STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495347	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Consulate Health Care of Windsor	23352 Courthouse Highway Windsor, VA 23487

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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** 34894 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 Residents (# 362) in a survey sample of 55 Residents. 1. For Resident # 362, the facility staff failed to ensure the bed was an appropriate size for a resident with morbid obesity (Body mass index greater than 40). The findings included: 1. For Resident # 362, the facility staff failed to ensure the bed was an appropriate size for a resident with morbid obesity (Body mass index greater than 40). Resident # 362 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, Acute and Chronic Respiratory Failure, Hypertensive Heart and Chronic Kidney Disease-Stage 5 with Heart Failure, Diabetes- Insulin Dependent, Chronic Pulmonary edema, Chronic Sleep Apnea and Persistent Mood Affective Disorder . There was no Minimum Data Set (MDS) Assessment because it was too soon to complete the assessment. indicating no cognitive impairment. Review of the clinical record was conducted on 4/29/2025-5/1/2025. During rounds on 4/29/2025 at 1:45 p.m., Resident # 362 was observed sitting up in bed, eating lunch and talking with a visitor. Resident # 362 was able to converse with the surveyor. When the surveyor asked if there were any concerns, Resident # 362 stated he needed rails to help move himself up in the bed. He complained that his bed was too small. He stated he needed a larger bed. Resident # 362 stated he did not have enough room to move in the bed. He stated that he felt like he was going to fall out of the bed whenever he tried to move. He stated rails would at least give some support. He showed the surveyor that it was difficult to move in the bed. It was observed that there were less than three inches of space on either side of of the mattress when Resident # 362 was lying in bed. Resident # 362 was struggling to adjust his position in the bed. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/2025 at 12:30 p.m., Resident # 362 was observed lying in bed tilted toward his right side. There was very limited space on the mattress. On 4/30/2025 at 3:10 p.m., an interview was conducted with the Director of Nursing who stated residents had to be assessed for the use of rails before any rails could be used. She also stated that it was important for residents to be safe from entrapment. Review of the clinical record revealed Resident # 362's weight was 334 pounds and height was 70 inches. His body mass index was listed as 47.8. Staff persons were observed in the room talking with Resident # 362 during the survey, picking up food trays, and delivering ice and water. No staff person addressed the issue of the bed being to small for Resident # 362. On 04/30/2025 at 3:22 p.m., an interview was conducted with Licensed Practical Nurse # 1 who stated a resident's size should be utilized to determine the appropriate sized bed. She stated the bed size should be tailored to the size of the Resident if possible. On 5/1/2025 at 9:30 a.m., observed Resident # 362 lying in a bariatric bed. Resident # 362 stated the bed was much more comfortable and that he felt much better being able to move more freely. He stated he slept better also. On 5/1/2025 at 11 a.m., an interview was conducted with the Maintenance Director who stated he had replaced the bed with a bariatric bed. During the end of day debriefing on 5/1/2025, the Facility Administrator, the Regional [NAME] President of Operations, Regional Nurse Consultant and Director of Nursing were informed of the findings. They all stated it was important for residents to have beds that fit the residents properly. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on interviews, record reviews, and facility policy reviews, the facility failed to notify the Responsible Party (RP) of a change in condition for one resident (Resident (R)71) investigated for changes in condition out of a total sample of 55 residents. Findings include: Review of the facility policy titled, Notification of Change in Condition, revised 12/16/20 revealed The Center to promptly notify the Patient/Resident , the attending physician and the Resident Representative when there is a change in the status or condition .Need to alter treatment significantly- new treatment . Review of R71's undated Admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of dementia. Review of R71's quarterly Minimum Data Set (MDS) Assessment located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 04/08/25 included a Brief Interview for Mental Status (BIMS) score of 99 indicating that the resident was not capable of participating in the assessment and had severe cognitive impairment. The resident was dependent on staff for all activities of daily living (ADL). Review of R71's Care Plan Report, initiated 03/09/23, located in the EMR under the Care Plan tab included having the potential for pressure injury development related to impaired cognitive function, incontinence, and limited mobility. Interventions included following facility policies/protocols for the prevention/treatment of skin breakdown and informing the resident/resident representative of any new area of skin breakdown. Review of R71's Consulate Weekly Skin Integrity Review, dated 03/12/25, located in the EMR under the Assessments tab, indicated she had an unstageable deep tissue injury to the right hip, stage two pressure ulcer to the left hip, and moisture associated dermatitis to the sacrum. Treatment initiated as ordered and wound physician in the facility per documentation. Review of R71's Initial Wound Evaluation & Management Summary by VOHRA Wound Physicians dated 03/12/25 and located in the EMR under the miscellaneous tab included R71 presenting with wounds to the left lip, right hip, and sacrum. Diagnoses included unstageable deep tissue injury (DTI) to the right hip, stage two pressure ulcer (PU) to left hip, and MASD to sacrum. Review of R71's Change in Condition (SBAR) located in the EMR under the Assessments tab dated 03/18/25 indicated that R71's Responsible Party (RP) was notified of deep tissue injury to the right hip, and open areas to the sacrum and left hip. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/25 at 6:22 PM with the RP/Family Member (FM)1 stated she was not notified of the resident's stage 3 pressure ulcer until the physician called her with a follow up. The physician acted like she already knew, which she did not. She was only aware of her Mother requiring an air mattress and wedge pillow to help prevent pressure ulcers. During an interview on 05/01/25 at 6:49 PM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed that R71's wound was discovered on 03/12/25. The wound care specialist was onsite (VOHRA) started and initiated treatment. On 03/18/25 the VOHRA physician and LPN notified daughter of wounds. The wound should have been reported to FM1 on 03/12/25.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on interviews and record reviews, the facility failed to timely report an injury of unknown origin for one of one residents (Resident) (R71) reviewed for reporting of alleged violations out of a total sample of 55 residents. This had the potential for further abuse. Findings include: Review of the facility's policy titled, Abuse, Neglect, Exploitation, & Misappropriation initiated 11/16/22 stated, .An incident report shall be filed by the individual in charge who received the report .The Abuse Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be reported .injuries of unknown source .is obligated to report such information immediately, but no later than 2 hours after the allegation is made . Review of R71's undated Admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of dementia. Review of R71's Care Plan located in the EMR under the Care Plan tab initiated 11/25/22 stated R71 was dependent on staff for her physical needs due to cognitive deficits. Review of R71's quarterly Minimum Data Set (MDS) Assessment located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 04/08/25 included a Brief Interview for Mental Status (BIMS) score of 99 indicating that the resident was not capable of participating in the assessment and had severe cognitive impairment. R71 was also noted to be dependent on staff for all activities of daily living (ADL). Review of R71's Progress note dated 05/30/23 at 9:47 AM located in the EMR dated under the Progress Notes tab were reviewed and confirmed that R71 was noted with a bruise to the right forehead, right eye, bridge of nose, and slight bruising under the left eye. The resident was evaluated by the nurse practitioner and sent to the Emergency Department (ED) for evaluation and treatment 05/30/23 at 9:35 AM. A computed tomography scan (CT) (medical imaging technique using x-rays to create images of the body) was performed with no abnormal findings. The responsible party (RP) was notified and the resident returned from the facility at 5:14 PM on 05/30/23. Review of the Facility Reported Incident (FRI) provided by the facility revealed the facility filed an initial report with the Virginia (VA) Department of Health (DOH) on 05/30/23 at 12:22 PM for an injury of unknown origin, over three hours after being aware of R71's bruising. The FRI included a timeline indicating that on 05/30/23 at 9:40 AM bruising was noted to R71's face, at 9:47 AM, 911 was called and at 9:58 AM the resident was transported to the ED. R71 returned to the facility on [DATE] at 5:14 PM with no abnormal findings. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/29/25 at 5:30 PM with the current Administrator stated that Certified Nursing Assistants (CNA9 and CNA17), Licensed Practical Nurse (LPN9), and Registered Nurse (RN1) were on duty on 05/30/23 at the time R71 was noted with an injury. The Administrator stated that she was not employed at the facility at the time of the reported incident, and that CNA17 and LPN9 no longer work at the facility. Her expectation was that an injury of unknown origin be reported immediately (within two hours) to the DOH and the completed investigation be submitted to the DOH on the fifth day. The Administrator confirmed that she had no completed investigation on file, witness statements, or investigation notes but should have.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on interview, record review, and review of facility policy, the facility failed to thoroughly investigate an injury of unknown origin for one of one residents (Resident (R)71) reviewed for abuse out of a total sample of 55 residents. This had the potential for further abuse to the resident. Findings include: Review of the facility's policy titled, Abuse, Neglect, Exploitation, & Misappropriation initiated 11/16/22 stated, .An incident report shall be filed by the individual in charge who received the report .The Abuse Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be reported .injuries of unknown source .is obligated to report such information immediately, but no later than 2 hours after the allegation is made . Review of R71's undated Admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of dementia. Review of R71's Care Plan located in the EMR under the Care Plan tab initiated 11/25/22 revealed R71 was dependent on staff for her physical needs due to cognitive deficits. Review of R71's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/25 located in the EMR under the MDS tab included a Brief Interview for Mental Status (BIMS) score of 99 indicating that the resident was not capable of participating in the assessment and had severe cognitive impairment. R71 was also noted to be dependent on staff for all activities of daily living (ADL). Review of R71's Progress note dated 05/30/23 at 9:47 AM located in the EMR under the Progress Notes tab revealed that R71 was noted with a bruise to the right forehead, right eye, bridge of nose, and slight bruising under the left eye. The resident was evaluated by the nurse practitioner and sent to the Emergency Department (ED) for evaluation and treatment on 05/30/23 at 9:35 AM. A computed tomography scan (CT) (medical imaging technique using x-rays to create images of the body) was performed with no abnormal findings. The responsible party (RP) was notified and the resident returned from the facility at 5:14 PM on 05/30/23. Review of the Facility Reported Incident (FRI) revealed the facility filed an initial report with the Virginia (VA) Department of Health (DOH) on 05/30/23 at 12:22 PM for an injury of unknown origin. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up investigation dated 07/06/23 was sent to the VA DOH concluding at R71 had a Brief Interview for Mental Status (BIMS) score of 99 as of 04/27/23 with a primary diagnosis of vascular dementia without behavioral disturbances. A complete investigation was conducted and Adult Protective Services (APS) was notified on an unknown date/time. The Director of Nursing (DON) (RN1) and Unit Manager visited with R71 and her roommate to discuss concerns on an unknown date/time along with staff interviews on an unknown date/time. The follow-up investigation sent to VA DOH concluded that abuse was unsubstantiated. During an interview on 04/29/25 at 5:30 PM with the current Administrator stated that Certified Nursing Assistants (CNAs)9 and CNA17, Licensed Practical Nurse (LPN)9, and Registered Nurse (RN)1 were on duty on 05/30/23 at the time R71 was noted with an injury. The Administrator stated that she was not employed at the facility at the time of the reported incident, and that CNA17 and LPN9 no longer work at the facility. The Administrator confirmed that she had no completed investigation on file, witness statements, or investigation notes but should have. During an interview on 04/30/25 at 7:39 PM with CNA9 stated that she recalled R71 having bruising to her face on 05/30/23 and did not recall R71 and her roommate (R100) being involved in any disputes, however the roommate was very volatile and was known to strike out with very little provocation. The incurred injury received by R71 was unwitnessed. On 04/30/25 at 8:32 PM a voicemail was left for RN1 and no return phone call was received.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on observation, interview, clinical record review and facility documentation the facility staff failed to develop and implement a comprehensive person-centered care plan for 1 Resident (# 38) in a survey sample of 55 Residents. The findings included: For Resident # 38 the facility failed to develop a comprehensive care plan that addressed measures to reduce the possibility of any injures during falls and to protect the recently replaced hip. Resident # 38 was admitted to the facility on [DATE] with diagnoses that included but were not limited to: Hypertensive Heart Disease with Heart Failure, presence of artificial hip joint following cerebrovascular disease, and depression. Resident # 38's most recent MDS (Minimum Data Set) was coded as an Admission Assessment with an ARD (Assessment Reference Date) of 4/11/2025. The MDS coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of 15 indicating no cognitive impairment. Resident # 38 required assistance with Activities of Daily Living. On 4/29/2025 at 2:28 p.m., Resident # 38 was observed sitting up in a wheelchair next to his bed. His wife was visiting and told the surveyor that she had some concerns. She stated the resident had fallen at home and fractured his hip which had to be replaced. Resident # 38's wife stated he was in the facility to get therapy before returning home. On 04/29/0225 at 2:31 p.m.- Resident # 38's wife stated resident has fallen twice since admission. She stated she heard about fall mats and wants one for Resident # 38. She stated she was afraid he was going to re-injure that hip. She stated she noticed that some other residents in the facility had fall mats. No fall mats were noted on either side of the bed. On 4/30/2025 at 9:45 a.m Resident # 38 was observed lying in bed. He stated he was just resting. No fall mats were noted on either side of the bed. On 05/01/25 at 12:22 p.m., an interview was conducted with Licensed Practical Nurse # 1 who stated nursing measures were discussed in the IDT (Interdisciplinary Team) meeting. Licensed Practical Nurse # 1 stated it was important for interventions to be implemented to help the residents maintain optimal health and safety. On 05/01/25 at 12:24 p.m., an interview was conducted with the Physical Therapy Director who was asked if Resident # 38 had been assessed for the use of floor mats to reduce the possiblity of any injures and to protect the recently replaced hip. The Physical Therapy Director stated he would have been present at the Risk Meeting regarding Resident # 38 where the administrative team discussed new admissions and plans of care. The Physical Therapy Director stated he would check any notes to see why mats were not listed as an intervention. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan revealed that Resident # 38's care plan did not address the use of fall mats to to reduce the risk of injuries if any falls occurred. On 5/1/2025 during the end of day meeting, the Administrator and Director of Nursing were made aware of the findings that interventions did not include fall mats to reduce the risk of injuries during falls. 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** 40711 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to review and revise the care plan for 1 resident (#43) and invite the interdisciplinary team to the care plan meeting for 2 residents (Resident #59 and 71), of 55 residents in the survey sample. The findings included: 1. The facility's staff failed to review and revise Resident #43's care plan to include self catheter care. Resident #43 was originally admitted to the facility 11/05/22 and readmitted [DATE] after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Neuromuscular Dysfunction of the Bladder. The quarterly revision, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/22/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #43 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities Goals) the resident was coded as requiring set-up help with eating and oral hygiene. Resident coded as dependent with toileting hygiene. Requiring substantial/maximal assistance with shower/bathe self. Requiring partial/moderate assistance with personal hygiene. (Functional Limitations in Range of Motion) Resident coded as no impairment for upper extremity. Resident coded as impairment on both sides for lower extremities. (Mobility Devices) Resident coded as requiring a wheelchair. (Mobility) Resident coded as independent with rolling left and right. Requires supervision or touching assistance with sit to lying and lying to sitting. Resident coded as a dependent chair to bed. In Section H (Bladder and Bowel) the resident was coded as having an indwelling, external catheter. The April 2025 Physicians Order Summary (POS) read: Catheter care every shift and as needed every shift for Foley catheter -Start Date- 11/08/2024 7:00 pm. The person-centered care plan dated 10/30/23 read that Resident #43 has an indwelling foley catheter as well as a colostomy r/t diabetes, BPH, and dx of other obstructive and reflux uropathy. The Goals for Resident #43 are the resident will The resident will show no s/sx of Urinary infection through review date and the resident will be/remain free from catheter-related trauma through review date (4/22/25). The interventions for Resident #43 are to monitor/document for pain/discomfort due to catheter and Monitor/record/report to MD for s/sx UTI (Urinary Tract Infection). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/25 at approximately 10:17 am, a brief interview was conducted with Resident #43. Resident #43 said that he had an enlarged prostate a few years ago that's why I have a foley. I have had infections (Urinary Tract Infections/UTI's), I see the Urologist one a month to get my foley changed. Resident #43 was asked if the staff performs daily catheter care. Resident #43 stated, I do my own (foley) catheter care. Permission was granted from resident to be observed performing his foley catheter care. A review of the resident's medical records read that he's had several Urinary Tract Infections last year (2025). On 4/30/25 at approximately 11:00 am., foley catheter self care was observed. Certified Nursing Assistant (CNA) #14. CNA #14 was observed setting up one basin, placing 2 wash cloths inside with a bar of soap. The steps were as follows: CNA #14 washed Resident's back, wash cloth placed back inside the basin with clean wash cloth, resident reached for clean wash cloth in the basin, rung it out, washed his left and right groin area, placed wash cloth in basin and rung out cloth again, took wash cloth out of the basin, wipe his foley catheter moving downward and placed wash cloth inside basin. On 4/30/25 at approximately 11:15 AM., a brief interview was conducted with CNA #14 concerning Resident #43s catheter care. CNA #4 said that she realized that she should have provided 2 basins, 1 basin with soap water and the other with rinse water. On 05/01/25 at approximately 1:45 pm., a brief interview was conducted with Certified Nursing Assistant (CNA) #14. CNA #14 said that she was never informed to assist the resident with catheter care other than emptying his foley. On 05/01/25 at approximately 12:13 pm., an interview was conducted with Licensed Practical Nurse (LPN) #10. LPN #10 said that the CNAs do the catheter care as part of the (Activity of Daily Living) ADLs. On 05/01/25 at approximately 11:08 am., a brief interview was conducted with the Assistant Director of Nursing (ADON). The ADON said that the CNAs should help with foley catheter care. We will educate the resident on proper foley care. On 5/01/25 at approximately 7:00 p.m., during the pre-exit the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant and [NAME] President of Operations. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided. 40824 Review of the facility's policy titled, Plans of Care revised 09/25/17 revealed, .An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) .Develop and implement an individualized person-centered comprehensive plan of care by the Interdisciplinary Team that includes but is not limited to - the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R59's undated Admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with a Wernicke's encephalopathy (mental status changes and gait ataxia). Review of R59's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 02/17/25 included a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that the resident was cognitively intact. Review of R59's Care Planning Invitation scheduled for 05/29/24 indicated that the Social Services Director (SSD), Social Services Assistant (SSA), responsible party and R59 attended the care conference. No other departments attended the care conference. Review of R59's Care Planning Invitation scheduled for 08/21/24 indicated that the Social Services Director (SSD), Social Services Assistant (SSA) and R59 attended the care conference. No other departments attended the care conference. Review of R59's Care Planning Invitation scheduled for 12/04/24 indicated that the Social Services Director (SSD) and R59 attended the care conference. No other departments attended the care conference. Review of R59's Care Planning Invitation scheduled for 03/06/25 indicated that the Social Services Director (SSD), Social Services Assistant (SSA), and R59 attended the care conference. No other departments attended the care conference. During an interview on 04/29/25 at 1:30 PM with R59 stated that he had concerns with his social security checks, returning to the community and his clothing. He did not recall attending any care conferences. 3. Review of R71's undated Admission Record located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of dementia. Review of R71's quarterly MDS located in the EMR under the MDS tab with an ARD of 04/08/25 included a BIMS score of 99 indicating that the resident was not capable of participating in the assessment and had severe cognitive impairment. Review of R71's Care Planning Invitation scheduled for 07/11/24 indicated that the Social Services Director (SSD), Social Services Assistant (SSA), and Family Member (FM)1 attended the care conference. No other departments attended the care conference. Review of R71's Care Planning Invitation scheduled for 10/15/24 indicated that the SSD and FM1 attended the care conference. No other departments attended the care conference. Review of R71's Care Planning Invitation scheduled for 01/14/25 indicated that the SSD and FM1 attended the care conference. No other departments attended the care conference. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/25 at 11:06 AM with R71's Family Member (FM)1 stated that the facility called her with updated information at times, but other times she doesn't find out information until later. When she was not able to attend care conferences she did not receive notification of information discussed or changes that were taking place. FM1 had concerns with pressure ulcers, activity participation, and hydration status. During an interview on 05/01/25 at 10:38 AM with the Director of Nursing (DON) confirmed that care conferences were to be held quarterly and as needed for each resident. The DON confirmed that a staff member from the nursing department should always attend and did not elaborate on why no one from the nursing department had attended the care conferences for these residents. During an interview on 05/01/25 at 12:57 PM with Licensed Practical Nurse (LPN)10 stated that she had not been invited to attend any care conferences and she was not sure who was supposed to attend the meetings. During an interview on 05/01/25 at 1:28 PM with SSD confirmed that all departments involved in the residents' care should attend the care conferences but due to staffing shortages, they frequently are unable to attend. Her protocol was to send an email to notify each department at the beginning of the month with the care conference schedule. All attendees were to sign the attendance sheet if they attended. The SSD was unable to locate any sign in sheets and did not recall speaking with R59 regarding concerns with transferring to the community, his clothing, or his social security checks. The SSD did not bring it to the attention of Administration regarding all departments not attending the care conferences, no reason was given. Additionally, SSD said she was not clinical, so when dietary, therapy, nursing, etc. were not available she would just have to review their notes in EMR (if they were available) to determine if there were any concerns that needed to be shared with the resident/RP. SSD stated that in the past (unknown dates/timeframes) she had used a sign in sheet, but couldn't recall when she last used one. During an interview on 05/01/25 at 4:11 PM with the Dietary Manager (DM) confirmed that she either received email invitations or a paper copy of care conference meeting dates. DM confirmed that all departments were required to attend and in the past, most departments attended and if they had done so they would sign to confirm their attendance. During an interview on 05/01/25 at 5:00 PM with the Director of Rehabilitation (DOR) stated that he received invitations for care conferences at the beginning of each month but only attended meetings if the family or the resident requested him to do so. He did not confirm/deny if he was required to attend if the resident was currently receiving services.

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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** 40026 Based on interview, clinical record review and facility documentation, the facility staff failed to ensure services were provided to meet professional standards of quality for 1 Resident (55) in a survey sample of 55 Residents. The findings included: For Resident #55 the facility staff failed to schedule follow up with cardiology as ordered by physician. Resident # 55 was admitted to the facility on [DATE] with diagnoses that included, but we're not limited to hypertension, high cholesterol, dementia, depression, major depressive disorder, muscle, weakness, cognitive, communication, deficit, insomnia, and presence of a pacemaker. Resident # 55's most recent MDS (Minimum Data Set), with an ARD (Assessment Reference Date) of 3/3 25, scored the resident as having a BIMS (Brief Interview of Mental Status) score of 4 out of 15 indicating severe cognitive impairment. During the survey Resident #55 was observed to be unable to follow simple instructions by staff, feed herself or engage in meaningful conversations. On 4/30/25 during clinical record review it was found that Resident #55 had a recent emergency room visit. Excerpts from the discharge summary read as follows: 4/10/25 instructions your work up show evidence of thyroid nodules. I would recommend that you follow up for outpatient ultrasound of your thyroid. The battery life on your pacemaker is towards the end. Please follow up with your cardiologist as soon as possible you will likely require battery replacement within the next three months. On the afternoon of 4/30/25 an interview was conducted with administrative staff #14 who stated that she scheduled the transportation to appointments. She looked in the transportation book and stated that she did not have Resident #55 scheduled for cardiology through the end of 2025. On the afternoon of 4/30/25 an interview was conducted with LPN #7, the unit manager, who stated that she schedules follow up appointments for the Residents on her unit. LPN #7 stated that she was not aware of any cardiology appointments for Resident #55. LPN #7 checked her appointment book and stated that she did not have any appointments scheduled for cardiology through the end of 2025. When asked to read the discharge summary from the ER she stated that the follow up must have gotten missed when she returned to the facility. She stated that they did follow up on the thyroid nodules but must have missed the cardiology appt. When asked what could happen if a pacemaker battery is not replaced timely, she stated the Resident would become symptomatic and may have skipped heartbeats, dizziness, fainting and slow heartrate. On 5/1/25 a review of the clinical record revealed the following progress note: 4/30/35 at 7:33 p.m. - Pacemaker battery replacement-Cardiology [address and phone number redacted]. Awaiting call back for the appointment time and date, RP [name redacted] and MD notified. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The National Institutes of Health (NIH) and its affiliated institutions, including the National Library of Medicine (NLM), heavily rely on following physician orders as the foundation of patient care. Physician orders are the initial communication that enables healthcare providers to implement treatment plans, and they are essential for ensuring coordinated care, patient safety, and quality measures according to the National Institutes of Health (NIH.gov) On 5/1/25 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on observation, interview, record review, and facility policy review the facility failed to ensure that activities of daily living (ADL) care related to toenail care was provided to one resident (Resident (R)80) out of a total sample of 55 residents. This failure had the potential to cause the resident foot problems. Findings include: Review of the facility policy titled Foot Care revised 08/23/17 included .Examine feet and report any unusual condition to nurse and/or physician . The policy did not indicate which department was responsible for toenail care. Review of R80's undated Admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of dementia. Review of R80's quarterly Minimum Data Set (MDS) Assessment located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 03/23/25 included a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating that the resident was severely cognitively impaired. Review of R80's Care Plan Report initiated 08/30/23 located in the EMR under the Care Plan tab included ADL care self-care performance deficit related to dementia and required staff to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Review of R80's Order Summary Report located in the EMR under the Orders tab included an order for podiatry referral to clip toenails as of 11/18/24. Review of R80's Consulate Weekly Skin Integrity Review dated 04/27/25 and located in the EMR under the Assessment tab did not indicate R80 had any concerns with her toenails. Review of R80's undated Visual/Bedside Kardex Report located in the EMR under the Tasks tab included checking nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. During an observation and interview on 04/29/25 at 2:17 PM R80 was in bed and reported to this surveyor that she had been waiting to see the podiatrist for four years. R80 proceeded to take off her left shoe and it was noted that she had long, thick, discolored toenails. During an interview on 04/30/25 at 5:16 PM with Social Services Director (SSD) stated that she spoke with Licensed Practical Nurse (LPN)10 and confirmed that R80 needed her toenails trimmed. SSD confirmed that R80 had not been seen by a Podiatrist since she was admitted to the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/25 at 10:25 AM with Certified Nursing Assistant (CNA)8 confirmed that she had assisted the resident to dress prior to this surveyor entering the room. She was not aware of R80 having long, thick, discolored toenails. CNA8 stated that it was the facility policy for CNA's to trim the resident's finger nails, but if toenails needed trimming or had concerns the CNAs were to notify the nurse who would make a referral to podiatry. Once the nurse is aware the resident needs toenail care, the SSD would be notified who would then schedule an appointment. During an interview on 05/01/25 at 10:38 AM with the Director of Nurses (DON) stated that it was her expectation for the CNAs to let the nurse know if the resident needed toenail care. The nurse would then notify the SSD who would schedule a podiatry visit. During an interview on 05/01/25 at 10:45 AM with LPN10 stated that she was not aware that R80 had long, thick, discolored toenails. LPN10 stated that it was her understanding that CNAs trimmed the toenails unless the resident was diabetic and she confirmed R80 was not diabetic. The facility policy was for the CNA to notify the nurse if a resident needed to be seen by podiatry, then the SSD puts the resident on the podiatry list.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on interview, record review, and facility policy review, the facility failed to ensure that three residents (Resident (R) 66, R71 and R55) had valid advanced directive documents on file. Specifically, R66 and R71 had orders on file for Do Not Resuscitate (DNR) but did not have valid documentation to carry out the orders. This failure had the potential for the resident's wishes to be unmet in the event of cardiac arrest. Findings include: Review of the facility policy titled, Advanced Directives revised [DATE] revealed, .Social Services and/or Business Development Coordinator/designee will assist the resident/ resident representative to complete the Advance Directives Discussion Document. If an advance directive exists the Social Services and/or Business Development Coordinator/designee will obtain a copy and place it in the resident's medical record .Upon completion of Advanced Directives Discussion Document, Social Services or nurse will notify the Physician of the resident's wishes and procure a state approved Do Not Resuscitate Order, if necessary .Advanced Directives will be reviewed: quarterly, hospice admission .Any changes to advanced Directives will require a new Advanced Directives Discussion Document to be completed and place in the medical record 1. Review of R66's undated Admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of hypertensive heart disease with heart failure. Review of R66's quarterly Minimum Data Set (MDS) Assessment located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of [DATE] included a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that the resident was cognitively intact. Review of R66's Care Plan Report initiated [DATE] located in the EMR under the Care Plan tab included an advance directive status of DNR. Review of the facility document titled DNR Chart Audit dated [DATE] included R66 having an order for DNR and state specific DNR form. Review of R66's Durable Do Not Resuscitate Order Virginia Department of Health dated [DATE], revealed no physician's signature but indicated that the resident was incapable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probably consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision . During an interview on [DATE] at 2:10 PM with R66 stated that she was on hospice and that her advanced directive status was DNR. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R71's undated Admission Record located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of dementia. Review of R71's quarterly MDS Assessment located in the EMR under the MDS tab with an ARD of [DATE] included a BIMS score of 99 indicating that the resident was not capable of participating in the assessment and had severe cognitive impairment. Family Member (FM)1 was R71's responsible party (RP). Review of R71's Care Plan Report revised [DATE] located in the EMR under the Care Plan tab indicated that R71 had no advanced directive on file and was to be a full code. Review of R71's Order Summary Report included an order for Do Not Resuscitate dated [DATE]. Review of R71's Virginia Advance Directive dated [DATE] located in the EMR under the miscellaneous tab included her deceased spouse's name on the document. No documentation was located with R71's name. Review of the facility document titled DNR Chart Audit dated [DATE] included R7 not having an order for DNR or state specific DNR form. During an interview on [DATE] at 11:28 AM with FM1 confirmed that R71's advance directive status was DNR. FM1 confirmed that the name on R71's Virginia Advance Directive document was her deceased father's name/her mother's deceased spouse. During an interview on [DATE] at 12:43 PM with Social Services Assistant (SSA)2 stated that advanced directives are reviewed during care conferences and confirmed that the orders on file for R66 and R71 were for DNR. During an interview on [DATE] at 12:50 PM the Social Services Director (SSD) stated that both R66 and R71 had orders for DNR status. The procedure for a resident coding who didn't have complete or accurate documentation for DNR status was for the nurse on duty to contact the Emergency Contact/RP, if not able to contact them, then they would need to contact the resident's physician for authorization and ensure a second nurse was witness to the conversation. SSD confirmed that the Durable Do Not Resuscitate Order Virginia Department of Health on file for R66 did not have a physician's signature and was not sure if the document was in effect with no physician signature. SSD confirmed that R71's Virginia Advance Directive on file was for R71's deceased spouse and not for R71. SSD confirmed that she did not have proper documents for R66 or R71 but that SSA2 had just called R71's FM1 and they would make arrangements to obtain the correct documents. SSD confirmed that advance directive status was reviewed during care conferences, and she was not sure why/how these issues were overlooked. During an interview on [DATE] at 4:55 PM with Emergency Medical Technician (EMT) on site at the facility stated that R66's Durable Do Not Resuscitate Order Virginia Department of Health and R71's Virginia Advance Directive would not be in effect if EMS would be called for either resident because R66's did not include a physician's signature and because R71's did not have her name on it. In either case, EMS would have to perform cardiopulmonary resuscitation (CPR) in the case of an emergency. 40026 (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. For Resident #55 the facility staff failed to have a signed copy of the DNR available in the clinical record. Resident # 55 was admitted to the facility on [DATE] with diagnoses that included, but we're not limited to hypertension, high cholesterol, dementia, depression, major depressive disorder, muscle, weakness, cognitive, communication, deficit, insomnia, and presence of a pacemaker. Resident # 55's most recent MDS (Minimum Data Set), with an ARD (Assessment Reference Date) of ,d+[DATE] 25, scored the resident as having a BIMS (Brief Interview of Mental Status) score of 4 out of 15 indicating severe cognitive impairment. During the survey Resident #55 was observed to be unable to follow simple instructions by staff, feed herself or engage in meaningful conversations. On [DATE] during clinical record review it was found that Resident #55 had a DNR dated [DATE], this document was filled out to read as follows: 2. (box checked) The patient is INCAPABLE of making informed decision about providing, withholding or withdrawing specific medical treatment . (If you check box 2 above check A, B, or C below) C. The patient has not executed a written advance directive (living will or durable power of attorney for health care). (Signature of Person Authorized to Consent on the Patient Behalf is REQUIRED) This document was unsigned. On [DATE] an interview was conducted with the Administrative Staff #6 who were asked who is responsible for the DNR forms being entered into the system. She stated that Social Services Dept was responsible. When asked to pull up Resident #55's DNR form she did so in the electronic health record. She was asked if there is any problem with the DNR form and she stated that there was no signature on it. When asked what the problem is if there is no signature, she stated that it is not legal if it has not been signed. When asked what the implications of that are and she stated the Resident would receive CPR because the form is not valid without a signature. On [DATE] a review of the clinical record revealed the progress following note: [DATE] at 7:08 p.m. NP [Nurse Practitioner name redacted] DON, and UM spoke to POA [name redacted] to confirm code status. [Name Redacted], daughter POA acknowledged and confirmed resident is a DNR and she has faxed a sign copy to the Facility. DON repeated code status and POA [Name redacted]. NP [name redated] signed DNR Code Status form. A review of the policy, entitled advanced directives, revealed the following excerpts: Policy: the center will abide by state and federal laws regarding advanced directives. The center will honor all properly executed advanced directives that have been provided by the resident and/or resident representative. Process: (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Upon admission, social service Director or business development coordinator/designee will: a) Communicate to resident and/or resident representative his or her right to make choices concerning healthcare and treatments, including life-sustaining treatments. b) Determine whether a resident has an advanced directive, and if not, determine whether the resident wishes to establish an advanced directive. c) Document in the resident record via the advanced discussion form that a resident and or represent resident representative has been apprised of his or her right to formulate in advanced directive. 2. Social services and or Business development coordinator/designated will assist the resident/representative to complete the advanced directives discussion document. If an advanced directive exists, the social services and/or business development coordinator/design will obtain a copy and place it in the residence medical record. 3. If the resident has not executed in advanced directive, but wishes to establish an advanced directive, the social services will assist the resident/resident representative with obtaining the state approved, advanced directive documents. Formulating and advanced directed is the choice of the resident and is not required. No center employee shall act as witness or notary for advanced directive forms, but staff can assist in ensuring documentation is properly executed 4. upon completion of the advanced directive discussion, document social services, or nurse will notify the physician of the residence. Wishes and procure state approved. Do not resuscitate order if necessary. Notification will be documented in the clinical record. On [DATE] during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 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** 25232 Based on record review, interview and policy review, the facility failed to ensure that physician's orders were followed for one of 55 residents (Resident (R) 116) whose records were reviewed. This failure has the potential to negatively impact R116 and others that have similar orders that currently reside at the facility. Findings include: Review of facility policy titled, Administering Medications, revised 04/2019, indicated, Medications are administered in a safe and timely manner and as prescribed. Policy Interpretation and Implementation . 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). Review of R116's Admission Record, located under the Profile in the Electronic Medical record (EMR), indicated that R116 was admitted to the facility on [DATE] with diagnoses that included hypertension, chronic kidney disease (CKD), major depressive disorder (MDD), atrial fibrillation (a-fib), and vitamin b-12 deficiency. Review of R116's Order Summary Report, dated 03/15/24 and located under the Orders in the EMR, indicated the resident was to receive: amiodarone 200 milligrams (mg), give one tablet by mouth (PO) one time a day for a-fib; amlodipine 2.5 mg, give one tablet PO one time a day for hypertension ascorbic acid 1000 mg, give one tablet PO one time a day for supplement bumetanide 1 mg, give one tablet PO one time a day every other day for hypertension calcitriol .25 micrograms (mcg), give one capsule PO one time a day every Monday, Wednesday, Friday for low calcium citalopram hydrobromide 20 mg, give one tablet PO one time a day for depression cyanocobalamin 1000 mcg, give one tablet PO one time a day for supplement Eliquis 5 mg PO one time a day for anticoagulant lidocaine external patch 5%, apply to lower back topically every 12 hours for pain metoprolol succinate extended release (ER) 25 mg, give one tablet PO a day for hypertension and hold for systolic blood pressure (sys) less than 110 potassium chloride ER 20 milliequivalent (meq), give one tablet PO twice a day (BID) for low potassium multivitamin with minerals, give one tablet PO one time a day for supplement; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	house supplement twice a day (BID) with breakfast and lunch vital signs every shift. Review of Medication Administration Record (MAR), dated 03/15/24 through 03/24/24, revealed no documented evidence that R116 received the morning medications as ordered. There was no documented evidence that R116's evening dose of metoprolol tartrate ER and potassium chloride were given on 03/21/24 and/or 03/24/24. There was no documented evidence that vital signs were taken as ordered on the day shift on the following days: 03/16/24, 03/18/24, 03/20/24, 03/21/24, and/or 03/24/24. Also, there was no documented evidence that vital signs were taken as ordered on the night shift on the following days: 03/21/24 and/or 03/21/24. Interview on 05/01/25 at 8:50 PM, the Director of Nursing (DON) confirmed that R116's medications should have been given as the physician ordered and they were not.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure residents received vision services for 2 of 55 residents (Resident #43 and 87), in the survey sample. The findings included: 1. The facility's staff failed to ensure Resident #43 received services to maintain vision. Resident #43 was originally admitted to the facility 11/05/22 and readmitted [DATE] after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Primary open angled Glaucoma, Left Eye, Severe Stage, Acquired Absence of Left Leg Below the Knee. The quarterly revision, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/22/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #43 cognitive abilities for daily decision making were intact. In section B (Hearing, Speech and Vision) the resident was coded moderately impaired with vision and coded Yes, for corrective lenses. In sectionGG(Functional Abilities Goals) the resident was coded as requiring set-up help with eating and oral hygiene. Resident coded as dependent with toileting hygiene. Requiring substantial/maximal assistance with shower/bathe self. Requiring partial/moderate assistance with personal hygiene. (Functional Limitations in Range of Motion) Resident coded as no impairment for upper extremity. Resident coded as impairment on both sides for lower extremities. (Mobility Devices) Resident coded as requiring a wheelchair. (Mobility) Resident coded as independent with rolling left and right. Requires supervision or touching assistance with sit to lying and lying to sitting. Resident coded as a dependent chair to bed. The person-centered care plan dated 3/08/23 read that Resident #43 has impaired visual function r/t Diabetes, Glaucoma R eye severe impairment, L eye adequate. (Revised on 3/08/23). The Goals for Resident #43 are the resident will maintain optimal quality of life within limitation imposed by visual function through the review date and the resident will have no indications of acute eye problems through the target date of 4/22/25. The interventions for Resident #43 are Arrange consultation with eye care practitioner as required (3/08/23). Monitor/document/report PRN any s/sx of acute eye problems (3/08/23). The Physician's Order Summary (POS) for April 2025 read: Please refer to eye doctor to evaluate and treat one time only for eye exam for 1 Day -Start Date- 04/09/2025 5:45 pm., (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Medication Administartion Record (MAR) showed that the above order was not checked off by staff as being completed. Please refer to eye MD, for eyeglasses one time only for Needs eye exam and eye glasses for 3 Days -Start Date- 04/25/2025 3:30 pm. Signed off on 4/25/25. A review of the April 2025 MAR show that a staff signed off on the MAR but no call but no appointment was made. On 04/30/25 at approximately 10:14 am., during the initial tour Resident #43 said that he was blind, needed glasses and could only see people as gray shadows. Resident #43 also said that he had mentioned needing glasses to the activities staff (Others Staff #4) a while back and was given a pair of reading glasses. On 04/30/25 at approximately 4:29 pm., a brief interview was conducted with the met with the Social Services Assistant (SSA#1). The SSA #1 said that Resident #43 was not on the list to receive services when the vision van came two weeks ago. I knew he had vision problems. The list is taken to each unit by me for the nurses to list residents needing to be seen. The nurses will inform us. On 5/01/25 at approximately 9:50 am., an interview was conducted with Activities Staff (Other Staff #4) The activities staff said while working 1:1 with Resident #4, he was asked to help him get a pair of glasses about a month ago. He initially said the glasses help. Then he mentioned to me to talk with the Social Worker about making him an appointment to see the eye doctor and I did. On 05/01/25 at approximately 10:50 am., a brief interview was conducted with the SSA #1. The SSA #1 said that the Assistant Director of Nursing (ADON) had mentioned to her last Friday that Resident #43 needed an eye appointment but it hadn't been made. On 5/01/25 at approximately 7:00 p.m., during the pre-exit the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant and [NAME] President of Operations. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided. 40026 2. For Resident #87 the facility staff failed to schedule vision services for a resident with visual impairment. Resident # 87 was admitted to the facility on [DATE] with diagnoses that included, but we're not limited to dementia, schizophrenia, anemia, hypertension, psychotic disorder with delusions due to unknown physiological condition, and cognitive communication deficit. Resident number 87's most recent minimum data set with an ARD (Assessment Reference Date) of 4/16/25 coded Resident # 87 as having a BIMS (Brief Interview of Mental Status) score of 6 out of 15 indicating severe cognitive impairment. Resident number 87 could follow simple conversation. On 4/29/25 Resident #87 stated I need glasses, I can't see. When asked if she had an eye examination, she stated that she could not remember when the last time she had an eye examination. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record revealed that since admission she had not been seen by an optometrist for a routine vision examination. On 4/30/25 an interview with Administration #6 was conducted and she was asked if the facility provides routine screening for eye exams, she stated that there is a company that came to the facility to provide those services. She stated that she is the person who arranges the vision services to come to the facility and schedules the appointments for Residents to be seen. She stated that the unit managers usually are the ones who notify her of Residents needing vision services. She looked in the electronic health record for Resident #87 and stated that she had not been seen by the eye doctor since admission to the facility in 2023. When asked how often most Residents are seen for screening she stated, they should be seen yearly. On 4/30/25 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49916 Based on observation, clinical record review and staff interviews, the facility staff failed to provide foot care for two (2) Residents (#65 and #90) of 55 residents, in the sample survey. The findings included: 1. Resident #65 was admitted to the facility on [DATE] with diagnoses of but not limited to hemiplegia and hemiparesis of right-side cerebral infarct, dysphagia, chronic congestive heart failure, and dementia. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 04/24/25. Resident # 65's BIMS (Brief Interview for Mental Status) Score was a 15 out of 15, indicating no cognitive impairment. Resident #65 required assistance with all ADL's (Activities of Daily Living). On 4/30/2025 during an afternoon tour, Resident # 65's was observed in bed on her back, sitting up. Resident # 65's toenails were thick, long with uneven edges. They were brown in color with some lighter brown to yellow areas. Resident #65 stated that she would see the podiatrist but that she does not remember seeing a podiatrist in the past. A review of Resident #65's progress notes did not reveal any foot or podiatry care. On 04/30/2025, at 5:40 p.m., an interview was conducted with the LPN #2 who stated she would put Resident #65 on the schedule to see Podiatry when they come to the facility next month. 2. Resident #90 was admitted to the facility on [DATE] with diagnoses of but not limited to visual loss, dementia, vitamin D deficiency, pulmonary disease, cognitive communication deficit. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 03/05/25. Resident # 90's BIMS (Brief Interview for Mental Status) Score was a 15 out of 15, indicating no cognitive impairment. Resident #90 required assistance with Activities of Daily Living. On 4/29/25 and 4/30/2025 during an afternoon tour, Resident #90's was observed in bed. Resident #90 stated that she needed to see the Podiatrist because her toe nails are long and are had begun to get snagged in her bed covers. Resident #90's toenails were observed long, thick and curved. They had little discoloration. Resident #90 said she had seen the podiatrist before, but that it was early like 7:00 am on a Saturday and that it had been a long time ago. She stated that she would let the Podiatrist trim and treat her toenails because they get caught in the bedcovers now and cause her pain. A review of Resident #90's progress notes did not reveal any foot or podiatry care. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/2025, at 5:40 p.m., an interview was conducted with LPN 2 who stated that Resident #90 had refused to have Podiatry in the evaluate her feet and toenails in the past but that she would put her on the schedule to see Podiatry when they come to the facility next month. On 04/29/2025, an interview was conducted with the DON who stated that the facility does not have an independent Foot Care Policy, but she provided the Health Care Agreement for Podiatry. She went on to say that Resident #65 and Resident #90 had been added to the Podiatry list for evaluation and treatment. On 4/29/2025, during the end of day meeting the Administrator, DON (Director of Nursing) and the Regional Consultant were informed of the concerns. No additional information was provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observation, interviews, and record review, the facility failed to 1.) provide supervision for one of five residents (Resident (R) 35) identified as requiring one-to-one supervision for aggressive behaviors, 2) ensure potential hazardous items were not left unattended in the room of one (R) 2 and provide supervision for a resident (R) 114 with a known balance/gait issues, of 55 sampled residents. These failures had the potential for injury to other residents from R35's aggressive behavior and for injury related to exposure to unknown substances. Findings include: 1. Review of R35's Admission Record located in the resident's electronic medical records section titled Profile revealed the resident was admitted to the facility on [DATE] with diagnoses that include cerebral infarction with left sided hemiplegia and hemiparesis, severe vascular dementia with agitation, and memory deficit. Review of the facility's Accident and Incident Log, dated 12/24/24 and provided by the facility, revealed R35 had an incident of verbal aggression with other residents. A review of the facility's investigation, dated 12/27/24, revealed R35 threatened to smother his roommate R21at the time with a pillow. The physician, resident's responsible party, and the police department were notified. R35 was placed on one-to-one supervision. The resident was evaluated by psychiatric services and his medications were reviewed with no changes. R21 was moved to another room on the unit, and 1:1 supervision continued for R35. The resident's care plan was revised to reflect the supervision. The investigation was completed and submitted to the office in a timely manner. Review of R35's Care Plan, with a revision date of 01/05/25, revealed the resident failed to cooperate with activities of daily living (ADL) care related to dementia and had potential for verbal and physical aggression. The intervention for these behaviors included one-to-one supervision as needed. Review of R35's Quarterly Minimum Data Set (MDS), with an Assessment Reference date (ARD) of 02/05/25 and located in the resident's EMR section titled MDS revealed the resident had a Brief Interview for Mental Status score of 14 out 15 which indicated the resident's cognition was intact. The resident did not exhibit any behaviors during the assessment period. The resident required substantial with all activities of daily living. The resident was assessed to have limited range of motion of the left upper and lower extremities. The resident was coded to receive anticonvulsant medication. Review of the facility's Accident and Incident Log, dated 03/10/25 and provided by the facility, revealed R35 had an incident of verbal aggression with other residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R35's Psychiatric Consultant Progress Notes, dated 04/11/25 and located in the resident's EMR section titled Miscellaneous, revealed the resident was a poor historian due to cognitive and psychiatric impairment. It was documented the resident denied hallucinating, insomnia, or poor appetite. It was documented that the resident was refusing medications. The consultant's recommendation was for nursing to continue supportive care, and training the staff on 1:1 supervision and how to address residents with aggressive behaviors. A review of R35's Physicians Orders, dated 05/01/25 and located in the resident's EMR section titled Orders, failed to reveal an order for the resident to have one-to-one supervision. A review of the facility's investigation dated 03/11/25 for an incident that occurred 03/07/25, revealed R35 and R72 had a heated verbal exchange in which R72 threatened to shoot R35 and R35 threatened to cut off R72's head. The responsible parties for both residents were notified of the incident, and the police department and the physician were notified. It was decided since R35 was the aggressor, he was placed on one-to-one supervision. Both residents' care plans were revised. As soon as a male room opened on the unit, R72 was to be moved to another room. The facility investigation (day one and five day) was completed and submitted to the office within the allotted timeframe Observation on 04/29/25 at 1:30 PM revealed R35 in a wheelchair propelling himself in room with his left hand resting on a pillow. The resident had a staff member providing one-to-one supervision. An observation on 04/30/25 at 5:21 AM revealed R35 in bed asleep. The resident did not have staff member present providing one-to-one supervision. An interview on 04/30/25 at 9:40 AM with a Certified Nursing Assistant (CNA)15 revealed that she was also responsible for staffing the facility. CNA15 stated that R35 was placed on one-to-one supervision a couple of months ago after the resident threatened to cut off his roommate's head. CNA15 stated the supervision included making sure the resident did not have access to any objects that he could harm himself or others. An interview on 04/30/25 at 11:47 AM with Licensed Practical Nurse (LPN)7 revealed the resident initially resided in the Blue Unit until the resident went out the back exit door. The incident was discussed with the resident's responsible party, and it was decided to place the resident on the secure unit. LPN7 stated there was an incident that occurred on 12/24/24 in which R35 threatened physical harm to his roommate (R21). R35 was placed on one-to-one supervision until R21 could be moved to a different unit. LPN7 stated R35 seemed to calm down after having the room to himself and the supervision was discontinued. LPN7 added that R72 was placed in the room with R35 since there were no other male rooms available. Both R35 and R72 made verbal threats to each other (threatening to shoot one and the other threatened to cut the other's head off). Since R35 was the more aggressive threat, he was placed again on one-to-one supervision. The only time both residents are in the room together is at night when they go to bed. Neither resident had made any more threats. LPN7 stated the facility does not have a policy for one-to-one supervision or for the physician to write orders for one-to-one supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 05/01/25 at 2:00 PM revealed that whenever a resident makes that kind of threat she immediately starts an investigation, separates the residents when possible; notifies the appropriate parties; obtains witness statements; have residents examined for possible injuries; and notify the police department. The Administrator stated that with the first incident involving R21, she was able to move that resident to another unit; however, with R35 and R72, neither of them can be relocated to non-secure unit and currently there are no male bed beds available on the secure unit. The Administrator stated the resident is being followed closely by psychiatric services. At this time neither resident has not exhibited or verbalized any aggressive behaviors. 25232 2. Review of Admission Record, located under tab Profile tab in the EMR, indicated R2 was readmitted to the facility on [DATE] with diagnoses that included bipolar disorder and post-traumatic stress disorder (PTSD). During the initial observational tour on 04/29/25 at 2:02 PM, a 10 milliliter (ml) syringe containing an unknown clear liquid was observed lying on top of R2's dresser. There was no needle attached to the syringe. At 2:05 PM, confirmed with Licensed Practical Nurse (LPN) 2, that the syringe was there and confirmed that it should not have been. Interview on 05/01/25 at 7:51 PM, the Director of Nursing (DON) indicated that she expected staff to ensure syringes were not left in resident rooms. 40711 3. The facility staff failed to maintain adequate supervision/safety for a resident known to have balance and gait issues when ambulating for 1 resident during a fall on 5/31/23, sustaining a fracture of his right hip, on the memory care unit. Resident #114 was no longer a resident of the facility; therefore, a closed record review was conducted. Resident #114 was admitted to the facility on [DATE] and discharged on [DATE]. Resident #114's diagnoses included Vascular Dementia, Unspecified Severity, with Agitation. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/11/23 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired for daily decision making. In section G (Functional Status) the resident was coded as an activity occurring once or twice with the assistance of one person with transfers, Locomotion on and off unit, walking in the room. Requires total dependence of two people with toilet use and personal hygiene. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The personal centered care plan dated 1/16/24 read that resident is at risk for falls r/t Confusion, Deconditioning, Gait/balance problems, Psychoactive drug use, new admission. A Goal for Resident #114 was Minimize the risk of sustaining a serious injury through the review date. The interventions for the resident were to ensure that the resident is wearing appropriate footwear and or nonskid socks when ambulating or mobilizing in wheelchair (w/c), Anticipate and meet the resident's needs, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. On 04/30/25 at approximately 4:14 pm., an interview was conducted with the Director of Rehab., (DOR) Services concerning the above. The DOR said from 5/08/23-5/31/23 Resident #114 received therapy services for ambulation and balance. It was brought to my attention that he had a few loss of balances, poor cognition. He was a resident on memory care. I came to get him for therapy and found him on the floor. The DOR also said that the resident walked independently, We tried to stand him and he couldn't bare weight. On 4/30/25 a telephone interview was conducted with the complainant at 7:05 PM., The complainant said that her father had fallen, fracturing his right hip at the facility for rehabilitation. A review of a nursing progress note dated 5/31/2023 at 1:30 PM., read that patient (pt) was found lying in his room bathroom by staff, assessment completed with noted pain to right hip, 911 was called and transported to ER for evaluation, pt was unable to explained what he was trying to do prior to fall. pts daughter Responsible Party (RP) was called, Nurse Practitioner (NP) aware. A review of an Interdisciplinary Team note on 6/01/23 at 10:05 AM., read (IDT) 5/31/23 Resident tripped over shoes and fell , Sent to ER. According to the hospital discharge summary Resident #114 was admitted on [DATE] and discharged on [DATE] for a closed fracture of neck of the right femur. The hospital note read: Resident came from the nursing home to the hospital with a fall in the facility bathroom, unwitnessed fall complaining of pain in the right hip. Patient underwent right hemiarthroplasty on 6/01/23, tolerating the procedure. Patient ready to discharge back to the nursing facility for rehab. On 05/01/25 at approximately 12:45 PM., an interview was conducted with Certified Nursing Assistant (CNA) 16. CNA #16 said that Resident #114 was very combative and stayed in his room a lot. He didn't want to be bothered with. CNA #16 also said that she doesn't remember him falling but does remember seeing Physical Therapy (PT) working with him a couple of times. On 05/01/25 at approximately 12:25 PM., an interview was conducted with CNA #19. CNA #19 said that the Physical Therapy wasn't successful working with the resident because he never liked leaving his room. On 5/01/25 at approximately 7:00 p.m., during the pre-exit the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant and [NAME] President of Operations. An opportunity was offered to the facility's staff to present additional information, but no additional 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review, and facility documentation the facility staff failed to ensure Residents received adequate nutrition to prevent weight loss for 1 Resident (#55) in a survey sample of 55 Residents. The findings included: For Resident #55 the facility staff failed to ensure adequate nutrition to prevent a weight loss of over 17% in five months since admission. Resident # 55 was admitted to the facility on [DATE] with diagnoses that included, but we're not limited to hypertension, high cholesterol, dementia, depression, major depressive disorder, muscle, weakness, cognitive, communication, deficit, insomnia, and presence of a pacemaker. Resident # 55's most recent MDS (Minimum Data Set), with an ARD (Assessment Reference Date) of 3/3 25, scored the resident as having a BIMS (Brief Interview of Mental Status) score of 4 out of 15 indicating severe cognitive impairment. During the survey Resident #55 was observed to be unable to follow simple instructions by staff, feed herself or engage in meaningful conversations. Resident #55 was admitted to the facility on ,d+[DATE], her admission weight was 184.4 pounds. On 4/21/25 Resident # 55 weighed 151 pounds which is a 17.68% weight loss in five months' time. A review of the clinical record revealed Resident #55 had orders for a regular diet, dysphagia advanced texture with regular/thin liquid consistency. She started receiving liquid protein on 2/6/25, large protein portions were supposed to start on 2/12/25, however, this was not reflected on the meal ticket or the diet orders in her clinical record. Med-Pass 120 ml. 3 times per day was not added until 4/2/25. Attempts x 2 by telephone were made to contact the Dietician, however, with no results. The following excerpts are from the dietician's notes: 1/29/25 at 2:03 PM Significant weight loss trigger 1/16/25, 164.4 pounds. Note documented edema in November with Lasix ordered. Discussed with teen and MD referral entered notify dietary to update preferences for optimal meal intake remove lactose restriction and provide large portions per unit feedback will continue to trend and adjust accordingly 2/12/25 nutrition: significant weight trigger, noting diuretic use some fluid related weight changes anticipated. 1/29/25 lactose restriction removed, and large portions added to optimize meal intake. 2/6/25 liquid protein Q Day added. Will continue to follow and trend above MNT accordingly no current healthy weight within normal limits. 2/19/25 8:18 am nutrition: significant weight change trigger 2/3/25 154.2 pounds. February weekly weights indicate desired weight gain trend with nutrition intervention in place will continue to follow, noting potential for additional fluid related changes related to diuretic use. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/26/25 4:35 p.m. - Nutrition: significant weight change trigger: 3/24/25: 156.4 lb. Resident remains stable in mid-150 lb. range with current nutrition interventions. Appropriate weight for age and height. Will continue to monitor as reported well-nourished status, 4/2/25 4:59 p.m.: Nutrition: Significant weight change trigger: 3/31/25: 156.0 lbs. -10% - Resident is maintaining 155 lbs. +/- 3 lbs., noting Lasix use with some anticipated weight related changes. 4/1/25: Med Pass 120 ml TID added to orders. Remeron remains in orders. Will continue to follow and discuss with team prn. 4/24/25 6:05 p.m. Nutrition Follow Up: significant weight changes -7.5%, -10% 4/21/25: 151.8 lbs. Noted on 4/2/25 that resident was maintaining weight in the 150's range. Assess at this time that this represents new baseline weight, with some fluid related changes anticipated with diuretic use. Will plan to keep Med Pass and Remeron in POC at this time to maintain current status. On 4/29/25 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observations, interviews, and record reviews, the facility failed to ensure sufficient staffing to meet the needs of the 106 of 106 residents in the facility. The facility failed to ensure there was one nurse on each the Blue Unit and the Pink Unit during the night shift on 04/29/25 and failed to ensure enough staff to implement the care plan intervention of one-to-one supervision for five residents who required one-to-one-supervision. Findings include: 1. Review of a document provided by the Administrator on 04/30/25 revealed there were five residents (R35, R54, R55, R87, and R98) on the secure unit that required one-to-one supervision. a. Review of R35's Admission Record, located in the resident's electronic medical records (EMR) section titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that include cerebral infarction with left sided hemiplegia and hemiparesis, severe vascular dementia with agitation, and memory deficit. A review of R35's Care Plan, with a revision date of 01/05/25 and located in the resident's EMR section titled Care Plans, revealed the resident failed to cooperate with activities of daily living (ADL) care related to dementia and had potential for verbal and physical aggression. One of the interventions for these behaviors included one-to-one supervision as needed. b. Review of R54's Admission Record, located in the resident's EMR section titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that included vascular dementia with behavioral disturbances, moderate intellectual disabilities, and reoccurring major depressant disorder. A review of R54's Care Plan, with a revision date of 03/15/25 and located in the resident's EMR section titled Care Plans, revealed the resident had attempted to leave the facility, inappropriate sexual behaviors, and physical aggression towards when redirected. One of the interventions for these behaviors include one-to-one supervision. c. Review of R55's Admission Record, located in the resident's EMR section titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that included major depressive disorder and dementia with behavioral disturbance. A review of R55's Care Plan, with a revision date of 01/20/25 and located in the resident's EMR section titled Care Plans, documented the resident had poor impulse control and an allegation of physical contact to another resident. One of the interventions for these behaviors included behavior monitoring. d. Review of R87's Admission Record, located in the resident's EMR section titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia, schizophrenia, and psychotic disorder with delusion. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of R87's Care Plan, with a revision date of 04/08/25 and located in the resident's EMR section titled Care Plans, documented the resident was involved in a resident-to-resident physical contact altercation. One of the interventions for this behavior included one-to-one monitoring to prevent striking others and/or impulsive acts. e. Review of R98's Admission Record, located in the resident's EMR section titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia with mood disturbances, major depressive disorders, and anxiety disorder. A review R98's Care Plan, with a revision date of 02/12/25 and located in the resident's EMR section titled Care Plans, revealed the resident was assessed for wandering, inappropriate behavior such as allegations sexual contact with a female resident and exposing his genitals. One of the interventions for these behaviors included one-to-one supervision by staff as needed. Review of staff assignment sheets on the following revealed the following: 03/15/25 (Saturday) - only two Certified Nursing Assistants (CNAs) were scheduled to work each shift. None of the five residents received one-to-one supervision. 03/16/25 (Sunday) - only two CNAs scheduled to work the evening and night shifts; two residents (R54and R98) on the evening shift received supervision; and none of the five residents received supervision on the night shift. 03/23/25 (Sunday) - only two CNAs were scheduled for the night shift; none of the five residents received one-to-one supervision. 04/18/25 (Friday) - on the day shift only R54 and R98 received the one-to-one supervision; the other three residents (R35, R55 and R87) did not receive the supervision. 04/25/25 (Friday) - only two CNAs were scheduled to work the night shift; none of the five residents received the one-to-one supervision. 04/29/25 (Tuesday) - on the night shift only two CNAs were scheduled to work; none of the five residents received one-to-one supervision. Observation during the initial tour on 04/29/25 at 2:00 PM revealed that R54 and R98 shared the same room, and one staff member provided one-to-one supervision for both residents. R35, R55, and R87 each had an individual staff member for supervision. Observation on 04/3025 at 5:33 AM revealed R35, R54, R55, R87 and R98 were asleep in their rooms. None of the residents had staff members assigned them to provide one-to-one supervision. There were only two Certified Nursing Assistants scheduled to work that night. An interview on 04/30/25 at 5:40 AM with CNA9 revealed the evening nurse worked overtime until about three or four that morning and the nurse on the blue unit was covering unit until the day shift staff arrived. CNA9 stated that she and another CNA were the only CNAs scheduled to work that. CNA9 stated it was impossible to provide one-to-one supervision with only two staff members. CNA9 also stated that this was not the first time that only two CNAs were scheduled on the unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 04/30/25 at 5:55 AM with CNA18 revealed there were only two CNAs scheduled to work that night. She stated if you look at the resident's behavior monitoring notebook you will notice the night shift section is left blank since they were unable to provide monitoring for those residents. CNA18 stated that to her knowledge none of those residents exhibited any behaviors during the night. An interview with CNA15 on 04/30/25 at 6:20AM revealed that she also functioned as the staffing coordinator. CNA15 stated that she tries hard to ensure there is sufficient staffing throughout the facility, especially on the secure unit. CNA15 states there have been times that she herself has provided one-to-one supervision for those five residents. CNA15 stated It is like robbing [NAME] to [NAME] to ensure there's coverage for the residents on the secure unit that require one-to-one supervision. An interview on 04/30/25 at 4:20 PM with LPN7 revealed that she was aware there were only two CNAs scheduled on Tuesday 4/29/25 night shift. LPN7 stated that the facility was staffing challenged, meaning it was difficult to get sufficient coverage especially for the residents that require one-to-one supervision. LPN7 reviewed the residents' behavior monitoring sheets and stated it was an expectation that staff assigned to supervision will document each hour of supervision and the documents the resident behavior during that time. LPN7 also stated since there was no documentation on the behavior monitoring sheet, it would seem the residents did not receive 1:1 supervision. An interview on 04/30/25 at 6:00PM with the Director of Nursing (DON) revealed the facility did not have a policy for staffing or a policy for one-to-one supervision. The DON stated that when residents are placed on one-to-one supervision it is a nursing judgement and currently, they do not require physicians to write orders for that supervision. The DON stated that probably the physician or the nurse practitioner could write orders for a timeframe for supervision and look at tapering the residents off one-to-one supervision. 35690 2. During the survey on 04/30/25 at 2:00 PM, a Resident Council meeting was held. R2 stated she had to wait for help and was told by the CNAs if you get up you can't go back to bed because there was not enough staff. R2 stated she needed the mechanical lift for transfers and sometimes there would only be one CNA who would assist with the transfer. She stated it depends on who is working (if there are one or two CNAs). 3. During an interview on 05/01/25 at 12:50 PM, the Social Services Director (SSD) stated that due to staffing shortages, not all departments were able to attend care conferences. The facility failed to ensure all required Interdisciplinary Team (IDT) Members attended care conferences. Cross Reference F657: Comprehensive care plan prepared by an IDT and the resident and/or resident's representative. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During an interview on 05/01/25 at 4:34 PM, LPN 1 stated the scheduler would frequently ask her to be responsible for both the Peach Unit and Blue Unit. She stated she would never do that because it would put her license at risk. LPN 1 stated I can't be on one hall because I couldn't see the other hall. 5. The facility failed to ensure residents received adequate supervision. Cross Reference F689: Supervision. During an interview on 05/01/25 at 5:24 PM, the Administrator stated they had six open CNA positions, seven open LPN positions, and seven open Registered Nurse (RN) positions. The Administrator stated they did not have a Staffing Policy.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 35690 Based on interviews and record reviews, the facility failed to ensure Certified Nurse Aides (CNA) received performance reviews at least once every 12 months and regular in-service education based on the outcome of the reviews for four of five CNAs (CNA6, CNA9, CNA10, and CNA12) whose personnel files were reviewed. This had the potential to have a negative impact on resident care. Findings include: Review of CNA 6's personnel file revealed a start date of 02/02/23. There was no documented evidence in the personnel file that CNA6 had a performance evaluation or in-service education based on the outcome of the review. Review of CNA 9's personnel file revealed a start date of 08/01/22. There was no documented evidence in the personnel file that CNA9 had a performance evaluation or in-service education based on the outcome of the review. Review of CNA 10's personnel file revealed a start date of 09/20/23 There was no documented evidence in the personnel file that CNA10 had a performance evaluation or in-service education based on the outcome of the review. Review of CNA 12's personnel file revealed a start date of 12/13/23. There was no documented evidence in the personnel file that CNA12 had a performance evaluation or in-service education based on the outcome of the review. During an interview on 05/01/25 at 4:30 PM, CNA 1 stated she had not received a performance evaluation in many years. She stated she would like to have one because it is nice to be recognized and get feedback on how she is doing. During an interview on 05/01/25 at 5:02 PM with CNA3 and CNA4, CNA 3 stated she had worked in the facility for one year. She stated she had not had a performance review and had not received any competency training since she started. CNA 4 stated he had worked at the facility for three years. He stated he had had one performance review since he started and had never received competency training. During an interview on 05/01/25 at 5:24 PM, the Administrator stated as a result of multiple changes in nurse management, competencies and performance evaluations had not been completed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free from significant medication errors for 2 Residents (#87 & #94) in a survey sample of 55 Residents. The findings included: 1. For Resident #87 the facility staff failed to ensure she received Risperdal Consta injections every 2 weeks as ordered by physician for Schizophrenia. Resident # 87 was admitted to the facility on [DATE] with diagnoses that included, but we're not limited to dementia, schizophrenia, anemia, hypertension, psychotic disorder with delusions due to unknown physiological condition, and cognitive communication deficit. Resident number 87's most recent minimum data set with an ARD (Assessment Reference Date) of 4/16/25 coded Resident # 87 as having a BIMS (Brief Interview of Mental Status) score of 6 out of 15 indicating severe cognitive impairment. Resident number 87 could follow simple conversation. On 4/29/25 a review of the clinical record revealed that Resident #87 had the following orders: Risperdal Consta Intramuscular Suspension Reconstituted ER 25 MG Inject 25 mg intramuscularly one time a day every 14 day(s) for schizophrenia due to noncompliance with oral tablets/worsening behaviors. A review of the MAR revealed that Resident #87 was started on Risperdal Consta due to refusal of oral medications. She received her first dose on 1/3/25 however did not get another dose until 2/3/25 and then a third dose on 2/17/25 followed by a missed dose on 3/3/25, and given a dose on 3/19, followed by 2 missed doses in April finally getting a dose on 4/30/25. A review of the clinical record revealed the following notes about the injections not being available: 3/3/25 5:09 p.m. - Risperdal Consta Intramuscular Suspension Reconstituted ER 25 MG Inject 25 mg intramuscularly one time a day every 14 day(s) for schizophrenia due to noncompliance with oral tablets/worsening behaviors Medication will be delivered tonight **There was no follow up indicating the Resident received this dose. ** 4/2/25 5:55 p.m. - Risperdal Consta Intramuscular Suspension Reconstituted ER 25 MG Inject 25 mg intramuscularly one time a day every 14 day(s) for schizophrenia due to noncompliance with oral tablets/worsening behaviors Not Available, Pharmacy Made aware Note from psychiatric provider on 4/10/25 read: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Date of Service: 04/10/2025 - Schizophrenia: No reported delusions or hallucination, the patient is on Risperdal Consta [NAME] 25 mg every 14 days for schizophrenia because of noncompliance with oral medication. Recommend continuing the current medications. 4/16/25 4:46 p.m. - Risperdal Consta Intramuscular Suspension Reconstituted ER 25 MG - Inject 25 mg intramuscularly one time a day every 14 day(s) for schizophrenia due to noncompliance with oral tablets/worsening behaviors not available [sic] pharmacy made aware On 4/28/25 at 11:00 a.m. an interview was conducted with LPN #6 who was asked what the procedure is if you do not have a medication for your Resident, she stated that they look in Omnicell (stat meds), and if it is not there, we notify the pharmacy, and they usually get it on the next run. When asked about documenting she stated that they should document what they have done to try and obtain the medication and who they have notified. When asked who they should notify she stated the physician, pharmacy, resident or representative, and the DON or Unit Manager. When asked if Resident #87 was receiving any oral antipsychotics she stated that she was not. When asked if her psychiatric provider was made aware of the lack of consistent administration of this medication, she stated that the NP is notified. When asked if the NP is managing Schizophrenia and medications like Risperdal Consta or is the psychiatrist, she stated that she was not sure. 4/30/25 at 10:20 a.m. spoke with LPN #7 the unit manager and we went to the medication refrigerator on the unit and discovered that Resident #87's Risperdal Consta was unopened, and it was dated as sent from the pharmacy on 4/16/25. On 5/1/25 a review of the clinical record revealed the following note: 4/30/25 at 7:22 p.m. - Resident was given injection in left upper arm per her request. According to Johnson & Johnson the manufacturer of Risperdal Consta: Managing missed doses The appropriate strategy for patients who have missed a dose or doses of RISPERDAL CONSTA will depend on whether a steady-state plasma concentration of RISPERDAL CONSTA has been reached. Generally, steady-state plasma concentrations are achieved after 4 consecutive injections. Steady-state plasma concentration achieved The next dose of RISPERDAL CONSTA should be given as soon as possible if steady-state concentrations of RISPERDAL CONSTA have been achieved and only 3-6 weeks have passed since the last injection. Clinicians should monitor symptom recurrence. If more than 6 weeks have elapsed since the last injection, risperidone long-acting should be initiated as soon as possible and 3 weeks of coverage with an oral antipsychotic should be given. Steady-state plasma concentration not achieved (<4 consecutive injections) RISPERDAL CONSTA should be reinitiated as soon as possible, and oral antipsychotic coverage for 3 weeks should be given. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the MAR revealed no oral coverage was being administered. On 5/1/25 during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 2. For Resident #94 the facility staff failed to ensure Midodrine was given as prescribed by the physician according to the parameters in the order. Resident number 94 was admitted to the facility on one/22/24 with diagnoses that included but we're not limited to alcohol abuse anemia, hypertension, muscle weakness was Wernicke's encephalopathy, cognitive communication deficit, insomnia, and signs and symptoms involving cognitive functions and awareness. On 4/28/25 a review of the clinical record revealed the following orders: Midodrine HCl oral tablet 2.5 mg give one tablet by mouth three times a day for low blood pressure hold for systolic >110 A review of the MAR (Medication Administration Record) for April 2025, revealed that in the following days and times the proper assessment, and parameters were not followed with regard to the Midodrine administration order: Blood pressure not assessed, and medication not given: 2 p.m. - 4/5, 4/12, 4/16, 4/20 9 p.m. - 4/ 2/, 4/9, 4/11, 4/18, 4/21, 4/22, 4/25, 4/28 The following dates blood pressure was not assessed, and medications were given: 9 p.m. - 4/3, 4/8, 4/16, 4/22, 4/23, 4/26, 4/27 The following dates blood pressures were assessed out of parameters and meds given anyway. 8 a.m. - 4/14/25 - 140/77 9 pm - 4/4/24 - 122/62, 4/14/25 - 116/74 2p.m. - 4/28/25 - 114/78 A review of the previous MAR's for February and March revealed the same errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/25 at approximately 3:00 pm an interview was conducted with the Unit Manager about the administration of Midodrine and parameters. When asked what Midodrine was used for she stated keeping your blood pressure up, when asked why the use of parameters with Midodrine, and she stated so that you don't use it and make the blood pressure too high. When asked if the order has parameters should a nurse ever give it without first checking the blood pressure, she stated they should not. When asked if the nurse should hold the medication if the blood pressure was not taken, she stated that there would be no reason to hold it if you don't know the blood pressure. When asked if a nurse checks the blood pressure and it is above the parameters, she should give the medication she stated that she should not. When asked if the blood pressure assessment, and parameters ordered in Resident #94's chart were followed and she stated that they were not. On 5/1/25 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on observation, interview, and facility policy review, the facility failed to ensure medications were stored and labeled for three of four medication carts observed and one of two medication rooms observed. This had the potential for misappropriation of medications and possible unsafe medication administration. Findings include: Review of the facility policy titled Storage and Expiration Dating of Medications and Biologicals revised [DATE] revealed, .Facility should ensure medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding .Facility should ensure external use medications and biologicals are stored separately from internal use medications and biologicals . Facility should ensure all controlled substances are stored in a manner that maintains their integrity and security .Facility should ensure medications and biologicals for expired or discharged or hospitalized residents are stored separately, away from use, until destroyed or returned to the provider .Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with pharmacy return/destruction guidelines and other applicable law .Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis . 1. During an observation and interview on [DATE] at 6:20 AM of the Blue Unit medication cart, revealed in the second drawer there were eight solid tablets laying loose, six partial/broken tablets, and one capsule loose in the drawer; the third drawer had one loose capsule. The Administrator was present and confirmed the loose medications and stated that it was the expectation of the facility for loose medications to immediately be removed from the cart. Licensed Practical Nurse (LPN) 10 was also present and stated that she normally would discard the loose medications in the sharps container. Staff confirmed that they did not know what the medications were or to whom they belonged. 2. During an observation and interview on [DATE] at 6:50 AM with LPN5 of the medication cart on the [NAME] Unit revealed in the fourth drawer was a resident's cipro (antibiotic) 250 milligram (mg) with a pharmacy dispense date of [DATE], there were five tablets remaining. One tablet of pyridium (pain reliever for urinary tract infections)100mg was in the fourth drawer with a dispense date of [DATE]. LPN5 stated that the cipro had been discontinued and no longer in use. LPN5 was unable to locate the start and stop date of the medication in the EMR. LPN5 stated that the medication should not have been in the drawer and should have been placed in the medication storage room until the pharmacy could pick up the medications and dispose of them. Additionally, there was a narcotic blister pack with two tablets taped closed. LPN5 confirmed that the tablets should not be taped in the blister pack and should have been disposed of. The sixth drawer contained two and a half tablets and one capsule that were loose. LPN5 was unable to determine what the loose medications were or to whom they belonged. There was a card of cephalexin (antibiotic) 500 mg capsules with one capsule remaining. LPN5 stated that the medication had been completed. The third drawer had eight tablets and three half tablets loose in the third drawer, and the second drawer had 44 solid tablets, one capsule, and 13 partial tablets loose in the drawer. LPN5 stated that all nurses should maintain the medication carts. (continued on next page)

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	495347	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Consulate Health Care of Windsor	23352 Courthouse Highway Windsor, VA 23487

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an observation and interview on [DATE] at 7:25 AM with LPN5 of the [NAME] Unit medication storage room included a blister pack for a resident dated [DATE] for cipro HCL 250 mg tablets with three tablets remaining in the pack. LPN5 stated that normally the Unit Manager disposes of any discontinued medications, and she was not sure why this pack was propped up against the wall behind intravenous supplies. 4. During an observation and interview on [DATE] at 8:45 AM with LPN11 of the Peach Unit revealed the second drawer had 22 tablets, two capsules, and eight half tablets that were loose in the drawer. The third drawer had five partial pills loose; fourth drawer had one tablet loose; and the eighth drawer had a bottle of alcohol and wound cleanser spray stored with a resident's permethrin 5% cream dispensed by the pharmacy on [DATE]. Additionally, a resident's ammonium lactate 12% cream was with other resident's oral medications. The narcotic drawer had one loose solid tablet and eight partial/broken tablets. LPN11 stated that when they find loose pills the protocol was for them to put them in the sharps container. LPN11 confirmed that the resident's permethrin cream had been discontinued and should have been put in the medication storage room for return to the pharmacy and that all topical medications should be kept separate from oral medications. LPN11 was not able to identify the loose tablets.

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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** 40711 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure a resident visually impaired resident received training and assistance on infection prevention measures were followed while providing urinary catheter care self care for 1 of 55 residents (Resident #43), in the survey sample. The findings included: Resident #43 was originally admitted to the facility 11/05/22 and readmitted [DATE] after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Neuromuscular Dysfunction of the Bladder. The quarterly revision, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/22/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #43 cognitive abilities for daily decision making were intact. In section B (Hearing, Speech and Vision) the resident was coded moderately impaired with vision and coded Yes, for corrective lenses. In sectionGG(Functional Abilities Goals) the resident was coded as requiring set-up help with eating and oral hygiene. Resident coded as dependent with toileting hygiene. Requiring substantial/maximal assistance with shower/bathe self. Requiring partial/moderate assistance with personal hygiene. (Functional Limitations in Range of Motion) Resident coded as no impairment for upper extremity. Resident coded as impairment on both sides for lower extremities. (Mobility Devices) Resident coded as requiring a wheelchair. (Mobility) Resident coded as independent with rolling left and right. Requires supervision or touching assistance with sit to lying and lying to sitting. Resident coded as a dependent chair to bed. In Section H (Bladder and Bowel) the resident was coded as having an indwelling, external catheter. The April 2025 Physicians Order Summary (POS) read: Catheter care every shift and as needed every shift for Foley catheter -Start Date- 11/08/2024 7:00 pm. The person-centered care plan dated 3/08/23 read that Resident #43 has impaired visual function r/t Diabetes, Glaucoma R eye severe impairment, L eye adequate. (Revised on 3/08/23). The Goals for Resident #43 are the resident will maintain optimal quality of life within limitation imposed by visual function through the review date and the resident will have no indications of acute eye problems through the target date of 4/22/25. The interventions for Resident #43 are Arrange consultation with eye care practitioner as required (3/08/23). Monitor/document/report PRN any s/sx of acute eye problems (3/08/23). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The person-centered care plan dated 10/30/23 read that Resident #43 has an indwelling foley catheter as well as a colostomy r/t diabetes, BPH, and dx of other obstructive and reflux uropathy. The Goals for Resident #43 are the resident will The resident will show no s/sx of Urinary infection through review date and the resident will be/remain free from catheter-related trauma through review date (4/22/25). The interventions for Resident #43 are to monitor/document for pain/discomfort due to catheter and Monitor/record/report to MD for s/sx UTI (Urinary Tract Infection). On 04/30/25 at approximately 10:17 am, a brief interview was conducted with Resident #43. Resident #43 said that he had an enlarged prostate a few years ago that's why I have a foley. I have had infections (Urinary Tract Infections/UTI's), I see the Urologist one a month to get my foley changed. Resident #43 was asked if the staff performs daily catheter care. Resident #43 stated, I do my own (foley) catheter care. Permission was granted from resident to be observed performing his foley catheter care. A review of the resident's medical records read that he's had several Urinary Tract Infections last year (2025). On 4/30/25 at approximately 11:00 am., foley catheter self care was observed. Certified Nursing Assistant (CNA) #14. CNA #14 was observed setting up one basin, placing 2 wash cloths inside with a bar of soap. The steps were as follows: CNA #14 washed Resident's back, used wash cloth placed back into the basin with clean wash cloth, resident reached for clean wash cloth in the basin, rung it out, washed his left and right groin and perineal area, placed wash cloth in basin and rung out cloth again, took wash cloth out of the basin, wipe his foley catheter moving downward and placed wash cloth inside basin. On 4/30/25 at approximately 11:15 AM., a brief interview was conducted with CNA #14 concerning Resident #43s catheter care. CNA #4 said that she realized that she should have provided 2 basins, 1 basin with soap water and the other with rinse water. On 05/01/25 at approximately 1:45 pm., a brief interview was conducted with Certified Nursing Assistant (CNA) #14. CNA #14 said that she was never informed to assist the resident with catheter care other than emptying his foley. On 05/01/25 at approximately 12:13 pm., an interview was conducted with Licensed Practical Nurse (LPN) #10. LPN #10 said that the CNAs do the catheter care as part of the (Activity of Daily Living) ADLs. On 05/01/25 at approximately 11:08 am., a brief interview was conducted with the Assistant Director of Nursing (ADON). The ADON said that the CNAs should help with foley catheter care. We will educate the resident on proper foley care. Policy: Effective Date: 11/30/2014. Revised Date: 9/05/17. Catheter Care, Urinary Assemble the following: Towel and wash cloth, soap, basin of warm water, disposable gloves, hand hygiene, remove catheter securement device, wash perineal area with soap and water from front to back, rinse and dry, clean catheter tubing with soap and water, reattach securement device, perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/01/25 at approximately 7:00 p.m., during the pre-exit the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant and [NAME] President of Operations. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49916 Based on clinical record review and staff interviews, the facility staff failed to maintain an effective pest control program for 1 of 55 residents (Resident #65), in the survey sample. Resident #65 was admitted to the facility on [DATE] with diagnoses of but not limited to hemiplegia and hemiparesis of right-side cerebral infarct, dysphagia, chronic congestive heart failure, and dementia. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 04/24/25. Resident # 65's BIMS (Brief Interview for Mental Status) Score was a 15 out of 15, indicating no cognitive impairment. Resident #65 required assistance with all ADL's (Activities of Daily Living). On 4/29/2025 during the initial tour, Resident # 65's room was observed with a bag sitting in a folding chair beside the bed with a large number of ants crawling in around and on the bag, chair and wall. Resident # 65 stated she did not know what exactly was in the bag or that it had ants. The CNA (Certified Nursing Assistant) #3, came in to clean the bag out and added Resident #65's room to the focus pest control log for 04/30/2025. A review of the facility pest control log revealed that Resident #65's room was treated on 04/30/2025. On 04/30/2025 during the end of day meeting, the Administrator and Director of Nursing were informed of the findings. No additional documentation provided.