in Training stated that CNA #3 was a full time employee on the 11pm - 7 am shift and full-time employment means 35 hours a week. The Administrator in Training also stated that CNA #3 was hired on 11/26/24 and worked throughout the entire facility and was not assigned to a dedicated unit/hall/or set of residents. The Administrator in Training further confirmed that CNA #3 had worked the prior night (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3/5/26 on the 11pm -7am shift. The facility's staff presented several unaccepted Removal Plans on 3/6/26 which required revisions. The removal plans failed to detail how the facility would prevent an employee with a barrier crime conviction to work in the facility and provide direct care to residents. The Facility's Final/Accepted Removal Plan dated 3/6/26 at 11:17 PM, read: This immediacy removal plan serves as [Name of the Provider redacted] response to the Immediate Jeopardy that occurred on March 6, 2026. The facility took the following actions: Immediately contacted the employee at 14:00 notifying her of the barrier crime and being removed from the schedule. At 17:45 employee was contacted by Administrator and was informed she could not return to work and employee resigned. Completed 3/6/2026. Complete skin assessments on 100% of non-interviewable residents under the employee's care to evaluate any unexplained injuries, bruises, or skin concerns. To be completed by 3/9/2026, 08:00. Interview alert and oriented residents regarding any concerns related to care, treatment, or interactions with any employee. Will contact responsible parties of non interviewable residents regarding any concerns related to care, treatment, or interactions with any employee. To be completed by 3/9/2026, 08:00. Conduct a 100% audit of current employee personnel files to confirm background checks were completed and properly reviewed prior to their next scheduled worked shift, and that no employee with a barrier crime was employed. Provide immediate education to 100% of all staff and contractors regarding the facility's abuse policy and procedure prior to employees returning to work Provide immediate education to the Administrator, DON and HR Staff on:- State barrier crime regulations- Required background screening procedures- Documentation requirements prior to employment clearance.- Abuse and neglect policy.- Completed 3/6/2026. HR manager was provided with 1:1 education to reinforce policy that no employee may begin work until background checks are fully reviewed and documented as cleared. Completed 3/6/2026. All aspects of the plan will be completed by 3/9/26 at 08:00 AM On 3/9/26, the survey team validated the facility's implementation of the IJ removal plan. The survey team verified skin assessments were conducted on 100% of non-interviewable residents under the CNA #3's care during the employee's employment to evaluate any unexplained injuries, bruises, or skin concerns. A reviewed was conducted of the interviews of alert and oriented residents and responsible parties regarding any concerns related to care, treatment, or interactions with any employee. The 100% audit of current employee files to confirm background checks were completed and properly reviewed prior to their next scheduled worked shift, and that no employee with a barrier crime was employed, was reviewed. The survey team verified immediate education of 100% of all staff and contractors regarding the facility's abuse policy and procedure prior to employee's returning to work. The team verified immediate education to the Administrator, DON, and HR staff on: State barrier crime regulations, required background screening procedures, documentation requirements prior to employment clearance, and abuse and neglect policy. Evidence was reviewed that the HR manager was provided 1:1 education to reinforce policy that no employee may begin work until background checks are fully reviewed and documented as cleared. A review of the Facility Reportable Incidents (FRI) between the dates of 11/26/24 to present to verify CNA #3 with the barrier crime was not subject to any abuse allegations. Interviewed the social worker, DON, and Administrator regarding any complaints from residents about CNA #3. Following the removal of IJ on 3/9/26 at 12:30 PM, the scope and severity was lowered to a level two, pattern. No additional information was provided prior to the conclusion of the survey.		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, staff interviews, and facility documentation review, the facility staff failed to ensure that medication(s), hazardous materials, and biologicals were properly secured to prevent unauthorized staff or resident access on three of three units. This deficient practice had the potential of placing all 93 residents residing in the facility, staff, visitors, and volunteers at risk of harm and resulted in the identification of immediate jeopardy and substandard quality of care. Following the removal of the immediacy, the scope and severity was lowered to a level two, pattern. The findings included: On 3/4/2026 at approximately 12:15 PM, on a facility tour of the Pinebrook unit, a medication storage room door was found to be unlocked and unsecured. It was easily accessed by pushing the door open. There was no staff monitoring the door and inspection of the door revealed the latch of the door was taped open to give access to the medication room without the use of a key. Observations of the area within the room revealed a toolbox with zip ties on the top drawer and the lower drawers not secured or locked. The contents included: Antibiotic medications of Ceftriaxone, Vancomycin hydrochloride, Piperacillin, Imipenem, Ceftazidime, Cefepime, Meropenem, Ertapenem. The bottom shelf system held approximately 10 sodium chloride solution bags. Per the container log, it appeared the following items were missing: one vial of Ampicillin sodium 2gm, one vial of Cefepime 1gm, and one vial of Sterile water missing 10ml. There was also a two-drawer filing cabinet that was unlocked and contained a shaving kit bag belonging to Resident #13. The bag contained medications that included, Famotidine 20 MG tablets, Pravastatin 40 MG tablets, Furosemide 20 MG tablets, Metoprolol Tartrate 50 MG tablets, Hydralazine 50 MH tablets, Ezetimibe 10 MG tablets. On 3/4/2026 at approximately 1:00 PM, a staff interview was conducted with a (Registered Nurse/the Pinebrook Unit Manager). RN #2 was asked about the medication room door and if it was to be locked. RN #2 stated, the door is to be locked but because of a key being broken off in the door and the staff needing access to the room, the door was taped open to allow staff access to the medication storage room. Maintenance was told to tape the door open to allow staff access to the medication room. There are no narcotics in the medication storage room and that the medication storage box should be locked. RN #2 stated they were not aware of resident medications being in medication room. On 3/4/2026 at approximately 1:15 PM, a staff interview was conducted with Licensed Practical Nurse (LPN #1) regarding resident medications and where they are stored. LPN #1 stated resident medications are stored in locked medication carts and locked medication rooms. LPN #1 stated she did not know about resident medications being stored in medication storage room on the Pinebrook unit. LPN #1 stated that the resident in question had resided on Pinebrook unit but now resided on Meadowlands unit and has been on the Meadowlands unit for about six months. On 3/4/2026 at approximately 1:25 PM a staff interview with LPN #2 (the Meadowland unit manager) and Director of Nursing (DON) was conducted regarding resident medications and an unlocked medication storage room on Pinebrook Unit. LPN #2 and the DON stated that medications are stored under lock and key in medication carts and in medication storage rooms. The DON stated, they were aware the medication storage room door on Pinebrook was broken and a key had broken off in the lock. LPN #2 and DON stated, they did not know about Resident #13 medications being stored in the Pinebrook medication storage room. DON said, the resident had transferred from Pinebrook unit to the hospital and then returned to the facility to the Meadowland unit. The medications were turned over to the DON for proper disposal. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/4/2026 at approximately 2:47 PM, a staff interview was conducted with the Director of Maintenance about the medication storage room door on the Pinebrook unit. The Director of Maintenance stated the following, they were aware that the door of the medication room on unit #4 had a key broken in the lock. The medication room door had been broken for about a month. The door had to be pried open to gain access: and that staff (nurses) needed immediate access to the room. The Director of Maintenance stated tape was applied to the latch to keep the door from locking to allow staff ease of access to the room without a key. On 3/4/2026 at approximately 3:45 PM, at the end of the day meeting, the Vice-President of Operations (VPO) stated the medication door on unit #4 was fixed and was secured and locked. On 3/5/2026 at approximately 8:38 AM, a facility tour with the DON was conducted of the Pinebrook unit. The medication room door was found to be secured and locked with a new locking mechanism installed. On 3/9/2026 at 9:43 AM, a staff interview with Registered Nurse (RN #2) was conducted and the question was asked, did you know the Pinebrook medication room door was broken? RN #2 stated, I know the door had been broken before I started here on 1/15/2026. On 3/9/2026 at 9:46 AM, a staff interview with RN #1 was conducted about the Pinebrook medication storage door. RN #1 stated initially not knowing the door was broken. Then RN #1 recanted her statement and stated I did know the door was broken but it was locked. I do not go into the medication storage room that often. On 3/9/2026 at approximately 9:30 AM, a facility tour of all units was conducted by a surveyor with the Director of Maintenance the following issues were noted: Meadowland Unit: An electrical room door was found unlocked and unmonitored with live (hot) wires. A Clean utility room, containing portable metal cylinders labeled oxygen, was found unlocked and unmonitored. Pinebrook Unit: Storage room beside the nursing office, contained cleaning supplies (multi surface disinfectant cleaner, max dual action floor cleaner was dripping onto floor, and bio-enzymatic odor eliminator) was unlocked and unmonitored. Rosewood Unit: Biohazard room containing two large sharps (needles and syringes) containers (approximately eighteen (18) inches tall) that were open and accessible. The needles and syringes were noted to have a red substance appearing to be blood on them. Two large full boxes (approximately twenty-four (24) inches tall by twenty-four (24) inches wide) lined with red bags were opened and accessible and appeared to contain biohazardous materials. Clean utility room, containing portable metal cylinder labeled oxygen, was found unlocked and (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	unmonitored. Beauty salon was found unlocked and unmonitored had water leaking into a large trash can that was overflowing water onto the floor. The water was noted traveling under a rotting cabinet to a wall with light outlets on it. The above-mentioned rooms that were unsecured and unmonitored could have been accessed by residents, visitors, and staff. On 3/9/2026 at 12:58 PM, the facility was notified that immediate jeopardy had been identified, related to securing medications and hazardous materials to prevent resident and unauthorized staff access. The immediate jeopardy began on 1/15/26 as confirmed by an interview with RN #2. The maintenance director confirmed it has been over a month since he had tapped the door where it could be opened without a key. On 3/9/2026 at 4:30 PM, the facility submitted an immediate removal plan that was accepted. The plan read as: The facility took the following actions: *Secured Hazardous Areas Immediately *All doors were audited for functionality by the ED, and regional [NAME] president and Maintenance Director *All medication rooms, supply rooms, biohazard rooms, and chemical storage areas were immediately secured. Locks were replaced and the tape was removed on the Medication room on Pinebrook unit. The housekeeping storage on the Pinebrook unit, had the door adjusted so that it would latch and lock as intended on March 9th. *The beauty shop, the biohazard storage and clean utility room on Rosewood had the locks replaced immediately by the maintenance director, then tested for functionality. *The facility had already identified the leak in the beauty shop and the regional maintenance will address today. *The electrical room door lock on Meadowland, is currently being replaced by the maintenance director. *The facility placed a staff member to sit at the door of the identified soiled utility room on meadowland, until the maintenance director can fix that final lock this afternoon. *For doors that are unsecure, a staff member was assigned to monitor the door till it could be fixed to function as intended. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Completed 3/9/2026 Provide immediate education to 100% of all facility staff regarding Medication Room Security Importance of rooms containing hazards such as oxygen, hazardous materials, sharps, and cleaning chemicals, being closed and locked at all times Reporting issues through the work order system. Education was initiated on 3/9/26 and all current staff will be educated prior to their next shift on medication storage and policy, hazardous material storage by Administrator or designee. All aspects of the plan will be completed by 3/9/26 by 11:59pm. On 03/09/26 at approximately 5:23 PM at the end of the day meeting with facility: attended: VPO (Vice President of Operations), Regional MDS (Minimum Data Set), Administrator, AIT (administrator in training), and DON, and the above findings were discussed. The staff had no additional information to add. On 3/10/2026 beginning at approximately 8:30 AM, the surveyors conducted staff interviews on all units throughout the facility to verify staff education on medication(s) and hazardous materials storage was provided per IJ removal plan. A facility tour was conducted to verify storage doors were secured and locking mechanisms were in working order to limit access. Following the removal of IJ (Immediate Jeopardy) on 3/10/2026 at 9:30 AM, the scope/severity was reduced to level 2 widespread.		

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **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 maintain an available call bell system for multiple Residents which was identified initially for one Resident (Resident #117), and secondarily as the sample was expanded, for three other residents (#118, #119, and #120) in a sample of 22 residents resulting in a finding of immediate jeopardy (IJ). Following the removal of IJ, the scope and severity was lowered to a level two pattern. The findings included. For Resident #117 and others, the call bell system was inoperable and no alternative means to call for assistance was in place for them in the facility. Resident #117 was most recently readmitted to the facility on [DATE]. The Resident's diagnoses included Cerebral palsy, left sided hemiplegia, Aphasia, stroke, malnutrition, dysphagia, contractures of upper extremities, lack of coordination, and dementia. The most recent MDS (Minimum Data Set federal assessment) was most recently completed as an annual assessment with an Assessment Reference Date (ARD) of 3-13-26. The assessment described the Resident with a Brief Interview for Mental Status (BIMS) score of unable to complete, indicating severe cognitive impairment. The Resident required extensive to fully dependent assistance from staff with all activities of daily living except eating, however, staff feeding was necessary at times. The Resident was dependent on staff for self-care and hygiene and had contractures of both hands. On 4-28-26 at 11:30 AM, Resident #117 was observed lying in bed with her call bell clipped above the Resident's head to the head of the bed and outside of the residents reach. An untouched breakfast tray remained on the overbed table in front of Resident. When asked whether the meal was cold, the Resident nodded affirmatively. When asked whether she still wanted to eat, the Resident again nodded affirmatively. She was asked if she could eat by herself or needed help, she held up both hands which were contracted and attempted to pick up the biscuit and put it in her mouth, then started coughing as she was in a reclined position and could not adequately expectorate the bread. A staff LPN [licensed Practical Nurse] entered the room to assist the Resident. The Resident's hands were both contracted in such a way that using the traditional corded spherical call button was impossible for the Resident even if she could have reached it. The call bell was depressed by the surveyor, and the call light did not light at the doorway, nor provide any auditory or visual signal to a centralized location. Resident #117's roommate's call bell was engaged and was again found to not be functioning. Registered Nurse #1 was interviewed and stated, we have to watch for the lights over the doors because the audible bell doesn't work. She was aware of an issue with the audible ring of the call bells on the unit but was not aware that Resident #117 nor her roommate's light over the door for the call bells had stopped functioning as well. Upon further immediate interview of the Maintenance Director, it was reported by him that a contractor came out in March 2026 regarding the call bell system not functioning properly, and the company sent a report with its recommendations. Unfortunately, the problem was never fixed or ok'd to be fixed so I called in a second company on 4-1-26. They came out on 4-7-26 and identified a facility wide issue with the call bell system and recommended it be fixed. I just called them after you asked me about it and they are sending a projected cost to us this week. Documents from the contractors were supplied to the surveyors and revealed the following excerpt from the documents. it is necessary to update your ring bell system. The summary is that they really need an update to their entire call bell system of the rooms. Their system is very old, and you can see the wear. Upon discovering the call system inoperability Surveyor #2 notified Surveyor #1 of the findings. Surveyor #1 then proceeded to other units, and Resident rooms, and found 3 other Residents rooms [Residents #118, #119, and #120] with call bells not functioning. The facility staff, despite knowledge of call-bell system failures, did not ensure residents have a means to call for assistance from the bedside and bathroom. The facility needed to take immediate action to ensure ALL residents can call for assistance with basic needs, or in the event of an emergency such as choking. The inability to call for assistance is likely to result in (continued on next page)		

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	serious injury, serious harm, serious impairment, or death due to a delay in treatment. On 4-28-26 at 2:30 PM Immediate jeopardy was levied by the survey team and state agency. The facility Administrator and Director of Nursing [DON] were notified and asked to provide an immediacy removal plan with a date and time for its implementation completion. On 4-28-26 at 3:45 PM after 2 iterations, a third immediacy removal plan was submitted by the facility and accepted by the survey team and the state agency. A time and date were chosen by the facility for completion of the plan, and for it to be fully implemented and successfully tested to be in place. That date and time was 4-28-26 at 6:00 PM. On 4-28-26 At 6:30 PM the plan was tested by surveyors and found to be fully implemented by the survey team onsite, thus immediacy was removed. The facility immediacy removal plan follows below. April 28, 2026 This Plan of Immediacy Removal serves as [name of facility] response to the Immediate Jeopardy that occurred on April 28, 2026. The facility has taken actions to remove immediacy at the center including the actions listed in this Plan. The facility took immediate action to respond to the Immediate Jeopardy that occurred when the facility failed to ensure residents had a means to call for assistance from the bedside due to inoperable call bell. Facility Administrator held an ad-hoc meeting, to include notification to facility medical director, on 4/28/2026 at 2:45pm to discuss details of Immediate Jeopardy and creation of this plan. Ad-hoc QAPI meeting attendees included Administrator, DON, corporate and regional support team. Immediately placed manual call bell for affected residents. For residents who may be unable to use a manual call bell, they will be relocated to a room with a functioning corded call bell, alternate pancake style call bell may be used in place or standard corded call bell based on resident need. Completed 4/28/2026 at 6:00 pm. Education on use of manual bell provided to affected residents. Completed 4/28/2026 at 6:00 pm. All resident rooms and resident bathrooms were inspected immediately for functioning call bells. Manual bells were provided to those rooms that were found to not have functioning corded call bells. For residents who may be unable to use a manual call bell, they will be relocated to a room with a functioning corded call bell, alternate pancake style call bell may be used in place or standard corded call bell based on resident need. Completed 4/28/2026 at 6:00. All communal shower rooms were inspected immediately for functioning call bells. All call bells in those areas were found to be in proper working order. Completed 4/28/2026 at 3:37. Provide immediate education to all staff on expectations for: Immediately reporting of broken call bells to facility maintenance director, Administrator and DON, Immediate placement of alternative call bell, example manual bell, when corded call bell broken, Completed 4/28/2026 at 6:00 pm. Staff members not present at time of immediate education will be educated prior to their next worked shift. On 4-28-26 at 5:30 PM, the survey team began conducting interviews with various facility staff from all departments to test the immediacy removal plan for successful implementation. The staff were able to answer questions about training regarding the call bell function checks and how to proceed should a call bell be found that is inoperable. Staff were expected to know where to access devices for the Residents according to each resident's assessed need such as manual [cow] bells, corded pancake style bells for those with contractures and dementia, and standard corded spherical button bells. Staff were expected to be able to describe how to use those devices, and in what situations a particular device would be used, and how to train residents should the need arise. Interviews were conducted with the residents of the facility, and they were able to identify how to use manual devices, and corded call bell devices including pancake corded devices. Residents with inoperable corded call bells were moved to other rooms with call bells which were operable. Call bells in current resident rooms were randomly checked by surveyors and found to be working on 4-28-26 from 6:00 PM to 6:30 PM and then continued 4-29-26 at 10:30 AM to cover a new shift entrance of staff. Staff education records with signatures were supplied to surveyors documenting staff completion. The facility policy on Call lights accessibility and timely response. was reviewed and revealed the following policy statement. The purpose of the policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will (continued on next page)		

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F 0919 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	directly relay to a staff member or centralized location to ensure appropriate response.After removing the immediacy the deficiency was levied at a scope severity of level 2 pattern.On 4-29-26 at 5:30 PM that facility Administrator and DON were made aware of findings. They stated they had nothing further to provide.		

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F 0600 Level of Harm - 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 staff interviews, resident interviews, facility document review and clinical record review, the facility staff failed to protect a resident's right to be free from physical abuse by a staff member for one Resident (Resident #114), in a survey sample of 46 Residents. The witnessed incident of physical and verbal abuse resulted in Resident #114 suffering psychosocial harm as evidenced by emotional distress and a decline in cooperation of care, which was harm for the resident. The facility self-identified the non-compliance and implemented a plan of correction that achieved past-noncompliance. The findings include: A certified nurse's aide (CNA #5) hit Resident #114 and used derogatory language when incontinence care was attempted after the resident refused/resisted the care. Resident #114 (R114) was admitted to the facility with diagnoses that included severe chronic kidney disease, diabetes, hypertension, deep vein thrombosis, myocardial infarction, history of pulmonary embolism, diabetic retinopathy, delirium, dementia with agitation, pulmonary edema and spondylosis. The minimum data set (MDS) dated [DATE] assessed R114 with severely impaired cognitive skills. R114's admission assessment dated [DATE] documented the resident had clear speech, was able to make herself understood, was sometimes able to understand instructions, had pleasant mood, no observed behaviors, was always incontinent of bowel/bladder, had no skin impairments and that the resident was ambulatory with use of a walker. Nursing documented daily skilled notes on 5/9/25, 5/10/25 and 5/11/25 listing the resident no voiced complaints, with no resistance to care or refusals noted. A change of condition form dated 5/12/25 at 9:30 a.m. documented the primary nurse caring for R114 witnessed a certified nurse's aide (CNA) hit the resident during incontinence care and the resident reacted with paranoid/aggressive behaviors following the incident. This change in condition form documented, The resident was in her bed being changed by the assigned aide and the resident became aggressive and swinging at the aide, broke her necklace. The aide had the nurse come in the room. The assigned nurse witnessed the aide punch the resident x 2 in her lower back both fist. (sic) This change of condition form documented the CNA was removed from the room, escorted to the administrator's office and immediately suspended. The facility documented R114 demonstrated aggression, refused to be assisted/changed, refused physical assessment and ran into the hallway with no pants following the incident. The form documented the resident would not allow anyone to touch her and sat in a chair in the hall with a sheet placed over her legs and that the administrator, resident's family member and the nurse practitioner (NP) were notified. The NP assessed R114 immediately following the incident. The NP note dated 5/12/25 documented, .Patient was seen today upon request of DON [director of nursing] and nurse. Staff report patient has become increasingly confused, agitated, and combative for staff .seen outside in the hallway sitting in a chair. She is currently soiled wearing a disposable brief, however she will not allow staff to change her. Patient is unaware of her self, surrounding, or location. She reports she is trying to get a hold of her father which is why she was attempting to leave the room . The NP documented that she was unable to complete a thorough review of systems or physical exam due to the resident's mental status and listed the resident as agitated, combative with staff, refusing care and disoriented to person, place and time. The NP assessed the resident with dementia with agitation and delirium. The NP listed the resident was on the medication Seroquel nightly for agitation/delirium prior to (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	admission, entered a new order for the anti-anxiety medication Ativan 0.5 mg (milligrams) every 24 hours if needed for acute agitation during next five days, ordered a urinalysis and culture to rule out infection, non-drug behavioral management strategies and psychiatry consultation. Nursing notes documented that the resident's family member came to the facility on 5/12/25 at 10:55 a.m. in response to the incident. Nursing documented R114 calmed after talking with the family member, returned to the room and then allowed staff to clean/change the resident with assistance of family. R114's vital signs were assessed, skin assessment completed with no impairments, pain or signs of injury or pain noted. Social services documented an attempt to talk to R114 on 5/12/25 at 1:36 p.m. following the incident. This note documented the resident stated she did not want to talk to any social worker. Nursing documented the resident calmed after the family arrived 5/12/25, resumed taking medicines and allowed staff members to provide care and services. A nursing note dated 5/13/25 documented the resident attended out of room activities, including exercises with other residents and listed, her mood was calm and happy. Daily skilled nursing notes on 5/13/25 and 5/14/25 documented the resident as oriented to person/place, with no aggressive behaviors, as conversive with staff, with calm/pleasant mood, ambulating in halls and with no pain. A nursing note dated 5/15/25 documented, .the resident has been calm and cooperative these last two days but there is confusion. She has no c/o [complaints of] pain. 5/13/25 and 5/14/25 I assessed he [the] skin and no new bruising noted .family are supportive and coming to visit her . Psychiatry assessed R114 on 5/16/25 regarding the altercation with a CNA on 5/12/25. The psychiatry progress note dated 5/16/25 documented, Patient states the CNA came from behind, grabbed, and started hitting her. She states she had to defend herself and staff intervened . Psychiatry documented the resident was recently started of Seroquel during hospitalization (prior to admission to the facility) due to delirium. Psychiatry documented under review of systems, .Denies feeling depressed, anxious or agitated, Denies any insomnia, Reports appetite to be good, No reported hallucinations or delusions, No reported suicide ideation, intent plan, No reported restlessness or irritability, No reported intrusive thoughts, No reported fatigue, No reported loss of interest in activities, Reported memory loss, No reported phobias or fears, racing thoughts . The psychiatry NP documented R114 as stable with orders to continue monitoring and current plan of care with no changes in treatment ordered. R114's medication administration record (MAR) documented no administration of the as needed Ativan prescribed for acute agitation during the five days following the incident. The urinalysis with culture ordered on 5/12/25 was negative for an infection. R114's clinical record documented ongoing assessment with the combative behaviors and resistance to care noted after diagnosis/treatment of a urinary tract infection on 5/19/25. The resident's plan of care was updated on 5/12/25 to include problems, goals and interventions related to maintaining psychosocial well-being due to physical abuse. The facility's investigation of R114's abuse incident of 5/12/25 was reviewed and documented that CNA #5, who was witnessed hitting the resident, was immediately removed from the room, taken to the administrator's office and suspended. The abuse incident was reported to the responsible party, medical provider, state survey agency, adult protective services, ombudsman, state department of health professions and law enforcement on 5/12/25 as required. The investigation documented skin assessments on all residents with BIMS (brief interview of mental status) score of 8 or below and (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	interviews with all other residents that were cared for by CNA #5. Investigation findings were reported to the state agency and documented that CNA #5 voiced that she became upset that her necklace was broken while performing personal care for R114. The investigation documented CNA #5 was aware that R114 did not want to be changed and that care was attempted because the resident was scheduled for therapy and needed to be cleaned. The investigation documented CNA #5's actions agitated R114, that RN #3 witnessed CNA #5 hit R114 with abuse substantiated and CNA #5 terminated. The facility's investigation documented the following written statements from registered nurse (RN#3) that witnessed the incident and CNA #5 that was witnessed hitting and using derogatory language in front of the resident. RN #3's written statement dated 5/12/25 documented, .I was called in the [R114's] room by the Aide [CNA #5] on assignment stating 'Can you come help me. She's [R114] try to fight me.' I entered into the room and saw the aide trying to remove the patients brief. The .paint [patient] expressed that she wanted the Aide to stop and to leave her alone. I asked the Aide to step out but she refused stating 'she broke my grandma chain and its somewhere in the bed or her breif [brief].' The aide then pushed the patient on her side stating 'She's shitty and I need my chain.' the patient tried to roll back over then the Aide punched the patient in her thigh/back twice and said 'I just don't care anymore' . (sic) A written statement from CNA #5 dated 5/12/25 documented, I went into [R114's room] after I picked up the breakfast trays to get her cleaned up for therapy. I explained to her what I was doing + she started getting combative with me. I tried to explain to her that she cant hit me + that I was trying to help her get cleaned up for the day. She continued to hit me. She grabbed my necklace + broke it + my nametag too. I then went + got the nurse to help me. She still was fighting + I was trying to grab her arms + explain that she cant hit me + that I was trying to help her. She kept refusing for me to clean her up even after the nurse tried to explain as well that she was dirty. (sic) On 3/5/26 at 9:05 a.m. the administrator, administrator in training (AIT) and the director of nursing (DON) were interviewed about R114's abuse and actions taken in response. The current administrator was not employed at the facility at the time of the incident. The DON stated that RN #3 immediately reported on 5/12/25 that she witnessed CNA #5 hit R114 when CNA #5 attempted to perform incontinence care after the resident stated she did not want to be changed. The DON stated R114 grabbed CNA #5's shirt during the incident and broke the CNA's necklace. The DON stated CNA #5 then pushed the resident and punched the resident in the back/thigh twice with her fist as witnessed by RN #3. The DON stated RN #3 told CNA #5 to get out of the room and she was escorted to the administrator's office. The DON stated she went to the unit and R114 was standing in the hall and would not return to her room. The DON stated she and staff members stayed with the resident and finally got the resident to sit. The DON stated R114 was agitated, confused, would not allow staff to assess or change her and that staff stayed with the resident in the hall. The DON stated she went to the office and interviewed CNA #5 about what happened with the administrator at that time and AIT present. The DON stated she asked CNA #5 if she hit R114 and that CNA #5 responded, Yes. The DON stated CNA #5 was upset that the resident broke her grandmother's necklace. The DON stated she informed CNA #5 that hitting the resident was abuse, that she was suspended and CNA #5 was then escorted out of the building. The DON stated she returned to check on R114 and after the resident's family arrived, the resident returned to her room and allowed staff members to clean, change and assess her. The DON stated the family came within an hour of the incident and were instrumental in getting the resident cleaned/changed as the resident did not want staff to clean her. The DON stated she assessed the resident with no pain, and a skin assessment revealed no signs of physical injury. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The DON stated the police were notified and came the same day. The DON stated the NP assessed R114 following the incident and the resident was later assessed by psychiatry. The DON stated the family member reported the resident had been combative and resistive to care at times prior to admission to the facility. The DON stated psychiatry assessed the resident with baseline cognitive status and that the resident was aware that she had been hit by a staff member. The DON stated the resident required no additional medication in response to the incident and did not display fear of staff in the days following the incident. The DON stated the resident ambulated with a walker, was out of the room and attended a group activity with other residents the next day. The DON stated interviews were immediately conducted with alert/oriented residents in addition to skin assessments for all other residents with no abuse findings. The DON stated education was initiated on 5/12/25 for all staff in response to the incident. The DON and AIT stated there had been no history of any concerns with CNA #5's performance prior to this incident and resident interviews revealed she was well-liked by residents. The AIT stated that CNA #5 was terminated as a result of this incident. The AIT presented a copy of a state and national criminal background for CNA #5 with no findings and signed acknowledgment of code of ethics and employee handbook that included abuse prevention policies completed in June 2024. The administrator at the time of this incident and RN #3 that witnessed the abuse were not available for interview as they no longer worked at the facility. The facility's policy titled Abuse, Neglect, Exploitation & Misappropriation (revised 11/16/22) documented, It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. Employees of the center are charged with a continuing obligation to treat residents so they are free from abuse. No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Physical Abuse includes hitting, slapping, punching. Verbal Abuse may be considered a form of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to resident within hearing distance. Mental and Verbal Abuse include Harassing a resident, mocking, insulting, ridiculing, Yelling or hovering over a resident, with the intent to intimidate. Acts of abuse directed against residents are absolutely prohibited. The facility presented the following plan of correction for abuse initiated on 5/12/25 in response to this incident 1. Corrective Action for Affected Resident - Immediately upon receiving the allegation on 5/12/25, the resident was protected from further potential harm. A licensed nurse completed a full skin-to-skin head-to-toe skin assessment to identify any injuries or changes in condition. No injuries were identified at the time of assessment. The DON reviewed the clinical findings and supervised continued monitoring of the resident following the incident to ensure safety. CNA #5 named in the allegation was immediately removed from resident care duties, suspended pending the facility's investigation in accordance with the facility's abuse prevention policy. 2. Identification of Other Residents Who May Have Been Affected - Review of all staff assignments was completed on 5/12/25. Interviews were conducted with residents assigned to the alleged staff (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	member. Review was conducted of all clinical documentation for residents receiving care during the shift. Additional skin-to-skin head-to-toe nursing assessments were completed for all residents who received care from CNA #5. All assessments were conducted by licensed nursing staff with oversight by the DON. 3. Systemic Changes Implemented - Immediate re-education of 100% of facility staff regarding abuse prevention and mandatory reporting requirements. Education included review of the facility's zero-tolerance abuse policy, reinforcement of professional conduct expectations during resident care, increased supervisory rounds by nursing leadership during resident care activities and review of reporting expectations with all department heads. 4. Monitoring Plan with Specific Dates &ndash; The DON or designee will monitor compliance through observational audits and skin-to-skin head-to-toe assessments according to the following schedule: Week 1 monitoring audit 5/19/25; week 2 monitoring 5/26/25; week 3 monitoring 6/2/25; week 4 monitoring 6/9/25. June 16, 2025 &ndash; Final review of the 4-week monitoring period. These audits include direct observation of CNA-resident care interactions and random skin-to-skin head-to-toe nursing assessments. Results will be reviewed by the DON. Following completion of the 4-week monitoring period ending 6/16/25, the results will be reviewed during the facility's Quality Assurance and Performance Improvement (QAPI) meeting to determine if additional monitoring is required. 5. Correction date was 6/13/25. The surveyor verified that R114's abuse incident was reported to the state survey agency, department of health professions, adult protective services, law enforcement in addition to the medical provider and family representative. There was evidence that the abuse prevention policies for reporting and investigating the incident were followed. Documentation was provided of resident interviews and skin assessments as listed in step 1 of the correction plan with no further abuse identified. Documentation was provided of staff education that started on 5/12/25 on abuse/neglect policies, professional conduct during care and abuse reporting. Skin assessments of residents care for by CNA #5 were documented in addition to weekly monitoring CNA-resident care and ongoing skin audits. The QAPI meeting agenda for August 2025 included review of the substantiated staff to resident abuse incident of 5/12/25, with staff member termination noted. On 3/5/26 starting at 11:48 a.m., multiple staff members on each nursing unit were interviewed and voiced education had been provided regarding abuse prevention, reporting and professional conduct during care with staff aware of abuse protocols for prevention, reporting and expectations for conduct during care. The survey team deemed the plan of correction was implemented as listed. During the current survey, resident interviews, family interviews, a resident group/council interview, staff interviews and record reviews conducted with no reports of resident abuse and no deficiencies cited for resident abuse since 6/13/25. This deficiency was cited as past non-compliance.		

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F 0686 Level of Harm - 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 observations, staff interview, clinical record review, and facility document review, the facility staff failed to provide treatment and services to prevent and heal pressure sores for two Residents (Residents # 113 and #9) in a survey sample of 46 Residents, resulting in harm for Resident # 113. The findings included: For Resident # 113, the facility staff failed to address the potential for developing a pressure ulcer, failed to identify the risks, failed to develop a plan of care and failed to implement interventions to prevent pressure ulcer development, resulting in Harm. Resident #113 was admitted to the facility on [DATE] with diagnoses that included but were not limited to pathological fracture of right femur, a history of malnutrition, B 12 deficiency, adult failure to thrive, need for assistance with personal care, difficulty in walking, lack of coordination and unsteadiness on feet. The most recent Minimum Data Set (MDS) assessment was an admission assessment with an Assessment Review Date of 5/20/2023. The MDS coded the BIMS (Brief Interview for Mental Status) as 7 out of 15, indicating severe cognitive impairment. Resident # 113 required assistance with ADLs (Activities of Daily Living.) The MDS Section M-Skin Conditions-M 150-Risk of Pressure Ulcers/Injuries was coded as a 1 indicating Resident # 113 was at risk of developing pressure ulcers/injuries. Section M0210 coded a 0 indicating there were no unhealed pressure injuries on admission. Review of the closed clinical paper record was conducted 3/5/2026 to 3/10/2026. Review of inpatient hospital records prior to admission to the facility revealed an inpatient Wound Care services consult dated 5/10/2023 for wounds to left second and third toes. The Plan was: Primary RN (Registered Nurse) to order and utilize wedges and heel medix boots from central supply if not already present in room. The note also stated "Aggressive repositioning-reposition patient at least every 2 hours utilizing wedges and pillows to offload pressure from bony prominences. Float heels-offload pressure from heels via pillows or heel medix boots any time patient is in bed. Resident # 113 was admitted to the facility on [DATE]. The admission assessment dated [DATE] at 4 p.m. described skin issues on the upper mid vertebrae, right elbow, groin and right thigh (rear) with bruises and 12 staples. There were no concerns noted on the feet. There was no documentation of orders carried over from the hospital regarding prevention of pressure wounds to include use of wedges, pillows, floating heels, repositioning or use of Medix boots. Resident #113's care plan did not address the presence of wounds, risk for pressure ulcer development, or implementation of interventions to prevent the development of a pressure wound. On 5/16/2023, the admission assessment documented no open areas. Weekly skin assessments were conducted and revealed the following: 5/25/2023- no open areas. 5/28/2023- Right Heel -red area. 5/31/2023-right heel open, redness, bleeding. 6/1/2023 @ 1728 (5:28 p.m.)-right heel-stage 3 pressure injury-5x3.2x.02 measurement (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Treatment-Collagen and santyl daily off load and reposition. Physicians Progress Notes were reviewed. The Physicians Progress notes on 5/17/2023 and 5/23/2023 revealed no skin issues. On 5/30/2023-Physicians Progress Notes stated has wounds to bilateral heels. The right is open and the left is DTI (Deep Tissue Injury.) skin right heel wound-left heel DTI-plan: left heel: paint with skin prep every shift. right heel: iodosorb every other day. Float heels with prevalon boots while in bed Review of Physicians orders from the Order Summary Report 5/16/2023-7/10/2023 totaling 8 pages revealed orders for the following listed under other orders 5/16/2023-verbal-Weekly skin checks 5/30/2023-prescriber written-Prevalon boots while in bed to bilateral heels 5/30/2023-prescriber written-right heel wound: clean with wound cleaner, apply iodosorb to wound, cover with bordered gauze every other day. 6/1/2023-verbal-right heel-clean with wound cleaner, apply santyl and collagen to wound bed, cover with gauze, and wrap with kerlex. Every day shift for wound care Under Pharmacy Orders was written:6/1/2023- Santyl External Ointment 250 unit/gm(gram) (Collagenase)- verbal -Apply to right heel wound bed topically every day shift for wound care 6/8/2023-verbal-right heel-clean with wound cleaner, apply santyl to wound bed, cover with moistened Dakins gauze; wrap with kerlex every day shift for wound care The wound care physician notes dated 6/15/2023 revealed documentation of pressure wound on the right heel as a Stage 4. The note stated: 6/15/2023-Consultant Wound Care Report-Wound Evaluation and Management Summary-stated referred by provider-chief complaint was about a wound on the right heel. Focused Wound exam-Site 2-Pressure, Stage 4, duration >14 days, Wound size (L x W x D) 4.5x 2.0 x Not measurable cm (centimeters)-Thick adherent black necrotic tissue (eschar)-30%, Thick adherent devitalized necrotic tissue-20% Granulation tissue-50%. Dressing treatment plan- Primary dressings -Santyl apply once daily for 16 days, sodium hypochlorite solution (dakins) apply once daily for 19 days. 1/4 strength dakens moistened gauze to be applied with santyl to the wound bed. Cover with kerlex daily. Secondary dressing-Gauze roll (kerlix) 4.5 apply once daily for 16 days. Periound Treatment-skin prep, apply once daily for 19 days. Plan of care reviewed and addressed Recommendations: Off-Load Wound, Reposition per facility protocol. During the consultant wound care physician's visit, the wound on the right heel was debrided of necrotic tissue to establish the margins of viable tissue. The thick adherent eschar and devitalized tissue were removed. After the Consultant Wound Care Specialists visit, Weekly Pressure Ulcer Wound Reports were conducted and revealed the following: 6/15/23- Pressure Ulcer Wound rounds -pressure-right heel-4.5 x 2 x nm- Stage 4 (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	6/22/23- Pressure Ulcer Wound rounds -pressure-right heel-5 x2 x nm-Stage 4 6/29/23- Pressure Ulcer Wound rounds -pressure-right heel -5 x2 x nm-Stage 4 7/6/23 - Pressure Ulcer Wound rounds -pressure-right heel-4.5 x 2 x nm- Stage 4 Resident # 113 resided in the facility for 12 days prior to the discovery of a reddened area on the right heel on 5/28/2023. No descriptions or measurements were documented. Two days later on 5/30/2023, the first physicians' orders were documented. Three days after the first discovery of a reddened area (on 5/31/2023), the area was described as right heel open, redness and bleeding. There was no documentation of the description to include staging or sizing. On 6/1/2023, the staging and documentation of measurements were documented as Stage 3 and measuring 5x3.2x.02. There was no order for interventions for the prevention of pressure wounds in Resident #113, who was a resident with known risks for the development of pressure ulcers. There was a physicians order for weekly skin checks on the day of admission but no further documentation of interventions for the prevention of the development of pressure ulcers/wounds. The order for Prevalon boots on bilateral heels and a treatment order were written on 5/30/2023, two weeks after admission. On 3/4/2026 at 11:10 a.m., an interview was conducted with Certified Nursing Assistant # who stated residents should be turned and repositioned at least every two hours. Certified Nursing Assistant # stated the staff check the skin of the residents during ADL care and any skin issues should be reported to the nurse. On 3/5/2026 at 2:20 p.m., an interview was conducted with Licensed Practical Nurse # who stated residents at risk of pressure ulcer development should be turned and repositioned every two hours or more if needed. She stated that the Certified Nursing Assistants were expected to inform the nurse of any noted skin issues. Licensed Practical Nurse # stated that interventions should be used for residents at risk for developing pressure ulcers. She stated if a pressure wound developed, the physician and the family would be notified. The facility's policy titled Pressure Injury Prevention and Management (revised 11/7/25) documented, .The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate .Assessments of pressure injuries will be performed by a licensed nurse, and documented accordingly. The staging of pressure injuries will be clearly identified .Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present .The attending physician will be notified of .presence of a new pressure injury upon identification . On 3/9/2026, the Director of Nursing was informed that there was no noted documentation of staging of the wound prior to a stage 3 on 6/1/2023. There were no noted interventions to prevent the development of pressure ulcers prior to the identification of a reddened right heel on 5/28/2023. The Director of Nursing stated she would check the documentation in the clinical record and any Quality Assurance Performance Improvement documentation. She stated that wounds should be identified prior to advance stages and interventions should be implemented for residents at risk of pressure ulcer development. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Newport News Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 12997 Nettles Drive Newport News, VA 23602	
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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 - Actual harm Residents Affected - Few	During the end of day debriefing on 3/10/2026, the Director of Nursing, Administrator and [NAME] President of Operations were informed of the findings resulting in harm for resident # 113. The Director of Nursing stated she did not find any further documentation. No further information was provided. 2. Topical treatment and dressing changes were not implemented for Resident #9's pressure ulcer until 15 days after admission when the resident was assessed by the consultant wound physician. Initial assessments by nursing of the pressure ulcer included no wound measurements or description of the wound's appearance and/or status. Resident #9 (R9) was admitted to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease), sacral pressure ulcer, bipolar disorder, benign prostatic hyperplasia, orthostatic hypotension, schizotypal disorder, chronic kidney disease, ichthyosis, anemia, dementia, hip fracture, psychotic disturbance, mood disorder and protein-calorie malnutrition. The minimum data set (MDS) dated [DATE] assessed R9 with severely impaired cognitive skills. R9's clinical record documented the resident was admitted from the hospital on 4/30/25 following treatment for hypotension and anemia. Hospital records documented that the resident was assessed and treated for an unstageable pressure ulcer on the sacrum during the hospitalization. A hospital wound assessment dated [DATE] documented R9's sacrum pressure injury measured 7.5 cm x 5.5 cm (length by width in centimeters) with eschar, purple/burgundy, non-blanchable erythema with eschar covering over 55% of the wound surface. The hospital Discharge summary dated [DATE] listed instructions for care of the pressure ulcer to include daily treatment with wound cleanser, application of hydrophilic dressing with silicone foam dressing to cover. R9's admission assessment dated [DATE] documented the resident was assessed upon admission with a sacral wound. The admission assessment documented no wound measurements and listed no description of the wound's appearance including size, wound/skin color, peri-wound color, pain presence or presence of drainage. A skin assessment dated [DATE] documented unstageable necrosis to sacrum but included no measurements or description of the wound's status/appearance. A skin assessment dated [DATE] documented the resident had an unstageable sacrum pressure ulcer and that the consultant wound physician would assess the wound. The consultant wound physician documented assessment of R9's sacrum pressure ulcer on 5/16/25. The wound note dated 5/16/25 documented the resident with an unstageable pressure injury on the sacrum measuring 5.5 cm x 3.0 cm with depth undetermined due to presence of necrotic tissue. The wound description listed 60% coverage with eschar and light serous drainage with no signs of infection. The wound physician ordered treatment with Santyl, and application of gauze saturated with 1/4 strength Dakin's solution covered with superabsorbent gel fiber with silicone border dressing daily and as needed. Skin prep was ordered once daily for application to skin surrounding the wound. Treatment orders for R9's pressure ulcer were entered and implemented starting on 5/16/25. The wound physician documented ongoing assessment of the pressure ulcer with changes in treatments implemented based upon assessments. Interventions in addition to topical treatments and dressing changes included turning and repositioning, weekly skin checks, low air loss mattress, off-loading of pressure areas, liquid protein supplement and a daily multivitamin. Wound assessments documented the wound improved without complications and was listed as resolved on 12/1/25. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/3/26 at 4:27 p.m., R9 was observed in bed with feet/heels elevated on a cushion and pressure relief mattress in use. R9's clinical record documented a foam dressing was applied three times per week to the sacrum for prevention of skin breakdown with no current pressure injuries. On 3/4/26 at 12:00 p.m., the director of nursing (DON) was interviewed about the delayed treatment and lack of assessment for R9's sacrum pressure ulcer. The DON stated she reviewed the clinical record and did not see treatment orders entered upon admission on [DATE]. The DON stated if a resident was admitted with a pressure injury, the admitting nurse should have assessed the wound, measured it, described it and obtained orders for care. The DON stated there should have been a thorough assessment of the pressure ulcer when noted on the weekly skin check sheets. The DON stated the admitting nurse noted there was a wound and the nurse should have obtained orders for care. The DON stated there was a delay in care. The DON stated the wound physician provided ongoing assessment with care/treatments implemented as ordered after 5/16/25. The DON stated R9's sacrum ulcer healed without complication and that the resident currently had no pressure injuries. On 3/5/26 at 8:26 a.m., the licensed practical nurse unit manager (LPN #8) caring for R9 was interviewed about the delay in treatment and lack of assessment for the pressure ulcer. The unit manager stated that if a pressure ulcer was identified, the nurse should document a full assessment with measurements. The unit manager stated the admission nurse should have obtained treatment orders upon admission. The facility's policy titled Pressure Injury Prevention and Management (revised 11/7/25) documented, .The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate .Assessments of pressure injuries will be performed by a licensed nurse, and documented accordingly. The staging of pressure injuries will be clearly identified .Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present .The attending physician will be notified of .presence of a new pressure injury upon identification . The National Pressure Injury Advisory Panel (NPIAP) defines a pressure ulcer/injury as localized damage to the skin and underlying soft tissue usually over a bony prominence .The injury occurs as a result of intense pressure, prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue . The NPIAP defines an unstageable pressure injury as, .Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, as Stage 3 or Stage 4 pressure injury will be revealed . (1) This finding was reviewed with the administrator, director of nursing and regional MDS coordinator during a meeting on 3/4/26 at 12:00 p.m. with no further information presented prior to the end of the survey. (1) Pressure Injury and Stages. National Pressure Injury Advisory Panel. 3/12/26. www.npiap.com/		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility documentation review, the facility staff failed to maintain a clean, comfortable, and homelike environment on 2 of 3 nursing units, shower rooms, storage rooms, and for four Resident's room (Resident #8, Resident #23, Resident #37, and Resident #72) within the greater facility. The findings included: From initial tour on 3/3/2026 through the course of survey concluding on 3/10/2026, the physical plant was observed and inspected. Those observations continue below. Initial tour of the facility revealed Resident #8's room on the Meadowdale unit to be crowded (hoarded) with boxes, and plastic storage containers in front of, and on top of the air conditioning unit restricting air flow. There were articles of clothing scattered around, opened large (16 to 18 ounce) containers of food sauces, and food spices all spilled and on surfaces. Also noted were partially eaten different food items mixed together and unidentifiable, 4 drinking glasses partially filled with dark liquid and dripped down the sides of the glasses. Nothing was refrigerated, and the room had a sour spoiled food smell. The Resident was sitting on a soiled bed encrusted with spilled food. The Resident's black sweatshirt was encrusted in a 6-inch by 6-inch stain on the front with dried, spilled foods and liquids, as the resident stated when asked I just spilled something on it. Resident #8's roommate was lying in his bed with a curtain drawn between them. There were several rooms with hoarding habitation noted during tour, and an interview with the Administrator in Training (AIT) revealed that a new program was being launched to address these issues. It was noted that during the rest of the survey Resident #8's roommate stayed out of the room most of the time and was found in the dining room, facility entry hallway, and at the nursing station most of the time during daytime hours. Resident #8's roommate was asked why he stayed out of his room, and he replied, I want to. Then he continued down the hallway ending the conversation. On 3/4/2026 beginning at 8:35 A.M., in the Meadowdale women's shower room observations by 2 surveyors revealed a black substance along corners and caulking area, and broken tiles in the showers. In the men's shower room, used soap and hair in the drain cover was sticking out. Handrail portions and end plugs/caps were broken in places and on the floor. A shower stretcher was found with used soap on it. Base boards were observed to be knocked down in places where they had become un-adhered. Used shampoo and soap was lying on the floors, and feces was found in the toilets within the shower rooms. The inspection continued on the Rosewood unit to reveal what appeared to be a shampoo bottle lying in the floor of the shower. Also found was calking that was pulled away from tiles which were lying on the floor and still attached to broken tiles. This revealed open holes in the wall approximately 6 inches in circumference. The shower chair was also observed with no anti slip grip on the seat and arm rest. The second shower area revealed that lights were out and this was where wheelchairs were being stored. On 3/4/2026 at 12:00 P.M., an interview was conducted with a housekeeping staff member cleaning the hallway on the Meadowdale unit. She was asked what her workload was like daily, and she replied (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	we do 22 rooms each, and public areas as needed every day. This statement was confirmed by the maintenance director and the Housekeeping Director. Schedules of cleaning assignments were requested and supplied. Resident rooms were devoid of personal items, photographs, or artwork, and were not comfortable and homelike. Divider bed curtains were stained and not clean. Few rooms contained clocks or personal items. The sink area and steam table in the main dining room were encrusted with a black substance on the top and in the bowl of the sink, and on the countertop. The stainless steel or aluminum steam table was dirty and unkempt. On 3/4/2026 at 12:30 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated that the hallway would be cleaned immediately, and his expectation was that staff should clean the shower rooms and bathrooms if they were dirty. On 3/9/2026 at 10:00 AM on a facility tour with the Maintenance Director, The Rosewood unit beauty shop was found to be open and had a continuous water leak covering about 30% of the back wall, the wall appeared to be rotten, and a kitchen trash can was in the middle of the floor overflowing with water dripping onto the floor and into the wall. On 3/9/2026 at 4:00 p.m., the Administrator, DON and Regional [NAME] President of Operations were notified at the end of day debriefing of the concerns of hoarding and unclean areas. They stated that cleaning had been completed in those areas mentioned and they had no further information to provide. 2. For R23 and R37 the resident's rooms were in disrepair and were not homelike. On 3/3/26 at 2:56 p.m. Resident #23 (R23) was interviewed. When asked about conditions of the room (room [ROOM NUMBER]), R23 verbalized there is unsanded and unpainted spackling on the wall, the bathroom door is scrapped up and unpainted, and the molding around the base of the wall is pulling away from the wall. R23 verbalized that the concerns had been reported but nothing is done about it. The concerns were observed at the time of the interview. On 3/4/26 at 9:20 a.m. Resident #37's (R37) family member (responsible party, RP) requested to speak to the surveyor. During the interview the RP verbalized that R37's closet door was no longer attached to the closet and R37 does not have a dresser for clothes and other items like other residents have. The RP verbalized buying a small plastic three draw storage bin but feels that it doesn't accommodate all items and can be easily fixed by getting a dresser from a room that is not being occupied. The RP verbalized these items have been requested to be fixed or replaced for a while. On 3/4/26 at 9:28 a.m., observations were conducted of R37's room. The closet door was detached and leaning against the side of the closet and there was not a facility owned dresser beside the R 37's bed like had been observed for R37's roommate and other rooms. On 3/05/26 at 1:30 p.m. the maintenance director was interviewed and confirmed the observations/concerns in each room noted above. The maintenance director verbalized the closet door of R37's room could not be fixed and would have to be replaced and the corporate would have to be contacted to get a replacement closet. Regarding the missing dresser, the maintenance director (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	verbalized he would try to get another one from an empty room. The maintenance director then observed R23's room and agreed that the above concerns need to be fixed. The maintenance director verbalized that there are two maintenance employees (including himself) and the other person was newly hired and at this time both the maintenance employees are currently working on priority issues and plan to come up with a maintenance schedule. On 3/5/2026 at 4:00 p.m. the above information was presented to the administrator, director of nursing, and administrator in training (AIT). The AIT verbalized that corporate is no longer replacing closets with another closet and will be replaced with a dresser. No other information was presented prior to exiting on 3/10/26. 3. For Resident #72, the facility staff failed to maintain a homelike environment, by failure to replace a broken receptical cover. A comprehensive record review of R72's medical record revealed that R72 has a most recent BIMS (Brief Interview for Mental Status) score of 6 indicating significant mental impairment on his most recent (Quarterly) MDS (Minimum Data Set) Assessment. The same MDS assessment demonstrated that R72 is dependent on staff for transfers and utilizes a wheelchair. Review of the medical record showed that R72 has poor impulse control, frequent falls out of bed, and behaviors. On 3/3/26 R72 was observed sitting in bed in their room. While standing at the foot of the bed, an electrical outlet was noted on the wall behind the right side of the bed. This electrical outlet had a plate that was broken with the left side of the plate no longer present and a subsequent hole in the wall exposing the elements of the outlet plug. This electrical outlet was within arm's reach of the floor mats placed on both sides of R72's bed. An interview with the Maintenance Director was conducted on 03/06/2026 10:50 A.M. States when a repair is needed the process is to place a work order in with maintenance. States that a broken electrical outlet would be considered an emergency and the expectation would be for it to be fixed immediately upon discovery. Maintenance Director stated that this electrical outlet had been repaired since this issue was brought to their attention after surveyor discovery on 3/3/26 and produced a photograph of the repaired outlet. No further information was provided prior to exit.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive plan of care for four of forty-six residents in the survey sample (Residents #2, #3, #113 and #115). The findings include: 1. Resident #2 had no care plan developed regarding PTSD (post-traumatic stress disorder). Resident #2 (R2) was admitted to the facility with diagnoses that included vascular dementia, schizophrenia, diabetes, PTSD, major depressive disorder, chronic kidney disease, cerebrovascular disease, atrial fibrillation, deep vein thrombosis, anxiety and peripheral vascular disease. The minimum data set (MDS) dated [DATE] assessed R2 as cognitively intact. R2's clinical record documented ongoing monitoring by a licensed clinical social worker (LCSW) for mental health conditions that included PTSD. The most recent LCSW note dated 2/3/26 listed the resident had agreed to psychotherapy up to twice per month to address depression/anxiety symptoms related to PTSD, vascular dementia and schizophrenia. The psychiatry note documented the resident's PTSD was related to a serious accident as a teenager that affected his life. Interventions included trauma-informed care approaches during psychotherapy sessions and continued provision of supportive counseling focused on coping strategies and therapeutic engagement. Barriers to progress included medical comorbidities with interventions listed that included psychotherapy sessions twice per month. R2's plan of care (revised 10/8/25) included no problems, goals and/or interventions regarding PTSD. The plan of care listed the resident took psychotropic medications for management of PTSD but did not include the resident's identified trauma (serious accident), triggers related to the trauma or interventions that included monthly psychotherapy sessions with the LCSW. On 3/5/26 at 11:00 a.m., the licensed practical nurse (LPN #6) responsible for MDS and care plan development, was interviewed about R2. LPN #6 stated the care plan mentioned medicines but there was nothing else in the plan about the PTSD. LPN #6 stated the care plan should include problems, goals and interventions regarding PTSD. This finding was reviewed with administrator, director of nursing and the regional MDS coordinator on 3/9/26 at 5:00 p.m. with no further information presented prior to the end of the survey. 2. Resident #3 (R3) did not have a comprehensive care plan developed to address the need for dialysis. R3 diagnoses include end stage renal disease with dialysis, diabetes, major depression, and kidney failure. The most recent MDS (minimum data set) was a quarterly 2/16/26 and indicated R3 was cognitively intact. Review of R3's physician orders indicated R3 went to dialysis three days per week. R3's care plan was also reviewed and did not have evidence that a dialysis care plan had been developed. On 3/05/2026 at 9:47 a.m. the MDS coordinator reviewed R3's care plan and agreed that there was no dialysis care plan on the current comprehensive care plan and stated she would get one completed. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/2026 at 4:00 p.m. the above information was presented to the administrator and director of nursing. No other information was presented prior to exit summary on 3/10/26. 3 For Resident # 113, the facility staff failed to develop a care plan for the risk of development of pressure ulcers/wounds and did not develop a care plan when a wound was discovered on the right heel. Resident #113 was admitted to the facility on [DATE] with diagnoses that included but were not limited to pathological fracture of right femur, a history of malnutrition, B 12 deficiency, adult failure to thrive, need for assistance with personal care, difficulty in walking, lack of coordination and unsteadiness on feet. The most recent Minimum Data Set (MDS) assessment was an admission assessment with an Assessment Review Date of 5/20/2023. The MDS coded the BIMS (Brief Interview for Mental Status) as 7 out of 15, indicating severe cognitive impairment. Resident #113 required assistance with ADLs (Activities of Daily Living.) Resident #113's admission MDS was coded as at risk for the development of pressure ulcers/injuries. Review of inpatient hospital records prior to admission to the facility revealed an inpatient Wound Care services consult dated 5/10/2023 for wounds to left second and third toes. The Plan was: Primary RN (Registered Nurse) to order and utilize wedges and heel medix boots from central supply if not already present in room. The note also stated "Aggressive repositioning-reposition patient at least every 2 hours utilizing wedges and pillows to offload pressure from bony prominences. Float heels-offload pressure from heels via pillows or heel medix boots any time patient is in bed. On 5/28/2023, twelve days after admission, a reddened area was identified on Resident # 113's right heel. No measurements were documented. On 6/1/2023, the pressure ulcer on the right heel was identified as a Stage 3 wound and measuring 5x3.2x.02. The care plan was reviewed and revealed no documentation that a care plan had been developed to prevent or reduce the risk of the development of pressure ulcers. There was no focus area, goals or interventions listed regarding the risk of pressure ulcer development. Treatment orders were written two days after the discovery of a reddened area on the right heel. There was no order for interventions for the prevention of pressure wounds in a resident with known risks for the development of pressure ulcers. The care plan was not updated when Resident #113 developed a pressure ulcer on the right heel. On 3/06/2026 at 10:27 a.m., the Director of Nursing reviewed Resident #113's care plan and agreed that there was no documentation of a care plan for risk for development of pressure ulcers/wounds on the comprehensive care plan. The Director of Nursing stated the care plan should reflect the problems related to the resident. On 3/6/2026 during the end of day debriefing, the Administrator, Administrator in Training and Director of Nursing were informed of the findings. No further information was provided. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. For Resident # 115, the facility staff failed to develop a care plan that was tailored to the specific needs of the resident. The care plan was not specific. Resident #115 was admitted to the facility on [DATE] with diagnoses that included but were not limited to: multiple myeloma, Diabetes with Diabetic chronic kidney disease, chronic obstructive pulmonary disease, atrial fibrillation, acute cystitis with hematuria, acute posthemorrhagic anemia, and hemorrhage of the anus and rectum. The most recent Minimum Data Set (MDS) assessment was an admission assessment with an Assessment Review Date of 4/10/2023. The MDS coded the BIMS (Brief Interview for Mental Status) as 15 out of 15, indicating no cognitive impairment. Resident # 115 required assistance with ADLs (Activities of Daily Living.) Review of the care plan revealed the care plan was not tailored for Resident # 115. There were concerns that were written that did not have specific information. The care plan was a template with the word specify included, the goal was not measurable and some problems/concerns were not included in the plan. A Focus area read- The resident has an ADL self-care performance deficit related to activity intolerance Goal: The resident will improve current level of function in (SPECIFY ADLs) through the review date. The goal was not specific and did not identify which activities of daily living. Another excerpt from Resident #115's care plan read: Focus- Has the potential for pressure injury development related to immobility. No Goal was written in the care plan. The Goal section was blank. The care plan did not address that Resident # 115 was known to be allergic to four (4) medications and prescribed two of them for pain relief. Tramadol was ordered as needed and Tylenol extra strength was scheduled for administration three times per day. There was no documentation of nursing staff assessing and monitoring for signs and symptoms of allergic reactions to those medications. On 3/06/2026 at 10:37 a.m., the Director of Nursing reviewed Resident # 115's care plan and stated that the care plan was not specific and tailored. She stated the comprehensive care plan should reflect the problems/concerns related to the resident. No further information was provided.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on Staff interview, clinical record review, and facility document review, the facility failed to provide medications as ordered by a physician for one Resident (Resident #113) in a survey sample of 46 residents. The findings included: For Resident # 113, the facility staff failed to ensure medications were available for administration. Resident #113 was admitted to the facility on [DATE] with diagnoses that included but were not limited to pathological fracture of right femur, a history of malnutrition, B 12 deficiency, adult failure to thrive, need for assistance with personal care, difficulty in walking, lack of coordination and unsteadiness on feet. The most recent Minimum Data Set (MDS) assessment was an admission assessment with an Assessment Review Date of 5/20/2023. The MDS coded the BIMS (Brief Interview for Mental Status) as 7 out of 15, indicating severe cognitive impairment. Resident # 113 required assistance with ADLs (Activities of Daily Living.) A review of Resident #113's electronic clinical record was conducted 3/6/2026-3/10/2026. This review revealed the following, but not limited to, excerpts from the progress notes: 7/7/2023-20:52 (8:52 p.m.)-Enoxaparin Sodium inject 0.3 ml (milliliters) subcutaneously two times a day for prevent blood clots until 6/20/2023- awaiting for medication 7/7/2023- 08:41- a.m.-Enoxaparin Sodium inject 0.3 ml (milliliters) subcutaneously two times a day for prevent blood clots until 6/20/2023- waiting for pharmacy to send 7/6/2023-9:57 a.m.- Enoxaparin Sodium inject 0.3 ml (milliliters) subcutaneously two times a day for prevent blood clots until 6/20/2023- calling pharm no more left 6/16/2023-Enoxaparin Sodium inject 0.3 milliliters subcutaneously two times a day for prevent blood clots until 6/20/2023- called pharm for refill 6/8/2023- 12:08 p.m.- Gabapentin 100 milligram oral capsule give one capsule by mouth three times a day for nerve pain -med not administered called pharm will come today. 6/5/2023- 20:02 (8:02 p.m.) Enoxaparin Sodium inject 0.3 ml (milliliters) subcutaneously two times a day for prevent blood clots until 6/20/2023- called pharm will send meds 6/5/2023-Enoxaparin Sodium inject 0.3 ml (milliliters) subcutaneously two times a day for prevent blood clots until 6/20/2023- ran outta med sent refill request to pharm 6/3/23/17/2023 0803- Gabapentin 100 milligram oral capsule give one capsule by mouth three times a day for nerve pain -med ordered waiting for pharm to send it 5/17/2023 12:04 p.m.- Gabapentin 100 milligram oral capsule give one capsule by mouth three times a day for nerve pain -waiting on pharm to deliver med Enoxaparin Sodium inject 0.3 ml (milliliters) subcutaneously two times a day for prevent blood clots until 6/20/2023- ran outta med sent refill request to pharm 6/3/23/2023 During medication pass and pour observation on 3/4/2026, an interview was conducted with the Licensed Practical Nurse # 2 who administered medications. She stated that medications should be given as ordered by the physician. On 3/6/2026 at 1:30 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 Inventory list was requested. On 3/9/2026 at 9:45 a.m., an interview was conducted with the Director of Nursing who stated medications should be available for administration as ordered by the physician. The Director of Nursing stated the Pharmacy should have ensured the medication was available for administration. She also stated the nurses should have checked the Omnicell (in house Stat box) for an available supply of the medication. The Director of Nursing presented a copy of the Omnicell inventory list. Review of the Omnicell Inventory list revealed that the medication, Gabapentin 100 milligrams capsules, was available in the Omnicell. The nurses should have notified the pharmacy to gain access (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Newport News Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 12997 Nettles Drive Newport News, VA 23602	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the medication. During the end of day debriefing on 3/9/2026, the Facility Administrator, Administrator in Training and Director of Nursing were informed of the findings. They stated medications should be available for administration as ordered by the physician. Enoxaparin was not available for administration. No further information was provided.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and staff interviews, the facility failed to appropriately store medications and medical supplies for 2 out of 3 total medication rooms, the Meadowland Unit medication room and the Rosewood Unit medication room. The findings include: An inspection of a medication room on the Meadowland unit took place on 3/5/26 at 12:15 P.M. The following expired items were discovered: An opened box of 2-piece urostomy pouches with a listed expiration date of 12/2024. An opened box of drainable ostomy pouches with a listed expiration date of 12/2024. An opened box of ostomy barrier rings with a listed expiration date of 9/2025. An opened box of no sting barrier film with a listed expiration date of 11/9/2025. Four saline enema sets all with listed expiration dates of 2/2026. Eleven urethral self-catheterization kits with listed expiration dates of 10/31/2024. A rigid tipped urinary catheter with a listed expiration date of 8/2/25. A female luer lock cap with a listed expiration date of 7/28/25. On 3/5/26 at 12:42 P.M. an inspection was conducted of a medication room located in the Rosewood unit. The following expired items were discovered: A package of 2 needles with an expiration date of 2/20/26. An opened box of 2-piece ostomy pouches with an expiration date of 2/1/26. An additional opened box of 2-piece ostomy pouches with an expiration date of 12/1/25. An opened box of closed ostomy pouches with an expiration date of 2/1/26. An interview was conducted with LPN (Licensed Practical Nurse) #3 on 3/5/26 at 12:42 P.M. LPN #3 stated these items are expired and the expectation is that expired medications and supplies are discarded upon discovery. An interview was conducted with LPN #1 on 3/5/26 at 2:07 P.M. LPN #1 stated these items are expired and when expired medical supplies and expired medications are discovered, the expectation is that they are discarded. According to the undated facility policy titled, Medication Storage, it read in part, . 8. Unused medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, and deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy. The Administrator and the Director of Nursing were made aware of the above findings at 4:35 P.M. on 3/5/26. No further information was presented prior to exit.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility documentation review, the facility staff failed to store food in accordance with professional standards for food safety in the main kitchen and in two of three nourishment room refrigerators (Rosewood Unit refrigerator and Meadowland Unit refrigerator) inspected. The findings include: On 3/3/2026 at 1:45 PM an initial tour of the kitchen was conducted with the Dietary Manager (DM). The DM explained that food products are dated when they are delivered and a use-by-date is labeled on individual items when they are opened. An observation of the dry storage room revealed half of a loaf of bread opened with no date. A hot dog bun package was found opened and not dated. A large container of apple cider vinegar was noted to be open without a date. The walk-in refrigerator revealed an opened package of shredded cheese that was not dated. The DM confirmed that opened and undated food items should not have been in the dry goods area or walk-in refrigerator and they were discarded. On 3/5/2026 at 10:56 AM the DM explained that outside food that is brought in by visitors for residents should be labeled with the residents' name, room number and date it was brought in prior to it being placed in the nourishment refrigerators. The Rosewood Unit refrigerator was then observed with DM and contained an opened container of soup that expired on 2/14/2026 and an opened bottle of salad dressing ([NAME] Creamy Italian) that was not dated. The DM stated that those items should have been labeled and should not have been put in the refrigerator. An observation of the Meadowland Unit nourishment refrigerator was conducted with the DM. Several items in the refrigerator were not labeled or dated, including small bags of packaged apple slices that were spoiled and past the expiration date of 1/31/2026. A small carton of whole milk that expired on 2/16/2026, the DM discarded the milk. On 3/5/2026 at 11:03 AM an interview with the Nursing Supervisor of the Meadowland Unit, Licensed Practical Nurse (LPN#1), was conducted. LPN #1 described the process of storing foods that were brought in for residents by family members or visitors. LPN #1 stated that all staff were aware that residents' food should be labeled with the residents' name, room number and the date it was brought in. It was verbalized that on Friday's the nursing staff were supposed to inspect the resident nourishment refrigerators and discard any out of date or spoiled food items. LPN #1 noticed the spoiled bags of apple slices with the expiration date of 1/31/2026 and stated that they should not have been in the refrigerator. On 3/5/2026 at 11:21 AM an interview with the Nursing Supervisor of the Rosewood Unit, (LPN #2), was performed. LPN #2 explained that nursing staff were supposed to label all food with the residents' name, room number and the date. LPN #2 confirmed that the opened and expired soup container and opened and undated salad dressing should not have been in the refrigerator. LPN #2 advised that resident families have been asked not to bring in any more outside food due to refrigerators being overcrowded with so much food. The Administrator presented a policy regarding food safety requirements and food storage and retention. The policy included practices to maintain safe refrigerated storage which included labeling, dating and monitoring refrigerated foods. A facility policy was presented titled Use and Storage of Food Brought in by Family or Visitors read in part, All foods items that are already prepared by the family or visitor brought in must be labeled with content and dated. On 3/9/2026 at 4:30 PM the Administrator, [NAME] President of Operations and Regional Minimum Data Set (MDS) Coordinator were notified of the above finding. No other information was provided prior to the exit conference at 12:30 PM on 3/10/2026.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record reviews and facility document reviews, the facility staff failed to ensure that 4 of 5 sampled residents were offered and/or provided the Pneumococcal/Influenza vaccine in accordance with facility policy in a survey sample of 46 residents. (Residents #18, 10, 48, and 9). Findings include: a. Resident #18 was originally admitted on [DATE] and readmitted on [DATE] after a brief hospitalization for treatment of acute on chronic hypoxic respiratory failure and fluid overload secondary to congestive heart failure. Her diagnoses included but are not limited to chronic obstructive pulmonary disease with acute exacerbation, hypertensive heart disease with heart failure, obstructive sleep apnea, morbid obesity with alveolar hypoventilation, type 2 diabetes mellitus, cocaine abuse, and chronic myeloid leukemia, BCR/ABL-positive, not having achieved remission. Resident #18's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) 1/26/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating no cognitive impairment. A review of Resident #18's immunization record showed no information of offering or administering the influenza or pneumococcal vaccines. A review of Resident #18's physician orders revealed orders for Flu vaccine annually and Pneumovax if needed. A review of the clinical record showed no known allergies. An interview was conducted with Resident #18, and according to her no one at the facility had asked her about what vaccinations she had received or offered any vaccines. b. Resident #10 was admitted on [DATE] with diagnoses to include but not limited to spina bifida with hydrocephalus, type 2 diabetes mellitus, hypertension, history of colon cancer, anxiety, depression and sacral pressure injuries. Resident #10's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) 2/10/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating no cognitive impairment. A review of Resident #10's immunization record showed no information of offering or administering the influenza or pneumococcal vaccines. A review of Resident #10's physician orders revealed orders for Flu vaccine annually and Pneumovax if needed. A review of the clinical record revealed allergies to ciprofloxacin, clonidine, nitrofurantoin, nystatin, tiroprium, cat dander, Latex, and hydrofera blue 4x4 wound dressing (according to the National Institute of Health, these medications, environmental factors or materials do not generally prevent a person from receiving the flu or pneumococcal vaccines). An interview was conducted with Resident #10, and according to him he does not recall anyone at the facility asking him about vaccinations or if he wanted any vaccines. c. Resident #48 was admitted [DATE] with diagnoses to include but not limited to cerebral infarction due to occlusion or stenosis of small artery, and type 2 diabetes mellitus, mild intellectual disabilities, epilepsy, chronic combined systolic and diastolic congestive heart failure, major depressive disorder, schizoaffective disorder, bipolar type, violent behaviors, acute respiratory failure with hypoxia, and hypertension. Resident #48's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) 2/10/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 09 out of a possible 15 indicating moderate cognitive impairment (meaning noticeable, moderate problems with memory and thinking). A review of Resident #48's immunization record showed no information on offering or administering the influenza or pneumococcal vaccines. A review of Resident #48's physician orders revealed orders for Flu vaccine annually and Pneumovax if needed. A review of the clinical record noted allergies to ibuprofen, Dilantin, and penicillin (according to the Centers for Disease Control and Prevention allergies to Dilantin, ibuprofen and penicillin generally do not prevent a person from getting the flu or pneumococcal vaccine). An interview was conducted with Resident #48, and according to her she cannot remember anyone asking her about vaccinations). d. Resident #9 was admitted on [DATE] with diagnoses to include but not limited to chronic obstructive pulmonary disease, bipolar disorder, altered mental disorder, paralytic ileus, dementia without behavioral disturbance, major depressive disorder, pressure ulcer sacral region, and diabetes mellitus type 2. His (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) 1/24/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 02 out of a possible 15 indicating severe cognitive impairment (having significant difficulties with memory, orientation and ability to process information). A review of Resident #9's immunization record showed no information of offering or administering the Pneumovax vaccine. A review of Resident #9's physician orders revealed orders for Flu vaccine annually and Pneumovax if needed. A review of the clinical record showed no known allergies. Resident #9 was non-interview able for information regarding whether he was educated or offered the pneumovax vaccination. On 3/4/26 an interview was conducted with the facility's IP (Infection Preventionist). According to the Infection Preventionist she had only been employed for a few months and was trying to catch up on the vaccination status of all residents. A review of Residents #18, #10, #48, and #9 was completed with the IP and she stated she was aware that some residents were missing vaccine information and she was working to obtain consents for the vaccinations and had just recently gained access to (VIIS) the State's Immunization Information System portal in order to access residents vaccination history. A review of the facility's Influenza and Pneumococcal Vaccines policies was completed which read in part: Policy entitled Influenza Vaccination dated 6/1/2025, reviewed/revised 11/13/25: Policy Explanation and Compliance Guidelines: . 2. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this period or refuses to receive the vaccine . 9. The resident's medical record will include documentation that the resident and/or the resident's representative were provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal . Policy entitled Pneumococcal Vaccine dated 6/1/2025, reviewed/revised on 10/22/25, Policy Explanation and Compliance Guidelines: 1. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. 2. Each resident shall be offered the pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. 3. Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization with the education documented in the clinical record . On 3/9/26 during the end of day meeting with the Executive Director, Regional Director of Operations, Administrator-in-Training and Director of Nursing, the above information was shared with them. An opportunity was offered to the facility staff to present additional information. On 3/10/26, the IP (Infection Preventionist) presented copies of vaccine information for Residents #48, #10, #18 and #9 she had printed from the State's VIIS on 3/10/26 but not yet entered into the residents' electronic clinical record. They had no further comments regarding the above information.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record review and facility document review, the facility staff failed to ensure 4 of 5 residents were educated, offered and/or provided the COVID-19 vaccine in a survey sample of 46 residents (Residents #18, 10, 48, and 9). Findings included: For Resident #18, 10, 48, and 9, the facility staff failed to provide education and offer the COVID-19 vaccine. a. Resident #18 was originally admitted to the facility on [DATE] and readmitted on [DATE] after a brief hospitalization for treatment of acute on chronic hypoxic respiratory failure and fluid overload secondary to congestive heart failure. Her diagnoses included but are not limited to chronic obstructive pulmonary disease with acute exacerbation, hypertensive heart disease with heart failure, obstructive sleep apnea, morbid obesity with alveolar hypoventilation, type 2 diabetes mellitus, cocaine abuse, and chronic myeloid leukemia, BCR/ABL-positive, not having achieved remission. Resident #18's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) 1/26/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating no cognitive impairment. A review of Resident #18's immunization record showed no information that the resident was educated, offered or had been given the COVID-19 vaccine. A review of the clinical record showed no known allergies. An interview was conducted with Resident #18, and according to her no one at the facility had asked her about whether she had been given the COVID-19 vaccine, provided her with education on the vaccine or offered her the vaccine. b. Resident #10 was admitted to the facility on [DATE] with diagnoses to included but not limited to spina bifida with hydrocephalus, type 2 diabetes mellitus, hypertension, history of colon cancer, anxiety, depression and sacral pressure injuries. Resident #10's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) 2/10/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating no cognitive impairment. A review of Resident #10's immunization record showed no information of education, offering or administration of the COVID-19 vaccine. A review of the clinical record revealed allergies to ciprofloxacin, clonidine, nitrofurantoin, nystatin, trospium, cat dander, Latex, and hydrofera blue 4x4 wound dressing (according to the National Institute of Health, these medications, environmental factors or materials do not generally prevent a person from receiving the COVID vaccine). An interview was conducted with Resident #10, and according to him he does not recall anyone at the facility asking him about the COVID-19 vaccine or any vaccine. c. Resident #48 was admitted to the facility on [DATE] with diagnoses to included but not limited to cerebral infarction due to occlusion or stenosis of the small artery, type 2 diabetes mellitus, mild intellectual disabilities, epilepsy, congestive heart failure, major depressive disorder, schizoaffective disorder, bipolar type, violent behaviors, acute respiratory failure with hypoxia, and hypertension. Resident #48's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) 2/10/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 09 out of a possible 15 indicating moderate cognitive impairment (meaning noticeable, moderate problems with memory and thinking). A review of Resident #48's immunization record showed no information on education, offering or the administration of the COVID-19 vaccine. A review of the clinical record noted allergies to ibuprofen, Dilantin, and penicillin (according to the Centers for Disease Control and Prevention allergies to Dilantin, ibuprofen and penicillin generally do not prevent a person from getting the COVID vaccines). An interview was conducted with Resident #48, and according to her she cannot remember anyone asking her whether she had any vaccinations. d. Resident #9 was admitted on [DATE] with diagnoses to included but not limited to chronic obstructive pulmonary disease, bipolar disorder, altered mental disorder, paralytic ileus, dementia without behavioral disturbance, major depressive disorder, pressure ulcer sacral region, and diabetes mellitus type 2. His most recent MDS (continued on next page)		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Minimum Data Set) with ARD (Assessment Reference Date) 1/24/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 02 out of a possible 15 indicating severe cognitive impairment (having significant difficulties with memory, orientation and ability to process information). A review of Resident #9's immunization record showed no information of education, offering or the administration of the COVID-19 vaccine. A review of the clinical record showed no known allergies. Resident #9 was non-interview able for information regarding whether he was educated or offered the COVID-19 vaccine. On 3/4/26 an interview was conducted with the facility's IP (Infection Preventionist). According to the Infection Preventionist she had only been employed for a few months and was trying to catch up on the vaccination status of all residents. A review of Residents #18, 10, 48, and 9 was completed with the IP and she stated she was aware that some residents clinical records were missing vaccine information and she was working to obtain consents for vaccinations and had just recently gained access to (VIIS) the State's Immunization Information System portal in order to access residents vaccination history. A review of the facility's COVID-19 Vaccine policy read in part: Policy entitled COVID-19 Vaccination dated 6/21/2025, reviewed/revised 11/13/25: Policy Explanation and Compliance Guidelines: .11. COVID-19 vaccinations will be offered to residents when supplies are available, as per CDC (Centers for Disease Control), and/or FDA (Food and Drug Administration) guidelines unless such immunization is medically contraindicated, the individual has already been immunized or refused to receive the vaccine. 12. Following assessment for potential medical considerations, COVID-19 vaccinations may be administered in accordance with physician approved standing orders .14. The facility will educate and offer the COVID-19 vaccine to residents, resident representatives and staff and maintain documentation of such . On 3/9/26 during the end of day meeting with the Executive Director, Regional Director of Operations, Administrator-in-Training and Director of Nursing, the above information was shared with them. An opportunity was offered to the facility staff to present additional information. On 3/10/26, the IP (Infection Preventionist) presented copies of vaccine information for Residents #48, #10, #18 and #9 she had printed from the State's VIIS on 3/10/26 but not yet entered into the residents' electronic clinical record. They had no further comments regarding the above information.		

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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. **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 assess and ensure it was clinically appropriate for the self-administration of medications for one resident (Resident # 73) in survey sample of 46 residents. Findings included: Resident #73 was admitted to the facility on [DATE], with a most recent readmission on [DATE]. Resident #73's diagnoses included but were not limited to: spinal stenosis, lumbar region with neurogenic claudication, type 2 diabetes with diabetic neuropathy, muscle weakness, need for assistance with personal care, mild cognitive impairment, dependence on wheelchair, ocular hypertension. Hypertension and chronic pain syndrome. Resident # 73's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 1/12/2026 was coded as a quarterly assessment. Resident #104 was coded as having had a BIMS (brief interview for mental status) score of 12 out of 15, which indicated moderate cognitive impairment. The Resident was also coded as requiring extensive assistance of staff with Activities of Daily Living. During the initial tour of the facility on 3/3/2026, a resident interview was conducted with Resident # 73. A tube of Neosporin Ointment was observed in a bin on the overbed table. When Resident #73 was asked what it was, Resident # 73 stated, cream for my fingers when I clip my fingernails. Resident # 73 stated a family member brought it in as requested by the resident. Resident # 73 stated I know I am not supposed to have it, but I want to use it whenever I need it. I like using it Resident # 73 told the surveyor don't get me in trouble. Review of the electronic clinical record was conducted 3/3/2026-3/10/2026. Review of Resident # 73's clinical record, to include but not limited to: physician orders, care plan, nursing notes, assessments, and interdisciplinary team meeting notes revealed there was no indication that Resident # 73 had been assessed for and/or determined to be safe to self-administer medications. During rounds on each day of survey, staff members were observed providing care, administering medications, passing water and ice and passing trays in Resident # 73's room. The Neosporin ointment was clearly visible on the front left in the bin during each observation. There were no observations of any staff member addressing the concern of medications at the bedside. On 3/4/2026 during the end of day debriefing with the Administrator, Director of Nursing and Administrator in Training, a request was made of nursing administration for any self-administration of medication assessments for residents. The Director of Nursing stated she thought there was only one resident with the self-administration assessment. The name mentioned was not Resident # 73. On 3/5/2026 during the end of day debriefing, the Administrator, Director of Nursing and Administrator in Training were asked again if any residents had assessments for self-administration of medications. The Director of Nursing stated there were no residents who were assessed and approved for self-administration of medications. On 3/6/2026 at 9:55 a.m., the Director of Nursing was interviewed about Resident # 73 and the Neosporin at the bedside. The Director of Nursing stated Resident # 73 had not been assessed for self-administration of the medication. She stated Resident # 73 was alert and oriented and would be assessed. The facility policy on Self-Administration was requested but not received prior to exit. 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 - Few	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 1 Resident (# 68) in a survey sample of 46 Residents. The findings included: For Resident # 68, the facility staff failed to ensure the clock on the bedroom wall was working and had the proper time. Resident # 68 was admitted to the facility on [DATE] with the diagnoses of, but not limited to: congestive heart failure, hypertension, depression, and anxiety. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/29/2025. Resident # 68's BIMS (Brief Interview for Mental Status) Score was 11 out of 15, indicating moderate cognitive impairment. Review of the electronic clinical record was conducted on 3/3/2026 to 3/10/2026. On 3/3/2026 during the initial tour at 1:30p.m., the time on the clock was observed to state 8:20. The hands of the clock were not moving. During subsequent rounds on 3/3/2026 at 3:20 p.m., 3/4/2026 at 9:50 a.m., 3/4/2026 at 12:10 p.m. and 3/5/2026 at various times, the clock continued to show the time of 8:20. On 3/5/2026 at 1:10 p.m., Resident # 68 was observed lying in bed. The television was on but Resident # 68 was not watching the television. When asked what time lunch was served, Resident # 68 expressed being unsure, looked at the clock, and stated the clock did not work. On 3/5/2026 at approximately 4:15 p.m., the Director of Nursing toured the unit with the surveyor. The Director of Nursing noted the clock in Resident # 68's room showed the time as 8:20. The Director of Nursing stated the clock was wrong and that it was important for the clocks to be correct in the residents' rooms. During the end of day debriefing, the facility Administrator, Director of Nursing, Regional Director of Clinical Services and Corporate [NAME] President were informed of the findings. No further information was provided.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on resident interview, staff interviews, clinical record review, and facility documentation review, the facility failed to provide proper notification of a resident room transfer for one of 46 residents (resident #13). The facility failed to give Resident #13 proper notification of room transfers 10 of 14 times and have documentation of notification of room transfers. The findings included: On 03/3/2026 at 2:00 PM, an interview with Resident #13 (R13) was conducted and R13 said, The facility moved me to this room from my previous room without notification. The staff put all of my belongings on the bed and wheeled me into this room. They wanted to fix up my previous room. On 3/6/2026 at approximately 11:35 AM a staff interview was conducted with the Director of Social Work (DSW) and the Assistant Social Worker (ASW). The DSW and ASW were asked to provide evidence that R13 was provided with notification prior to a room change on 8/12/2025. Neither could find documentation of notification to R13 for a room transfer. On 3/10/2026 at 9:00 AM, an interview was conducted with the DON (Director of Nursing). The DON was asked Do you know about R13's room transfers. The DON stated that R13 does have previous room transfer notification but could not locate a room transfer notification for 8/12/2025. The DON found a nursing progress note dated 8/12/2025 that read, ABT (antibiotics) complete, Pt (patient) to move back to original room, nurse made aware, no drainage noted to eyes, Pt made aware of return to room. There was no note of what room R13 was in or what room he was being transferred to. On 3/10/2026 at 9:05 AM, a medical record review was conducted with the DON. According to R 13's record, R13 had been diagnosed with PTSD (Post Traumatic Stress Disorder) and for staff to decrease triggers for R13 in their plan of care. Notification of three room transfers for R13 occurred on 4/23/2021, 2/17/2025, 5/14/2025 and each was signed by R13. There is one nursing progress note on 8/12/2025 at 14:35 (2:35 PM) noting Resident #13 of a room transfer but no signed notification from Resident #13. The resident stated he was not notified of the room transfer on 8/12/2025. The census tab of R13's chart noted, ten (10) of fourteen (14) room transfers for Resident #13 without documentation of notification: 5/20/2021, 6/1/2021, 9/1/2021, 9/24/2021, 1/10/2022, 1/19/2022, 2/26/2025, 5/21/2025, 8/5/2025, 8/12/2025, and 2/4/2026. Review of facility policy and procedure titled, Change of Room or Roommate with a date of implementation 6/1/2025 and reviewed/revised 11/14/2025, read in part: . 3. Requests for changes in room or roommate should be communicated to the Social Services Designee. 4. Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible. 5. The notice of a change in room or roommate will be provided in writing, in a language and manner the resident and representative understands and will include the reason(s) why the move or change is required . On 03/10/26 at approximately 12:30PM, during an end of day debriefing held with the VPO (Vice President of Operations), Administrator, AIT (Administrator in Training), and Director of Nursing (DON) the above findings were reviewed. The facility staff stated they had nothing further to provide.		

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on observation, staff interviews, and review of facility documents, the facility staff failed to prevent the employment of a person who has been convicted of a barrier crime, which disqualified the employee from employment in a nursing home for one of twenty-five employees reviewed (certified nursing assistant #3- CNA #3). The findings included: The facility staff permitted a Certified Nursing Assistant (CNA #3) to provide direct care to residents with unrestricted and unsupervised access despite the employee having a conviction for a barrier crime, which prohibits employment in a long-term care facility under regulatory requirements. On 3/6/26 at 11:55 AM, while completing a review of employee records it identified that Certified Nursing Assistant (CNA) #3's Commonwealth of Virginia Department of State Police criminal history and sex offender record read in part: 08/28/2023 Guilty - Felony 18.2 - 474.1 Jail: Delivery of Drugs to Prisoner. On 3/6/26 at 11:56 AM, an interview was conducted with the Administrator in Training and the Human Resource Coordinator. The findings of CNA #3's criminal history and sex offender record was brought to the Administrator in Training's attention and she stated, Can we please take a break? and exited the room. The Human Resource Coordinator then stated, You do not understand what is going to happen to me. On 3/6/26 at 12:30 PM, an interview was conducted with the Administrator. The Administrator stated that CNA #3 should not be working at the center due to the results of the employees background check. On 3/6/26 at 10:45 PM an interview was conducted with the Administrator in Training. The Administrator in Training stated that CNA #3 was a full time employee on the 11pm - 7 am shift and full-time employment means 35 hours a week. The Administrator in Training also stated that CNA #3 was hired on 11/26/24. The Administrator in Training further stated that CNA #3 worked the prior night 3/5/26 on the 11pm -7am shift. A review of the facilities payroll documentation revealed that CNA #3 worked from 11:22 PM on 3/5/26 until 7:35 AM on 3/6/26. According to the facility's work schedule, CNA #3 was scheduled to work again the night of 3/6/26. On 3/6/26 at 8:10 PM, the facility's Administrator in Training, Director of Nursing, and an Administrator from another facility within the company were informed of the above non-compliance. On 3/6/26, the employee was suspended from employment and subsequently resigned her employment. No additional information was provided.		

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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, facility documentation review and clinical record review, the facility staff failed to accurately code an MDS (minimum data set) assessment for one Resident (Resident #113) in a survey sample of 46 Residents. The findings included: For Resident # 113, the facility staff failed to code a Stage 4 pressure ulcer on a discharge Minimum Data Set Assessment. Resident #113 was admitted to the facility on [DATE] with diagnoses that included but were not limited to pathological fracture of right femur, a history of malnutrition, B 12 deficiency, adult failure to thrive, need for assistance with personal care, difficulty in walking, lack of coordination and unsteadiness on feet. The most recent Minimum Data Set (MDS) assessment was an admission assessment with an Assessment Review Date of 5/20/2023. The MDS coded the BIMS (Brief Interview for Mental Status as 7 out of 15, indicating severe cognitive impairment. Resident # 113 required assistance with ADLs (Activities of Daily Living.) According to Section M, Skin Conditions, Resident # 113 did not have any pressure ulcers/wounds upon admission. Review of the paper closed clinical record was conducted 3/5/2026-3/10/2026. Pressure ulcers were described interchangeably as pressure ulcers or wounds or pressure injuries in the clinical record. Review of the Physicians Progress Notes, Physician orders and Nurses notes revealed that Resident # 113 was diagnosed with a Stage 3 Pressure wound on 6/1/2023. Resident # 113 was assessed on 6/15/2023 by a Consultant Wound Care Physician who identified a Stage 4 pressure wound on the right heel. The pressure wound on the right heel was listed on the weekly Physicians Progress Notes. The Weekly Pressure Ulcer Wound round notes were reviewed and documented a Stage 4 pressure wound on the right heel was last evaluated on 7/6/2023. The weekly reports stated: 6/15/23- Pressure Ulcer Wound rounds -pressure-right heel-4.5 x 2 x nm- Stage 4 6/22/23- Pressure Ulcer Wound rounds -pressure-right heel-5 x2 x nm-Stage 4 6/29/23- Pressure Ulcer Wound rounds -pressure-right heel -5 x2 x nm-Stage 4 7/6/23 - Pressure Ulcer Wound rounds -pressure-right heel-4.5 x 2 x nm- Stage 4 The Discharge Plan and Instructions dated 7/7/2023 on page 6 of 13 listed wound care in Section A as one of the services provided during the stay at the facility. The discharge body audit, Skin Condition section on page 12 of 13 documented yes that the the skin was intact. The form was signed by the former Unit Manager (Licensed Practical Nurse # 9) who no longer worked at the facility at the time of the survey. The Discharge MDS dated [DATE] Section M Skin Conditions- M0210- Unhealed Pressure Ulcers/Injuries -Does this resident have one or more unhealed pressure ulcers/injuries? was coded as 0-No indicating Resident # 113 had no pressure ulcers/injuries. The MDS was signed by the former MDS Registered Nurse (Registered Nurse # 4) on 7/15/2023. On 3/10/2026 at 10:45 a.m., interviews were conducted with the Director of Nursing and Regional MDS Coordinator in the Director of Nursing office. They reviewed the clinical record to determine if Resident # 113 had a pressure ulcer/injury at the time of discharge. The Director of Nursing stated there was documentation in the Progress notes about a Stage 4 pressure ulcer identified in June of 2023. On 3/10/2026 at 10:48 a.m., the Regional MDS Coordinator stated the Discharge MDS was coded as no pressure ulcers/injuries. She stated the MDS was incorrect. Both stated it was important for the MDS to accurately reflect the resident's status. No further information was provided.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for three of forty-six residents in the survey sample (Residents #9, #72 and #113). The findings include: 1. Resident #9's plan of care was not revised to include current interventions for pressure ulcer prevention. Resident #9 (R9) was admitted to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease), sacral pressure ulcer, bipolar disorder, benign prostatic hyperplasia, orthostatic hypotension, schizotypal disorder, chronic kidney disease, ichthyosis, anemia, dementia, hip fracture, psychotic disturbance, mood disorder and protein-calorie malnutrition. The minimum data set (MDS) dated [DATE] assessed R9 with severely impaired cognitive skills. R9's clinical record documented that the resident had a sacral pressure ulcer that was healed as of 12/1/25. Current physician orders for prevention of pressure ulcers included pressure relief cushion to wheelchair, barrier cream to buttocks, a protective silicone foam dressing to sacrum each Monday, Wednesday and Friday and skin prep to heels on Monday, Wednesday and Friday. On 3/3/26 at 4:27 p.m., R9 was observed in bed with a pressure relief mattress in use and the resident's heels/feet were elevated on cushions. R9's plan of care (revised 1/20/26) documented the resident was at risk of pressure injury development due to limited mobility. The interventions for pressure injury prevention included, Monitor/document/report PRN [as needed] any changes in skin status. The plan of care had not been revised to include current interventions for pressure injury prevention including the wheelchair cushion, protective dressing, skin prep to heels, mattress and off-loading of heels/feet. On 3/4/26 at 3:04 p.m. the licensed practical nurse (LPN #6) responsible for MDS and care plan updates was interviewed about R9's plan. LPN #6 stated R9's care plan was most recently reviewed on 1/20/26. LPN #6 reviewed the care plan and stated the plan only listed monitoring for new pressure injuries. LPN #6 stated the current interventions for pressure injury prevention should have been included in the plan. LPN #6 stated she was not sure why the interventions in place had not been added to the care plan. On 3/5/26 at 8:26 a.m., the unit manager (LPN #8) caring for R9 was interviewed about the plan of care. LPN #8 stated R9 currently had no pressure injuries but that a protective dressing was kept on the sacrum for prevention in addition to barrier cream with incontinence care, turning and repositioning, skin prep to heels and elevation of heels/feet. LPN #8 stated she was not sure why the current interventions had not been added to the care plan. This finding was reviewed with the administrator, director of nursing and regional MDS coordinator during a meeting on 3/9/26 at 5:00 p.m. with no further information presented prior to the end of the survey. 2. For R72 who was a fall risk, the facility failed to review and revise the care plan to include the intervention of fall mats to the floor bilaterally. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A comprehensive review of R72's medical records included a care plan to address fall risk initiated on 10/30/24. Interventions include: anticipate and meet resident's needs, ensure call light is in reach and encourage resident to use it, bed in low position, and physical therapy to evaluate and treat as ordered and as needed. R72 also has a care plan to address an actual fall that was initiated on 11/3/25. Interventions include: Root Cause: Staff listen to what resident is requesting and exercise program with restorative, NP assess in AM, Review paperwork for any other findings/, reassess by nursing for injuries per the fall protocol, neurochecks, place on 1 to 1 (11/13/24 D/C), adopt a resident for fall prevention safety, determine root cause, treatment as indicated to injuries, hourly checks for 72 hours, lab work/urinalysis, low bed, non-skid socks, place on restorative walking program, and remind resident that staff must assist with transfers and assure all items are within resident's reach. On 3/3/26 at 2:35 P.M., R72 was observed in their room in bed. Floor mats were noted in place to both sides of the bed. During an interview with R72 on 3/4/26 at 8:39 A.M. floor mats were again observed on the ground to both sides of the resident's bed. On 3/5/26 at 9:53 A.M. an interview was conducted with LPN (Licensed Practical Nurse) #6. LPN #6 stated that they update care plans quarterly and as needed for significant changes such as falls. LPN #6 stated that they do not need a physician order for floor mats as it is a fall intervention. LPN #6 acknowledged that R72 had floor mats in place to both sides of their bed. LPN #6 reviewed the care plan for R72 and was unable to locate an intervention for floor mats. LPN #6 stated that the expectation is that this intervention would be placed on the care plan. LPN #6 stated they would add this intervention to the current care plan. No further information was provided prior to exit. 3. For Resident # 113, the facility staff failed to review and revise the care plan regarding a fall with injury on 6/19/2023 Resident #113 was admitted to the facility on [DATE] with diagnoses that included but were not limited to pathological fracture of right femur, a history of malnutrition, B 12 deficiency, adult failure to thrive, need for assistance with personal care, difficulty in walking, lack of coordination and unsteadiness on feet. The most recent Minimum Data Set (MDS) assessment was an admission assessment with an Assessment Review Date of 4/20/2023. The MDS coded the BIMS (Brief Interview for Mental Status) as 7 out of 15, indicating severe cognitive impairment. Resident # 113 required assistance with ADLs (Activities of Daily Living.) A review of Resident #113's electronic clinical record was conducted 3/6/2026-3/10/2026. The review of the progress notes revealed documentation of a fall on 6/19/2023. Review of the care plan revealed the care plan had not been reviewed or revised after the fall on 6/19/2023 until 7/11/23 The care plan read: has had an actual fall with no injury-date initiated 5/22/2023. The revision was on 7/11/2023. The three interventions were revised on 7/11/2023. On 3/9/2026 at 9:45 a.m., an interview was conducted with the Director of Nursing who stated the (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plans should be reviewed and revised after any falls within 7 days. During the end of day debriefing on 3/9/2026, the Facility Administrator, Administrator in Training and Director of Nursing were informed of the findings. No further information was provided.		

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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 interview and facility record reueiv the facility staff failed to provide services that meet professional standards of quailty for one resident (Resident #121-R121) in a survey sample of 22 residents.The findings included:For R121 the facility staff failed to ensure all medications were taken and consumed by the resident prior to leaving the room.R121 was admitted to the facility on [DATE] with diagnoses that included but were not limited to multiple sclerosis, opioid dependence, hypertensive heart disease and history of stroke. R121's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/9/26 coded R121 as having a BIMS (Brief Interview of Mental Status) score of 14 out of 15 indicating no cognitive impairment. R121's MDS also coded the resident as needing partial to moderate assistance with most ADL activities including transfers, toileting, bathing, dressing and grooming.On 4/47/26, a review of the clinical record revealed the following note: 4/25/26 10:30 am - Nurse went to give resident her morning meds and found a suboxone [a medication used for substance use disorder / opiate withdrawal] and two Tylenol in her room. She said she just dropped them, the suboxone was slightly wet in one cup and they 2 Tylenol were in another cup on top. The nurse told the resident she would have to do a room sweep looking for other medications, the resident refused and started getting agitated. Nurse attempted to educate the resident on why it's dangerous not to take medication, but she did not want to hear anything the nurse had to say . Predisposing Situation Factors: Not taking meds pretending she is letting it dissolve and taking it out after nurse leaves.A review of the clinical record revealed R121 had the following order:Suboxone Sublingual film - 8-2 MG (Buprenorphine HCL - Naloxone HCL Dihydrate) Give 1 film sublingually three times per day for opioid use disorder stand and wait until the resident fully swallows with water / take med cup up.On 4/27/26 at 2 pm R121 refused interview with surveyor.On 4/27/26 at 2:15 pm an interview with licensed practical nurse #3 (LPN3) was conducted. LPN3 stated that medications should be administered and taken in front of the nurse before the nurse leaves the room. LPN3 stated that she does not ever leave medications at the bedside. LPN3 was asked why this was important and she stated that medications left at bedside could be taken by someone else or a resident could forget to take them. When asked when sign off is done in the electronic medical record she stated that sign off should be done once the medications have been administered and the nurse has seen them being taken by the resident.On 4/28/26 at approximately 9:00 am an interview was conducted with the DON. The DON stated that it is the facility's expectation that all nurses ensure medications are taken in the presence of the nurse. The DON stated that [NAME] was the professional standard used by the facility.According to [NAME] Nursing Center website: (Lippincott Nursing Center, 2018), it referenced the standard for medication administration as: Right Patient: Use two identifiers (e.g., name, birthdate) and check against the ID band.Right Medication: Check the medication label against the medication administration record (MAR).Right Dose: Verify the dose, check for appropriateness, and perform double-checks (e.g., calculations).Right Route: Confirm the order for the specified route (e.g., IV, oral) and that it is appropriate.Right Time: Check frequency, ensure the medication is given at the correct time, and verify the last dose.Right Documentation: Document the medication immediately after administration, including time, dose, and any required assessments.Right Reason: Understand the rationale for the medication and the patient's history.Right Response: Monitor the patient for the intended effect and any adverse reactions. On 4/28/26 during the end of day meeting the Administrator was made aware of the concern and no further information was provided.		

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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 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, and clinical record review, the facility staff failed to provide assistance with activities of daily living for one resident (Resident #117-R117) in a survey sample of The findings included. The facility staff failed to provide assistance to Resident #117, who required assistance with eating her breakfast until it had sat in front of the resident and gotten cold. Resident #117 was most recently readmitted to the facility on [DATE]. The Resident's diagnoses included; Cerebral palsy, left sided hemiplegia, Aphasia, stroke, malnutrition, dysphagia, contractures of upper extremities, lack of coordination, and dementia. The most recent MDS (Minimum Data Set federal assessment) was most recently completed as an annual assessment with an Assessment Reference Date (ARD) of 3-13-26. The assessment described the Resident with a Brief Interview for Mental Status (BIMS) score of unable to complete, indicating severe cognitive impairment. The Resident required extensive to fully dependent assistance from staff with all activities of daily living except eating, however, staff feeding was necessary at times. The Resident was dependent on staff for self-care and hygiene and had contractures of both hands. On 4-28-26 at 11:30 AM, Resident #117 was observed lying in bed with a regular breakfast plate in front of her with scrambled eggs, a biscuit, and chunks of sausage sitting on the overbed table. The meal was untouched. The Resident was asked if the meal was cold, and the Resident responded with a head nod indicating yes. When asked if she wanted to eat it she again indicated Yes with a nod in the affirmative. She was asked if she could eat by herself or needed help, she held up both hands which were contracted and attempted to pick up the biscuit and put it in her mouth, then started coughing as she was in a reclined position and could not adequately expectorate the bread. A staff LPN [licensed Practical Nurse] entered the room to assist the Resident. The Resident's hands were both contracted in such a way that she had difficulty feeding herself. No feeding assistance had been provided for Resident #117 as she wanted to eat, however, being in a reclined position in bed, unable to see the food clearly and with very contracted hands she was not able to eat herself safely. Resident #117's most recent care plan was reviewed and revealed as a focus Swallowing problem related to cerebral palsy and dysphagia following stroke initiated 3-25-2020. Interventions included the following. Clothing protector for meals, instruct resident to eat in an upright position, eat slowly, chew each bite thoroughly. Monitor for shortness of breath, choking, labored respirations, lung congestion. Monitor, document, report any signs of dysphagia, pocketing, choking, coughing, drooling. The interventions go on to say specialized cup for liquids, 3 sectional plate, green nose cup, and resident to eat only with supervision. During the 11:30 AM observation of Resident #117 noted she was reclined, alone, no specialized cup nor three section plate was in the room, and no supervision was provided. The Resident choked on the dry biscuit when she attempted to eat it and a staff member happened to come into the room while the surveyor was there and assisted the Resident. On 4-29-26 at 5:30 PM that facility Administrator and DON were made aware of findings. They stated they had nothing further to provide.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility documentation review, the facility staff failed to ensure care and services met professional standards of practice to meet the physical, mental and psychosocial needs of two residents (Resident # 115 and Resident #107) in a survey sample of 46 residents. Findings included: For Resident # 115, the facility staff failed to identify, recognize and assess risk factors for prescribing and administering medications to which the resident was documented as being allergic. There was a reported history of allergies to medications that were prescribed for Resident # 115 and did not ensure medications were administered as ordered. Resident #115 was admitted to the facility on [DATE] with diagnoses that included but were not limited to: multiple myeloma, Diabetes with Diabetic chronic kidney disease, chronic obstructive pulmonary disease, atrial fibrillation, acute cystitis with hematuria, acute posthemorrhagic anemia, and hemorrhage of the anus and rectum. The most recent Minimum Data Set (MDS) assessment was an admission assessment with an Assessment Review Date of 4/10/2023. The MDS coded the BIMS (Brief Interview for Mental Status) as a 15 out of 15, indicating no cognitive impairment. Resident # 115 required assistance with ADLs (Activities of Daily Living.) The paper clinical record was reviewed 3/6/2026 to 3/10/2026. The electronic clinical record was unavailable due to the transfer of the facility's ownership per the facility's administrative staff. A paper copy was provided to the survey team for review. The facility staff attested to the paper submission being the entire clinical record. Review of the record revealed documentation on the 4/7/2023 -admission Data Collection Assessment, question 3, page 1 of 18 revealed documentation of Allergies to Acetaminophen, Hydrocodone, Oxycodone, Tramadol. Review of the admission Allergy List which included 4 medications: Tylenol, Hydrocodone, Oxycodone, and Tramadol. Review of the Nursing Progress Notes revealed a note on 5/3/2023-1319 (1:19 p.m.) which read: Resident daughter called stated resident allergic to tramadol. Resident had tramadol at 09:51 am, vitals were done at 11:45 and were within normal limits,. Np (nurse practitioner) d/c (discontinue) med out of chart Review of the Physicians orders summary revealed the following: Tramadol 50 milligrams give one tablet by mouth every 12 hours as needed for pain- start date 4/19/2023 10:15 a.m.- d/c (discontinue) 5/3/2023 12:01 p.m. Review of the Nursing Progress Notes revealed Resident # 115 was administered Tramadol at least 4 times including: Tramadol 50 milligrams give one tablet by mouth -administered 4/27/2023 at 1307-Pain level 9 Tramadol 50 milligrams give one tablet by mouth -administered 5/3/2023 at 9:15 for right hand pain (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tramadol 50 milligrams give one tablet by mouth -administered 5/1/2023 at 9:21 for right hand pain Tramadol 50 milligrams give one tablet by mouth -administered 4/27/2023 at 13:07 (1:07 p.m.) resident pain in both hips. Review of the orders revealed Tylenol Extra Strength was ordered: Tylenol Extra strength 500 milligrams give two tablets by mouth three times a day for pain. Ordered 5/8/2023 D/C 4/24/2024 2202 (10:02 p.m.)- Review of the May 2023 MAR (Medication Administration Record) revealed Tylenol Extra Strength was administered three times per day as scheduled for 14 days- 5/8/2023 through 5/20/2023. Review of the Physicians Progress Notes revealed documentation of the new admission on [DATE] by the nurse practitioner. The chief complaint was listed as New admission/acute cystitis with hematuria Under the Allergy List, it was written no known drug allergies. The History and Physical dated 4/11/2023 by the medical doctor listed the allergies to the medications:Tylenol, Hydrocodone, Oxycodone, and Tramadol. The notes written by the Psychiatric Nurse practitioner on 4/20/2023 listed Allergies to the medications: Tylenol, Hydrocodone, Oxycodone, and Tramadol. On the same day the family member complained about Resident # 115 being allergic to Tramadol, there was a Progress note written by the nurse practitioner on 5/3/2023 which listed Tramadol as one of the current prescribed medications. Directly underneath was the Allergy list of medications. The plan on page 4 of 4 stated Continue current treatment plan and mediation regimen. There was no documentation of a discussion with Resident # 115 or the family member about the order for Tramadol. On 3/9/2026 at approximately 10:35 a.m., an interview was conducted with the Director of Nursing who stated Residents should not be given medications to which they are allergic unless the physician has determined the medication was safe for the resident. The Director of Nursing stated questions about allergies should be clarified by the nurses and the physician should assess and determine the appropriate medications for the resident. She stated the nurses should document about the conversations about allergies and monitor for any signs and symptoms. The Director of Nursing was informed that the family member reported a history of severe reaction to Tramadol and other pain medication resulting in Resident # 115 being placed on life support. The Director of Nursing stated Resident # 115 did receive Tramadol and Tylenol Extra Strength while in the facility and there were no documented adverse reactions. On 3/10/2026 at approximately 9:50 a.m. an interview was conducted via telephone with the Nurse Practitioner who stated she would have to review the clinical record. The Nurse Practitioner stated she was able to access the clinical record. The Nurse Practitioner stated she did not see any documentation of why Tramadol and Tylenol were ordered despite documentation of allergy to those medications. She stated she was not sure if the order had been entered by an on call physician or if there were other circumstances. The Nurse practitioner stated that typically she would ask residents about their allergies and the type of allergic response experienced. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing stated she would check the record to see if there was any documentation of the issue being addressed. The Director of Nursing stated the Pharmacist usually would have addressed the concern. The Director of Nursing called the Pharmacist while the surveyor was in the room and advised that the call was on speaker phone. The Pharmacist stated she could not talk to the surveyor without permission from her supervisor. The Director of Nursing took the call off of speakerphone. The Pharmacist could be overheard stating that she did not know what happened. There was no documentation of the nursing staff responding to an Orders Progress note on 5/8/2023 at 11:29 a.m. that stated The system has identified a possible drug allergy for the following order: Tylenol Extra strength 500 milligrams (Acetaminophen) give two tablets by mouth three times a day for pain. There was no documentation of the staff clarifying the orders. There was no documentation of the nursing staff monitoring and assessing the resident for allergic reactions to the medications. There was no noted care plan with goals and interventions developed regarding known allergies to the prescribed medications, and the signs and symptoms of allergic reaction. Further review of the clinical record revealed documentation of the medication, Gabapentin 300 milligrams give one capsule by mouth three times a day, not being available for administration several times during the stay at the facility including: 4/8/2023 at 22:59 (10:59 p.m.)-awaiting for medication to be sent, 5/13/2023 at 1610 (4:10 p.m.)-new script required, 5/15/2023 8:37 a.m., -ran out of meds, sending script to Pharm, 5/15/2023 12:21 p.m.- med ordered, Gabapentin 300 milligrams was available in the Omnicell onsite STAT pharmacy system. The nurses did not access the system to obtain the medication to be administered as ordered by the physician. Valid orders were evident for the medication not available. An interview was conducted on 3/10/2026 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 administration. The Director of Nursing stated medications should be available for administration as ordered by the physician. The Director of Nursing stated the Pharmacy should have ensured the medication was available for administration. She also stated the nurses should have checked the Omnicell (in house Stat box) for an available supply of the medication. The Director of Nursing presented a copy of the Omnicell inventory list. Review of the Omnicell inventory list revealed that the medication, Gabapentin 300 milligrams capsules, was available in the Omnicell. The nurses should have notified the pharmacy to gain access to the medication. According to Lippincott Nursing Procedures, Eighth Edition, Chapter 2, Standards of Care, Ethical and Legal Issues, on page 17 read, Common Departures from the Standards of Nursing Care. Claims most frequently made against professional nurses include failure to make appropriate assessments, follow physician orders, follow appropriate nursing measures, communicate information about the patient, (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow facility policy and procedures, document appropriate information in the medical record . Guidance from the National Institutes of Health in the article The nurses medication day stated that Nurses serve as a barrier, protecting residents from potential hazards. Calls were also common to request 'missing meds' (medications) followed by waits until they were delivered. Waiting reflected system failures ncbi.nlm.nih.gov accessed 3/16/2026. During the end of day debriefing on 3/9/2026 and 3/10.2026. the Administrator, Director of Nursing and Administrator in Training were informed of the findings and the risk of a negative outcome for Resident # 115. No further information was provided. 2. For Resident #107, the facility staff failed to administer medications in accordance with physician orders. Resident #107 was admitted to the facility on [DATE], and discharged on 4-14-25 with diagnoses to include but not limited to; osteoarthritis, and left knee artificial joint replacement with instability, constipation, hypertension and macular degeneration. The Resident used a walker for ambulation. On 3-6-26 at approximately 11:00 A.m. the Resident was contacted and interviewed. The Resident stated she was placed in an adult brief because staff told her we can't come walk you to the bathroom every time. She further stated that she missed my pain meds for days, and stated I had to get out of there, it was horrible. The admission nursing assessment record revealed that the Resident was alert and oriented, and able to make her own decisions. Review of the physician's orders and Medication Administration Record (MAR) revealed that Resident #107 was ordered by the physician to be given the following medications. Levothyroxine sodium 88 mcg (micrograms) one tablet every morning for hypothyroidism. Lisinopril 20 mg (milligrams) one tablet every day for hypertension. Miralax 17 gms (grams) once per day for constipation. Senna 8.6 mg 2 tablets once per day for constipation. Verapamil 240 mg one in the evening for hypertension. Oxycodone 10 mg every 6 hours as needed for pain. Resident #107 received none of them on 4-8-25 as documented in the facility MAR. Levothyroxine, Lisinopril, Verapamil, and oxycodone are all significant medications. On 4-9-25 at 3:15 P.M., nursing notes indicated that the nursing staff were waiting for a call from the on call doctor to clarify BP meds. Another note documented at this time spoke with niece who relayed that medications were with the patient upon arrival to the facility. This indicated that they were (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	available to be given, however, they were not given. On 4-9-25 an SBAR note (change in condition) was documented in the clinical record. The document detailed that Resident #107's niece complained that the Resident was without pain medication and on the toilet in pain for 2 hours on 4-7-25. Review of the Resident's care plan indicated that the Resident needed assistance with activities of daily living care (ADL's) and would receive needed assistance. The Resident was also coded for fall precautions, and pain due to a knee replacement. During an interview with the Administrator in training (AIT), and the Director of Nursing (DON), They stated the software program for the clinical record and medication administration had gone offline, and that they had a way to print a hard copy on paper from a computer in the front lobby, however, the staff did not do that. They further stated that a new policy was being developed to add to the emergency management program to ensure this did not happen again, and surveyors were given a copy of the draft document for review. The AIT, and DON stated that it is the facility policy that if the facility doesn't have the medication available, the facility will call the pharmacy and then if the pharmacy can't get it from the backup pharmacy, the facility will call the Dr. and let him know and see if he can substitute it or put it on hold. The facility administration was made aware of the deficient practice during the end of day conference at 12:30 AM on 3-6-26. They stated they had no further information to provide.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **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 provide respiratory care, consistent with professional standards of practice, for 2 Residents (Residents # 11 and # 68) in a survey sample of 46 Residents. The findings included: 1. For Resident # 11, the facility staff failed to change oxygen tubing weekly. The tubing was dated 2/18/2026. Resident # 11 was admitted to the facility on [DATE] with the diagnoses of, but not limited to: congestive heart failure, hypertension, diabetes and renal disease. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/22/2025. Resident # 11's BIMS (Brief Interview for Mental Status) Score was 14 out of 15, indicating no cognitive impairment. Review of the electronic clinical record was conducted on 3/3/2026 to 3/10/2026. During the initial tour of the facility on 3/3/2026, the date on the tubing on the oxygen concentrator was observed to be dated 2/18/2026. There was tubing lying on the nightstand that was dated 1/27/2026. An interview was conducted with Resident # 11 who stated the nurses would date the tubing when they changed it. Resident # 11 stated the date on the tubing was correct and that the tubing had not been changed in 2 weeks. Resident # 11 stated the staff left the old tubing on the nightstand. On 3/4/2026 at 10:10 a.m., an interview was conducted with Licensed Practical Nurse # 2 who stated oxygen tubing was changed on the night shift each week. On 3/4/2026 during the end of day debriefing, the Administrator, Director of Nursing, and Administrator in Training were informed of the findings. The Director of Nursing stated oxygen tubing should be changed every Tuesday on the night shift. She stated the old tubing should be removed from the bedside. Review of the January 2026, February 2026 and March 2026 Medication Administration Records revealed an order of Change tubing, mask and /or nasal cannula every Tuesday and as needed for hygiene. Start date 5/6/2025. Review of the care plan revealed an intervention of change O2 (oxygen) tubing weekly and prn (as needed) that was initiated 3/6/2026. Review of facility's policy on Oxygen/Respiratory Care revealed that oxygen tubing should be changed weekly and as needed. No further information was provided. 2. For Resident # 68, the facility staff failed to change oxygen tubing weekly. The tubing was dated 2/18/2026. Resident # 68 was admitted to the facility on [DATE] with the diagnoses of, but not limited to: congestive heart failure, hypertension, depression, and anxiety. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/29/2025. Resident # 68's BIMS (Brief Interview for Mental Status) Score was 11 out of 15, indicating moderate cognitive impairment. Review of the electronic clinical record was conducted on 3/3/2026 to 3/10/2026. During the initial tour of the facility on 3/3/2026, the date on the tubing on the oxygen concentrator was observed to be dated 2/18/2026. An interview was conducted with Resident # 68 who stated the nurses would date the tubing when they changed it. On 3/4/2026 at 10:10 a.m., an interview was conducted with Licensed Practical Nurse # 2 who stated oxygen tubing was changed on the night shift each week. On 3/4/2026 during the end of day debriefing, the Administrator, Director of Nursing, and Administrator in Training were informed of the findings. The Director of Nursing stated oxygen tubing should be changed every Tuesday on the night shift. Review of the January 2026, February 2026 and March 2026 Medication Administration Records revealed an order of Change tubing, mask and /or nasal cannula every Tuesday and as needed for hygiene. Review of the care plan revealed an intervention of change O2 (oxygen) tubing weekly and prn (as needed). Review of facility's policy on Oxygen/Respiratory Care revealed that oxygen tubing should be changed weekly and as needed. No further information was provided.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review, and facility documents, the facility staff failed to ensure dialysis communication logs were completed for one of 46 residents in a survey sample. The Findings Include: Resident #3 (R3) did not have dialysis communication logs completed. R3 diagnoses included, end stage renal disease with dialysis, diabetes, major depression, and kidney failure. The most recent MDS (minimum data set) was a quarterly 2/16/26 and indicated R3 was cognitively intact. Review of R3's physician orders indicated R3 goes to dialysis three days per week. Review of R3's facility/dialysis communication logs/assessments were reviewed and revealed only one dialysis assessment dated [DATE] had been completed. On 3/05/2026 at 10:08 a.m. license practical nurse (LPN #4) was interviewed. LPN #4 verbalized that R3 had recently been admitted to the hospital, and the hospital didn't send the communication book back with R3. It was pointed out that there was missing documentation of a communication log prior to and after hospitalization. LPN #4 reviewed R3's clinical record and verbalized that the communication forms should be scanned in after each dialysis visit. LPN #4 reviewed the clinical record and was unable to locate any communication logs. On 3/05/2026 at 10:25 a.m. LPN #8 (unit supervisor) was interviewed. LPN #8 verbalized the communication book is probably still at the hospital and the assessment forms are kept in the book. On 3/5/2026 at 4:00 p.m. the above information was presented to the administrator and director of nursing. A policy titled Hemodialysis read in part: There is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff. No other information was presented prior to exit summary on 3/10/2026.		

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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 Resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed for 1 resident (Resident #107) to provide significant medications during a loss of the electronic healthcare records (EHR) software system of the 40 Residents in the survey sample. The findings included: Resident #107 was admitted to the facility on [DATE], and discharged on 4-14-25 with diagnoses to include but not limited to; osteoarthritis, and left knee artificial joint replacement with instability, constipation, hypertension and macular degeneration. The Resident used a walker for ambulation. On 3-6-26 at approximately 11:00 A.m. the Resident was contacted and interviewed. The Resident stated she was placed in an adult brief because staff told her we can't come walk you to the bathroom every time. She further stated that she missed my pain meds for days, and stated I had to get out of there, it was horrible. The admission nursing assessment record revealed that the Resident was alert and oriented, and able to make her own decisions. Review of the physician's orders and Medication Administration Record (MAR) revealed that Resident #107 was ordered by the physician to be given the following medications. Levothyroxine sodium 88 mcg (micrograms) one tablet every morning for hypothyroidism. Lisinopril 20 mg (milligrams) one tablet every day for hypertension. Miralax 17 gms (grams) once per day for constipation. Senna 8.6 mg 2 tablets once per day for constipation. Verapamil 240 mg one in the evening for hypertension. Oxycodone 10 mg every 6 hours as needed for pain. Resident #107 received none of them on 4-8-25 as documented in the facility MAR. Levothyroxine, Lisinopril, Verapamil, and oxycodone are all significant medications. On 4-9-25 at 3:15 P.M., nursing notes indicated that the nursing staff were waiting for a call from the on call doctor to clarify BP meds. Another note documented at this time spoke with niece who relayed that medications were with the patient upon arrival to the facility. This indicated that they were available to be given, however, they were not given. On 4-9-25 an SBAR note (change in condition) was documented in the clinical record. The document detailed that Resident #107's niece complained that the Resident was without pain medication and on the toilet in pain for 2 hours on 4-7-25. Review of the Resident's care plan indicated that the Resident needed assistance with activities of daily living care (ADL's) and would receive needed assistance. The Resident was also coded for fall precautions, and pain due to a knee replacement. During an interview with the Administrator in training (AIT), and the Director of Nursing (DON), They stated the software program for the clinical record and medication administration had gone offline, and that they had a way to print a hard copy on paper from a computer in the front lobby, however, the staff did not do that. They further stated that a new policy was being developed to add to the emergency management program to ensure this did not happen again, and surveyors were given a copy of the draft document for review. The AIT, and DON stated that it is the facility policy that if the facility doesn't have the medication available, the facility will call the pharmacy and then if the pharmacy can't get it from the backup pharmacy, the facility will call the Dr. and let him know and see if he can substitute it or put it on hold. The facility administration was made aware of the deficient practice during the end of day conference at 12:30 AM on 3-6-26. They stated they had no further information to provide.		

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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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, staff interview, and resident interview, the facility staff failed to provide food in accordance with the physician's order for one of 46 residents in the survey sample. The Findings Include: Resident #23 (R23) did not get yogurt as ordered by the physician. On 3/3/2026 at 3:00 p.m. R23 was interviewed regarding food. R23 verbalized food concerns not getting what is ordered and food being cold at times. R23 went on to say that she does a lot of her own grocery shopping and prefers it that way. Review of R23's diet order indicated a regular diet with regular liquids and is to be served two yogurts for breakfast. On 3/4/2026 at 8:30 a.m. R23's breakfast was observed. The breakfast consisted of hashbrown patty, biscuits, cereal, coffee and milk. R23 verbalized usually only eating cereal and would not be eating the hashbrown or biscuit. When asked about getting yogurt the R23 said that she used to get yogurt, but since the new company has taken over, she no longer receives yogurt but would like it. On 3/4/2026 at 8:35 a.m. certified nursing assistant (CNA #7) verified R23's breakfast tray. On 3/5/2026 at 8:45 a.m. R23's breakfast tray was observed and did not include yogurt as ordered. No further information was provided. On 3/5/2026 at 9:15 a.m. the dietary manager was interviewed. The dietary manager verbalized physician orders go through meal tracker and gets updated into the system to ensure proper diets are served. The dietary manager was shown R23's breakfast meal ticket, the dietary manager said that yogurt is on hand and would take care of the concern.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record reviews, and facility document review, the facility staff failed to follow established infection control practices in the storage of respiratory equipment and the administration of medications in a sanitary manner to prevent contamination for 3 residents in a survey sample of 46 residents. (Residents #18, 40, 21). Findings included: 1. For Residents #18, the facility staff failed to store unused respiratory equipment in a sanitary manner to prevent contamination. Resident #18 was originally admitted on [DATE] and readmitted on [DATE] after a brief hospitalization for treatment of acute on chronic hypoxic respiratory failure and fluid overload secondary to congestive heart failure. Her diagnoses included but are not limited to chronic obstructive pulmonary disease with acute exacerbation, hypertensive heart disease with heart failure, obstructive sleep apnea, morbid obesity with alveolar hypoventilation, type 2 diabetes mellitus, cocaine abuse, and chronic myeloid leukemia. Resident #18's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) 1/26/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating no cognitive impairment. A review of Resident #18's clinical record revealed orders for oxygen six liters per minute via a nasal cannula continuously, nebulizer treatments every six hours as needed for shortness of breath and wheezing, and a non-invasive ventilator with face mask at bedtime related to chronic obstructive pulmonary disease with acute exacerbation and as needed. On 3/3/26 at 1:55 PM, during initial tour of the unit, Resident #18's nasal cannula tubing and nebulizer mask were observed hanging on the overbed table, not stored in a bag. On 3/3/26 2:05 PM, an interview was conducted with LPN #4 on the storage of oxygen equipment such as tubing and masks when not in use and she said, they are to be bagged. On 3/4/26 at 9:30 AM, Resident #18's non-invasive ventilator mask and nasal cannula tubing were observed hanging over the top of overbed table, unbagged. On 3/5/26 at approximately 8:30 AM, Resident #18 was observed sitting on the side of the bed, her nebulizer and non-invasive ventilator masks observed hanging over the top of the overbed table, not stored in a bag. According to Resident #18, she had not seen the staff store them in a bag and was not aware that they should be stored in a bag when not in use. No bag was observed in the resident's room. According to a nurse progress note dated 3/5/26 at 4:56 PM, Resident #18 was educated on the importance of keeping her respiratory equipment in a bag when not in use. An interview with Resident #18 confirmed she was educated and a review of her care plan revealed the care plan had been updated on 3/5/26 by the MDS nurse to reflect the resident was at risk for infection related to oxygen therapy equipment use and potential contamination of oxygen tubing, interventions included education to the resident and staff to monitor for compliance. 2. For Resident #40, the facility staff failed to store unused respiratory equipment in a sanitary manner to prevent contamination. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #40, admitted to the facility on [DATE] with diagnoses to include but not limited to: aphasia following cerebral infarction, polyneuropathy, metabolic encephalopathy, attention-deficit hyperactivity disorder, anxiety, depression and hypertensive heart disease without heart failure. Resident #40's most recent MDS (Minimum Data Set) Assessment with an ARD (Assessment Reference Date) of 2/28/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 12 out of a possible 15 indicating moderate cognitive impairment (resident is experiencing some difficulty with memory, orientation, or attention, and may require assistance with daily activities). On 3/3/26 at 2:00 PM, during initial tour of the unit, Resident #40's nebulizer mask was observed laying on top of clothes on the bedside table, not stored in a bag. On 3/3/26 at 2:05 PM, an interview was conducted with LPN #4 on the storage of oxygen equipment such as tubing and masks when not in use and she said, they are to be bagged. On 3/4/26, at 9:35 AM, Resident #40 was observed lying in her bed, a nebulizer mask was observed lying on top of clothing on the bedside table, open to air. On 3/4/26 at 11:30 AM, Resident #40 was observed lying in her bed, the nebulizer mask was observed on top of clothing on the bedside table. A review of Resident #40's physician orders and Medication Administration Record revealed an order for Budesonide via nebulizer treatment twice daily (a steroid medication used to treat asthma). On 3/4/26, during the end of day meeting, the Director of Nursing (DON) was asked what her expectations were for the storage of respiratory equipment when not in use. The DON said, they should be stored in a plastic bag to prevent contamination. On 3/5/26 at 9:15 AM, Resident #40's nebulizer mask was observed lying on the bedside table not bagged. When asked if she was getting her breathing treatment she stated, Oh yes, they help me breathe better, sometimes I might refuse them, but not much. A review of the facility's policy titled Oxygen Administration, dated 6/1/25, reviewed/revised 11/7/25, reads in part; Policy Explanation and Compliance Guidelines: 5.e. Keep delivery devices covered in plastic bag when not in use. On 3/9/26 during the end of day meeting with the Executive Director, Regional Director of Operations, Administrator-in-Training and Director of Nursing, the above information was shared with them. An opportunity was offered to the facility staff to present additional information. They had no further comments regarding the above information. 3. The facility staff failed to follow established infection control practices during medication administration for Resident #21(R21). On 3/4/26 at 8:13 A.M., LPN (Licensed Practical Nurse) #2 was observed while passing medications to have fingernails with polish that extended past the fingertips. Observed LPN #2 open a stock medication bottle of Senna (a medication that treats constipation) and place their index finger inside the bottle. LPN #2 then brought out a pill from the container on their fingernail and dropped it into a medication cup. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/26 at 8:13 A.M. LPN #2 was observed to remove a half tablet of metoprolol, a medication for hypertension, from an individual bubble compartment of R21's thirty-day supply card into their palm and then drop the tablet from their palm into the medication cup. LPN #2 then went into R21's room and administered the medications in the medication cup. LPN #2 was then observed performing a bedside finger stick blood sugar test on R21. LPN #2 failed to sanitize their hands prior to putting on gloves. LPN #2 then performed the test, removed their gloves and exited the room. LPN #2 did not sanitize their hands after removing their gloves. An interview with LPN #2 was conducted on 3/4/2026 at 2:07 P.M. LPN #2 stated that the process for removing medications from a stock med bottle is to dump the medication directly into the cup and they should not reach into the stock medication bottle with their fingers. When removing a medication from the individual thirty-day medication card blister pack, the process is to pop the medication out of the individual compartment directly into the medication cup. The correct procedure for performing a finger stick blood sugar test is to gather equipment, sanitize hands, don gloves, disinfect the site, prick the finger, obtain the blood sample, clean the equipment, remove gloves, and sanitize hands. LPN #2 stated I know the process; I just did it wrong. A review of facility policy Employee Personal Appearance and Identification included the following: Direct care and dietary staff may not wear nails extending beyond the fingertip. A review of facility policy on Medication Administration revealed that medications should be removed from the source and are not to be touched by the bare hand. The facility's policy for finger stick blood sugar tests indicates that staff is to sanitize their hands prior to and after removing gloves. No further information was presented prior to exit.		