STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495354	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenspring Village	7470 Spring Village Dr Springfield, VA 22150

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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 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 49456 Based on resident interview, staff interview and facility documentation review, the facility staff failed to ensure that five residents, (Resident #4 (R4), Resident #8 (R8), Resident #22 (R22), Resident #30 (R30), and Resident #309 (R309)), had the information on how to file a complaint with the state licensure office and state survey agency in a survey sample of 33 residents. The findings included: The facility failed to make sure all residents was aware of how to file a complaint with the state licensure office and state survey agency. On 3/3/25 at 2:00 p.m., a resident council meeting was conducted. The five residents stated that they were not aware of where the postings were located with the information on how to contact the state licensure office and state survey agency if they needed to file a complaint. The surveyor observed the postings on each nursing unit that contained the state licensure office and state survey agency contact information. On 3/4/25 at 5:08 p.m., an end of day meeting was conducted with the administrator, assistant administrator, director of nursing, assistant director of nursing, and unit managers. The above concerns were discussed with the facility staff. The staff was made aware that the residents were not aware of how to file complaints with the state licensure office or the state survey agency. On 3/5/25 at 10:00 a.m. an interview was conducted with the assistant administrator. The assistant administrator stated that the complaint education for the residents was in the, Residence and Care Agreement, in the admission packet. The assistant administrator stated that information was in the packet on how to contact the state licensure and state surveyor's offices. On 3/5/25, a review of the facility admission packet was conducted. The state licensure office and the state surveyor agency information were not in the admission packet. On 3/6/25 9:30 a.m., a meeting with the administrator and assistant administrator was conducted. They were informed of the above concerns and that the state licensure office and state surveyor agency information were not in the admission packet. The assistant administrator looked at the admission packet and stated that she did not see the information. No additional information was provided prior to exit conference.

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49456 Based on observation, resident interviews, staff interviews and facility documentation, the facility staff failed to ensure that five residents,(Resident #4 (R4), Resident #8 (R8), Resident #22 (R22), Resident #30 (R30) and Resident #309 (R309), had the information on how to file a grievance out of a survey of 33 residents. The findings included: The facility staff failed to provide the information to the residents on how to file a grievance, where grievance forms are located, and who the grievance officer was for the healthcare residents on Unit 200 and 300. On 3/3/25 at 2:00 p.m. a resident council meeting was conducted, which was attended by R4, R8, R22, R30, and R309. The five residents stated that they were not aware of what a grievance form was or how to file a grievance. When asked who the grievance officer was, none of the residents able to. The surveyor was able to give a copy of a grievance form to each resident in the meeting and all five of the residents stated that they had never been told about this form. R30 said, We haven't had a social worker since [name redacted] left on my floor and didn't get another one. This is the kind of thing a social worker would take care of for me. On 3/4/25 at 5:08 p.m., an end of day meeting was conducted with the administrator, assistant administrator, director of nursing, assistant director of nursing, and unit managers. The above concerns were discussed with the facility staff. The staff was made aware that the residents was not aware of how to file a grievance, where to get the grievance form, or who the grievance officer was for the healthcare residents on unit 200 and 300. On 3/5/25 at 10:00 a.m., an interview was conducted with the assistant administrator. The assistant administrator stated that the grievance education for the residents was in the, Residence and Care Agreement, in the admission packet. On 3/5/25, a review of the facility admission packet was conducted. During the review, the surveyor was unable to find grievance education for the residents in the admission packet. On 3/6/25 9:30 a.m., a meeting with the administrator and assistant administrator was conducted. They were informed of the above concerns and that grievance education for the residents were not in the admission packet. The assistant administrator looked at the admission packet and stated that she did not see the information. No additional information was provided prior to exit conference.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 21875 Based on staff interview, facility document review, and clinical record review, the facility staff failed to protect a resident's right to be free from physical/verbal abuse by a private duty aide for one of thirty-three residents in the survey sample (Resident #252). The findings include: A clinical record review revealed that Resident #252 (R252) was admitted to the facility with diagnoses that included Parkinson's, post hip joint replacement, delusional disorder, anemia, dementia with behavioral disturbance, anxiety, vitamin deficiency and psychotic disorder. The minimum data set (MDS) assesment dated 3/8/23 coded R252 with short and long-term memory problems and severely impaired cognitive skills. A facility reported summary dated 3/15/23 documented that a housekeeper (other staff #15) reported on 3/15/23 at 12:45 p.m. that she witnessed R252's private duty aide (other staff #16) shove him back into his wheelchair and refer to the resident as crazy. The facility's investigation documented that the housekeeper stated she was cleaning R252's room when R252 was observed standing from his wheelchair. The investigation documented the housekeeper witnessed the private duty aide (other staff #16) harshly shove the resident back into the wheelchair. The investigation documented that when the housekeeper questioned the resident about the shoving incident, the private duty aide stated not to listen to the resident because he was crazy. The facility's synopsis documented that when questioned the private duty aide responded that she was attempting to keep the resident from falling and denied calling the resident crazy. The facility's synopsis revealed that the resident was pushed into the wheelchair with the private duty aide referring to the resident as crazy. The private duty aide was removed from the facility and not allowed to work for any residents in the facility. R252's clinical record documented a physical assessment on 3/15/23 in response to the incident, indicating no physical injuries from the incident. R252's clinical record documented assessment and follow up in the days following the incident with no changes in behavior/demeanor noted. R252 was discharged back to assisted living on 3/27/23. On 3/4/25 at 11:21 a.m., the assistant administrator (administration staff #2) was interviewed about R252. The assistant administrator stated the incident on 3/15/23 was reported to the state, adult protective services and the ombudsman. The assistant administrator stated the private duty aide was a companion and did not provide direct care to R252. The assistant administrator stated this private duty aide was removed from the facility at the time the incident was reported and had never provided care for any other residents in the facility. The assistant administrator stated that the private duty aide met prerequisites for sitters and was employed by the family through a local agency. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 2:42 p.m., the social worker (other staff #14) that investigated the reported incident on 3/15/23 was interviewed. The social worker stated the housekeeper (other staff #15) immediately reported the incident as required. The social worker stated the private duty aide was removed from the facility, was not allowed to care for any other residents, and had not been allowed to return. The social worker stated the private duty aide had cared for R252 in independent and assisted living prior to admission to the nursing facility and was familiar/known to the resident. The social worker stated the family reported no prior issues with the aide. The social worker stated the resident's family member did not want to terminate services with the private duty aide due to the incident but understood the actions taken by the facility in response to the incident were required. The social worker stated she interviewed the housekeeper and that the housekeeper reported she witnessed the private duty aide shove R252 back into his wheelchair. The social worker stated when the housekeeper asked about what was happening, the private duty aide said not to listen to the resident because he was crazy. The social worker stated private duty aides were not allowed to provide direct care to residents and were considered companions. The social worker stated the private duty aide denied calling the resident crazy, stated she was trying to prevent the resident from falling, and did not consider her actions rough. The social worker stated the private duty aide was removed from the facility with notifications made to the responsible party and provider. The social worker stated the incident was reported to the aide's employment agency and a self-report issued to the state agency, along with adult protective services and the ombudsman. The social worker stated nursing completed a skin assessment on R252 on 3/15/23 that revealed no injuries. The social worker stated R252 demonstrated no mood/behavior changes following the incident. The social worker stated the family hired a new companion following the incident and R252 had no concerns, reactions, or conflicts with the new companion. The social worker stated the resident discharged back to assisted living as planned on 3/27/23. On 3/4/25 at 2:52 p.m., the registered nurse unit manager (RN #3) that cared for R252 at the time of the incident was interviewed. RN #3 stated the private duty aide (other staff #16) had cared for the resident prior to admission to the facility. RN #3 stated that the housekeeper reported that she witnessed the private duty aide shove the resident back into his wheelchair and then refer to the resident as crazy when she questioned the incident. RN #3 stated private duty aides were considered companions and were not allowed to provide direct care. RN #3 stated the private duty aide had not reported any problems or concerns to nursing on 3/15/23 prior to the incident. RN #3 stated if R252 was standing repeatedly or demonstrating unsafe behaviors, the private duty aide should have notified a staff person. RN #3 stated private duty aides were supposed to get a staff member to intervene as needed with resident care concerns. On 3/5/25 at 10:15 a.m., the administrator and director of nursing (DON) were interviewed about R252's incident on 3/15/23. The DON stated the housekeeper reported the witnessed incident immediately as required and there was zero tolerance for abuse of any type. The DON stated that the private duty aide was removed from the facility, reported to her employment agency, and a facility summary was forwarded to the state agency. The housekeeper that reported the abuse incident with F252 was on leave and not available for interview. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Abuse Prevention (revised 5/21) documented the nursing facility, .is committed to providing an environment where residents' rights are protected and residents remain free from abuse, neglect, exploitation, mistreatment .To this end, [the nursing facility] has adopted a standard of zero tolerance of resident abuse, neglect, exploitation, mistreatment, including injuries of unknown source or misappropriation of property in our communities, and will ensure that such allegations, are reported as required by federal, state and local laws and investigated promptly .This standard will include all community staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, friends or other individuals . The facility's policy titled Private Duty Nurses-Aides in Continuing Care (revised 6/24) documented, .As defined in this policy, companionship includes the following duties: sitting with the resident to provide company and social engagement, bed making, and escort services .The PDN/A [private duty nurse/aide] will communicate relevant information regarding the resident to the Continuing Care staff member responsible for overseeing the care of the resident. Significant events and emergencies will be reported immediately . On 3/5/25 at 3:46 p.m., the administrator was interviewed about R252. The administrator stated the facility's analysis of the 3/15/23 revealed evidence of the events as witnessed/reported by the housekeeper. The administrator presented a summary of interventions/corrections that had been implemented in response to R252's abuse incident on 3/15/23. The administrator stated there had been no further allegations of abuse since 3/15/23. The facility's plan of correction included the following. 3/15/23 - Witnessed incident was immediately reported by the housekeeper to the housekeeping supervisor, social worker, and administrator. The private duty aide was removed from the facility and suspended. Notifications were made to the resident's family member, physician, state agency, adult protective services, and ombudsman. The private duty aide (other staff #16) was no longer permitted on the premises or allowed to sit for any other residents. Reviewed and determination made that the private duty aide (other staff #16) had provided care to no other residents in the facility. 3/15/23 - Initiated training with all nursing staff regarding abuse prevention policy, including reporting and investigation. 3/16/23 - Interviews and statements obtained from the housekeeper (other staff #15) and the private duty aide (other staff #16), and an attempted interview with R252. 3/22/23, 3/29/23 - Additional training for rest of the nursing staff on abuse prevention policy. 3/28/23 - In-service training conducted with department heads/leadership team regarding abuse reporting and investigation. Ongoing monitoring of facility reported incidents including abuse allegations. 4/21/23 - Incident reviewed/discussed in QAPI (quality assurance and performance improvement) meeting with facility leadership. Monthly QAPI meetings included ongoing review/discussion of all facility reported incidents including any abuse allegations. No further abuse allegations reported or identified. Date of correction was 4/21/23. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Actions taken were reviewed. Education was documented as listed in the correction plan. A review of facility reported incidents for 1/1/24 through 3/5/25 revealed no allegations of abuse. Review of the QAPI program evidenced ongoing monitoring of all facility reported incidents including abuse allegations. Interviews with residents, families, and staff during the current survey revealed no concerns about abuse and/or mistreatment. This deficiency was cited as past non-compliance.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 49456 Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to ensure residents were free from unnecessary psychotropic medications and perform gradual dose reductions for one resident, Resident #111 (R111), out of a survey sample of 11 residents. The findings included: A review of R111's clinical record revealed that a gradual dose reduction (GDR) was not completed for one of R111's antidepressant medications. On 5/14/25 at 9:03 a.m., an interview was conducted with a licensed practical nurse, LPN#1. LPN#1 was asked to explain the procedure for pharmacy recommendations. LPN#1 stated that pharmacy recommendations were given to the physician to review. LPN#1 said, Recommendations should be done right away, it needs to be taken care of. LPN#1 stated that the floor nurses and the clinical manager was responsible for notifying the physician of the pharmacy recommendations and making sure the recommendations were addressed. On 5/14/25 at 4:00 p.m., an end of day meeting was conducted with the administrator, director of nursing and the corporate staff. They were made aware of the above concerns. On 5/15/25 at 9:25 a.m., the regional of clinical operations presented additional information. The regional of clinical operations stated that when the provider was asked about the pharmacy recommendation for R111 that she only wanted to decrease the Lexapro and leave the Trazadone dose as ordered. The regional of clinical operations said, We did educations to the providers again yesterday. The regional clinical of operations acknowledged that she was aware that gradual dose reductions were required to be completed on psychotropic medications. Also present was the regional executive director, who nodded his head in agreement that the provider agreed with the drug reduction recommendations but only made changes to one medication. An additional clinical record review was conducted. R111's clinical record documented that Lexapro 10 mg (milligrams) was ordered on 6/19/24 and the first GDR was done on 5/2/25. R111's Trazodone 50 mg was ordered on 5/13/24 but no GDR had been attempted on this medication. R111 had a pharmacy recommendation on 3/13/25 that read in part, [R111's name redacted] receives multiple antidepressants for depression concomitantly without documentation in the medical record of an inadequate response to monotherapy: Trazodone Hydrochloride, Escitalopram Oxalate. Please consider gradual dose reductions, with the end goal of discontinuation. The clinical record documented that the provider checked to accept the recommendations above, noting please implement as written but provided no written instructions on the pharmacy recommendation form. Also found was a telephone order that decreased the Lexapro 10 mg to 5 mg on 5/2/25. The medication order for Trazodone remained at the same dose. There was no reason given on the recommendation to why the Trazodone dose was not decreased by the provider. The clinical record also documented a provider's note dated 5/2/25, which read in part, .Lexapro was decreased to 5mg once daily for symptoms management. Also documented in the providers' note was a section that read, recommendations Decrease Lexapro to 5mg. The pharmacy recommendation for the Trazodone was not addressed in the provider's note. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When provided, facility documents were also reviewed. The policy titled, Psychoactive Medications, read in part, .Gradual Dose Reduction Program: a structured approach aimed at systematically decreasing the dosage of certain medications to assess whether lower doses or complete discontinuation are feasible without adversely affecting a resident's well-being. The policy titled, Psychoactive Medication Management, read in part, .to ensure our guests/residents will not be chemically restrained during their stay. Guest/resident responds to their medical condition, their surrounding/environment and/or approach taken by others. No additional information was provided prior to the exit conference.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview and facility documentation review, the facility staff failed to implement their abuse policy with regards to the pre-screening of employees for 12 of 25 (Staff C, E, G, H, I, K, M, P, S, U, W, and X) employee/staff records reviewed. The findings included: 1. For Staff U, the facility staff permitted the employee to work 20 months without knowing the status of their criminal background check and if they had been convicted of any barrier crimes. On [DATE], a sample of 25 staff records was selected for review for pre-screening requirements. Staff U's file was provided, which indicated she was a certified nursing assistant (CNA) and was hired [DATE]. The facility provided evidence that a criminal record check was requested on [DATE], but no evidence that the criminal record check was received was provided. On [DATE] at 09:35 a.m., an interview was conducted with the Senior Human Resources manager, (other employee #10- OE #10). OE #10 stated, It is a state regulation for us to pull a criminal background check, they are pulled by our recruiter after an offer is made. We have two recruiters. When asked why they would want to see someone's criminal background when hiring someone, OE #10 said, It is an [company name redacted] policy, most of my career has been in corporate human resources, I've been here about ten years in facilities. All of them I have worked for have a policy for pulling a criminal background check. In Virginia, they require us to pull from the Virginia state police. On [DATE] at 10:09 a.m., an interview was conducted with the human resources coordinator (Other Employee #11- OE #11). When asked about the process and purpose of a criminal background check, OE #11 said, The criminal background check is with the pre-hire process . once the pre-screening is done and an offer is made and accepted, we do a criminal background check with Va State police, they get sworn statement and consent form via docu sign. The sterling process does federal background and with the Va state police, if nothing is pending it comes back immediately, if they have something, they mail it, and it could take 15 days. We need to make sure they don't have a barrier crime and are not a sex offender that would prevent them from providing care for our residents. On [DATE] at 10:10 a.m., following the above interview, OE #10 and OE #11, were down the employee file of Staff #U. When asked about the criminal background check, they stated, We know it was ran but when we went through her packet, we didn't see the results page attached. The facility's policy titled, Abuse Prevention was received and reviewed. According to the abuse policy, it read in part, . Procedure: 1. Employees will have criminal background checks completed and licensing/certification verified for good standing . On [DATE] at 4:38 p.m., the facility administrator and director of nursing were made aware of the above findings. They confirmed that Staff U is employed as a PRN (as needed) staff member and last worked [DATE]. Staff U was not scheduled to work again until [DATE]. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8 a.m., the facility provided evidence that a criminal background check had been obtained for Staff U on [DATE] at 6:26 p.m. No additional information was provided. 2. For ten employees (Staff C, E, H, I, K, M, P, S, W and X), the facility staff permitted the employees to work, providing direct resident care, without having verified they held an active and unincumbered license to practice in that position, performing assigned duties. On [DATE], the survey team selected a sample of 25 employee records to review and requested the records of the employees. On [DATE], the employee records were reviewed. The findings were as follows: I. Staff C was hired [DATE] as a licensed practical nurse (LPN). Staff C was permitted to work as an LPN and provide direct resident care. The facility staff failed to verify that Staff #C held an active and unencumbered license to practice in that role until [DATE]. II. Staff E was hired on [DATE] as a licensed practical nurse (LPN). The facility staff verified on [DATE], that Staff E had an active license with no disciplinary action. However, it was three months before Staff E started working for the facility, at which time they didn't confirm that Staff E's license had remained active with no adverse actions. III. Staff H was hired [DATE] as a certified nursing assistant (CNA). The facility staff permitted the employee to work in this role without knowing if the employee held an active license without any disciplinary action, until [DATE], when they verified the license. IV. Staff I was hired [DATE] as an occupational therapist. Staff I was permitted to work directly with residents, providing care, and the facility did not verify the license until [DATE]. V. Staff K was hired [DATE] as a CNA and permitted to provide direct resident care for an entire year before the facility verified the employee's professional license to determine that they held an active and unincumbered license on [DATE]. VI. Employee M, who was an occupational therapist, was hired [DATE]. The facility did not have any evidence that the professional license of Employee M was verified to ensure it was current and unencumbered until [DATE]. VII. On [DATE], the facility staff verified that Staff P held an active certification from the department of health professions to work as a certified nursing assistant. Staff P was hired [DATE] and had been permitted to work as a certified nursing assistant and provide direct resident care for 10 months before the facility verified the certification was current without any disciplinary actions. VIII. Staff S, who was a speech language pathologist (SLP), was hired [DATE]. The facility permitted Staff S to work in the capacity of a SLP and didn't verify the license to do so was active until [DATE]. IX. For Staff W, who was hired as an LPN on [DATE]. The facility staff did not verify Staff W's license to work as an LPN until [DATE]. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	X. Staff X was hired [DATE], as a certified nursing assistant. On [DATE], the facility staff verified that Staff X held a current and unencumbered certification to practice as a CNA. On [DATE] at 09:35 a.m., an interview was conducted with the Senior Human Resources manager, (other employee #10- OE #10). OE #10 stated, On [DATE] at 10:09 a.m., an interview was conducted with the human resources coordinator (Other Employee #11- OE #11). The facility's policy titled, Abuse Prevention was received and reviewed. According to the abuse policy, it read in part, . Procedure: 1. Employees will have criminal background checks completed and licensing/certification verified for good standing . The facility policy titled, Health Services License and Certification Tracking, was reviewed. It read in part, .1. Upon hire, each continuing care employee will have a license and/or certification added into the HCM [Human Capital Management system] under Certifications based on job requirements. This is collected during onboarding by Human Resources. 2. Human Resources team will track license/certification within HCM based on expiration date. Employees are ultimately responsible for maintaining their individual licenses and certification as required based on their position, however, it is important that each community monitor adherence to these requirements . Any employee without an active license must be removed from the schedule until an updated license is provided. This does include employee without an active care associate . On [DATE], the above findings were discussed with the facility administrator and senior human resources manager. 3. For Staff #G, the facility staff permitted the employee to work as a certified nursing assistant, whose certification had expired, without knowing if they had renewed their license from the department of health professions to work in such capacity. On [DATE], a sample of 25 employee records were reviewed, which included Staff #G. The facility staff indicated that Staff #G was hired on [DATE] as a certified nursing assistant. According to Staff #G's personnel file, the license verification was conducted on [DATE], which indicated Staff #G's certification as a nurse aide expired [DATE]. The facility staff permitted Staff #G to work as a certified nursing assistance without having evidence that they verified the employee renewed their license to work as a certified nursing assistant. On [DATE], the above findings were discussed with the facility administrator and senior human resources manager. As requested, the facility's policy titled, Abuse Prevention was received and reviewed. According to the abuse policy, it read in part, . Procedure: 1. Employees will have criminal background checks completed and licensing/certification verified for good standing No additional information was provided.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47067 Based on observations, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to develop and implement a timely and adequate baseline care plan for one resident (Resident #49) in a survey sample of 33 residents, that includes the instructions needed to provide effective and person-centered care. On 3/4/25 at 9:50 am, Resident #49 (R49) was observed sitting in a wheelchair beside his bed, wearing a large black molded plastic boot that encased his left foot, from the toes to just below the knee. Also present was R49's significant other/POA. When asked about care satisfaction, R49 nodded his head and looked at his significant other who replied, Yes, I believe that they do a good job here, much better than where he's been before . but I know one thing that they could do better. They really need to make sure everyone knows how to fasten his boot properly. The staff mean well, but they really [NAME] those straps. Everyone does it differently. Even PT has exclaimed at finding the boot with the straps so messed up. Noting a printed paper sign on the wall that read Left boot to LLE [left lower extremity/leg] when OOB [out of bed], R49's significant other said, Yes, PT put that sign up, but I wrote out what the abbreviations meant in pen because some of the staff didn't know. When asked how the staff knows how to properly apply the orthotic, R49's significant other said, Well, they look at that care plan book over there. So, it's probably in there. When asked if he had received a copy of any of the care plans, R49 started to shake his head No, but looked again to his significant other, who responded, Nope. I just look at that one over there [indicating the care plan binder behind the door] from time to time, but the print is so tiny. Actually, when he was first admitted , he had to wear the boot all the time, even in bed, but his last ortho appt was good news. The fracture is healing so now he can bear weight when using the walker, but that's really only with PT. When asked if there had been a different sign on the wall then, R49's significant other replied, No, they put that sign up when he no longer had to keep the boot on all the time. R49's significant other joined this surveyor in review of the care plan, but no reference to the orthotic boot was found. A later review of the printed care plan kept in R49's room revealed that it had been initiated 1/20/25 and was dated 2/13/25, but none of the goals/interventions had individual dates that reflected when they had begun or when the review was due. A few pages had manual entries, but there were no entries or updates that reflected the use of an orthotic boot. Under the Skin Integrity section of this care plan, the only care concern listed was Infections of the foot, with general interventions that included Inspect pressure areas related to splints/brace/immobilizer/cast/ Prosthesis during routine care and report concerns. There was no specific guidance to staff on how the boot should be applied or the associated special care considerations associated with the use of the orthotic boot. On 3/5/25 930 am, an interview was conducted with the licensed practical nurse (LPN3) working on R49's hall. When questioned about the timeline for the baseline care plan, LPN3 replied, We have 24 hours to get that care plan in. We constantly add & update until the next care plan time, when all those handwritten updates are entered into the electronic care plan. Then we do everything together . notify the NP or doctor of a decline or special equipment needs. When asked how special equipment needs are handled, LPN3 replied, They are referred to therapy and then they say what equipment they can use. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 10:20am, certified nursing assistant #1 (CNA1) working on R49's hall was interviewed. When asked about the boot that R49 wears, CNA1 said, When he first came, he wore the boot all the time. Then, it changed to when he gets out of bed. When asked how changes in care are communicated, CNA1said, When something changes, its supposed to go on the care plan. We keep them in each room, behind the door. When asked if she had ever seen any instructions on the right way to secure R49's boot, CNA1 said, No, but there's a sign on the wall. When pointing out that the sign tells 'when,' not 'how', CNA1 agreed and replied, I was working when rehab came to do the initial eval. They called me down to show me how to put it on. When asked how that type of information would be shared, CNA1 replied that it goes on the care plan, but was unable to locate that care guidance had been updated on R49's care plan. Reviewing the Rehab section of R49's paper chart revealed a PT eval dated 1/16/25 which documented LLE [left lower extremity] NON-WB [non-weight bearing] but omitted any reference that R49 had been admitted wearing a boot or that provided specific care guidance for this special equipment. The 1/16/25 OT Eval notes that R49 . is unable to adhere to NWB restriction in LLE and requires assistance lifting foot off floor during t/f [transfer]. This non-weight bearing status, apparently active upon admission, was not reflected on the baseline/interim care plan. A review of R49's clinical record documented that R49 was admitted on [DATE], with diagnosis that included Fracture of left ankle, Parkinson's Disease, Muscle Weakness, UTI, hx Falls, metabolic encephalopathy, Dementia with severe agitation, Urine Retention, Neuromuscular bladder dysfunction. It was also revealed that the first documented evidence that a baseline care plan had been developed and implemented was dated 1/20/25, which exceeded the required baseline. No evidence was found that R49 and/or his significant other had been offered/provided a copy or summary of the baseline care plan. On 3/5/25 at 5:30am, during the end of day meeting, concerns were shared that R49's baseline care plan had not been completed timely, nor did it address the minimal guidance staff needed to address his unique care needs. On 3/6/25 at 940am, when questioned about the history of R49's orthotic boot, RN1 responded that R49 had been admitted with the boot for his fractured left ankle, initially wearing it all the time, then, only when out of bed, but is now weight bearing as tolerated. When asked to locate where that was noted in the care plan, RN1 indicated the one entry dated 2/26/25, reflecting that the boot was to be worn when out of bed. When questioned about care directives for the use of the boot prior to that date, guidance to staff on care considerations associated with the orthotics or how to secure the straps correctly, and the initial weight bearing status, RN1 confirmed that this information should've been included in the care plan. When comparing the care plan in the electronic health record and the copy kept in R49's room, RN1 was asked which version is most accurate and RN1 responded that the one kept in the room is a working version . which means its updated as his orders and needs change. Pointing out the lack of start dates or review dates since it was implemented, RN1 was asked how the goals are measurable or how the effectiveness of the interventions is determined, RN1 made no verbal response, while slowly nodding head up and down and gazing at the care plan. When asked how the Baseline care plan differs from the Comprehensive Care plan, the RN1 stated that they start with the baseline and just keep adding to it, which becomes the Comprehensive Care Plan. Identifying 1/20/25 as the date of the Baseline Care Plan, RN1 had no explanation for why the CP had not been done within the first 48 hours from admission, as required. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy, Care / Service Plans, revealed the following: .An interim care plan will be generated by a nurse within 8 hours of admission . will reflect resident's goal and include interventions that address his or her current needs in a language and format that the resident and/or representative, if applicable, understand . will include healthcare information necessary to care for a resident . an interim care plan will be provided to the resident and responsible party, if applicable . documentation that the interim care plan was provided to the resident and/or responsible party, if applicable, will be documented in the medical record. No additional information was provided prior to survey exit.

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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** 47067 Based on observations, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to develop and implement an accurate comprehensive person-centered care plan for one resident (Resident R49) in a survey sample of 33 residents, that included measurable objectives and timeframes. On 3/4/25 at 9:50 am, resident was observed sitting in a wheelchair beside his bed, wearing a large black molded plastic boot that encased his left foot, from the toes to just below the knee. Also present was R49's significant other/POA. When asked about care satisfaction, R49 nodded his head and looked at his significant other who replied, Yes, I believe that they do a good job here, much better than where he's been before . but I know one thing that they could do better. They really need to make sure everyone knows how to fasten his boot properly. The staff mean well, but they really [NAME] those straps. Everyone does it differently. Even PT has exclaimed at finding the boot with the straps so messed up. Noting a printed paper sign on the wall that read Left boot to LLE [left lower extremity/leg] when OOB [out of bed], R49's significant other said, Yes, PT put that sign up, but I wrote out what the abbreviations meant in pen because some of the staff didn't know. When asked how the staff knows how to properly apply the orthotic, R49's significant other said, Well, they look at that care plan book over there. So, it's probably in there. When asked if he had received a copy of any of the care plan, R49 started to shake his head No, but looked again to his significant other, who responded, Nope. I just look at that one over there [indicating the care plan binder behind the door] from time to time, but the print is so tiny. Actually, when he was first admitted , he had to wear the boot all the time, but his last ortho appt was good news. The fracture is healing so now he can bear weight when using the walker, but that's really only with PT. When asked if there had been a different sign on the wall then, R's significant other replied, No, they put that sign up when he no longer had to keep the boot on all the time. R49's significant other joined this surveyor in review of the care plan, but no reference was found to the orthotic boot. A later review of the printed care plan kept in R's room revealed that it had been initiated 1/20/25 and was dated 2/13/25, but none of the goals had individual dates that reflected when they had begun or when the review was due. A few pages had manual entries, but there were no entries or updates that reflected the use of an orthotic boot. Under the Skin Integrity section of this care plan, the only care concern listed was Infections of the foot, with general interventions that included Inspect pressure areas related to splints/brace/immobilizer/cast/ Prosthesis during routine care and report concerns. There was no specific guidance to staff on how the boot should be applied or the associated special care considerations associated with the use of the orthotic boot. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/5/25 930 am An interview was conducted with the licensed practical nurse (LPN3) working on R49's hall. When questioned about the timeline for the baseline care plan, LPN3 replied, We have 24 hours to get that care plan in. We constantly add & update until the next care plan time, when all those handwritten updates are entered into the electronic care plan. Then we do everything together . notify the NP or doctor of a decline or special equipment needs. When asked how special equipment needs are handled, LPN3 replied, They are referred to therapy and then they say what equipment they can use. LPN3 listed action taken after a resident fall as including . monitoring, like every 2-hour checks, taking them to activities, keeping an eye on them, anticipating needs, keeping items within reach, no clutter, fall mats. 3/5/25 10:20am certified nursing assistant #1 (CNA1) working on R49's hall. When asked about the boot that R49 wears, CNA1 said, When he first came, he wore the boot all the time. Then, it changed to when he gets out of bed. When asked how changes in care are communicated, CNA1said, When something changes, its supposed to go on the care plan. We keep them in each room, behind the door. When asked if she had ever seen any instructions on the right way to secure R49's boot, CNA1 said, No, but there's a sign on the wall. When pointing out that the sign tells 'when,' not how, CNA1 agreed and replied, I was working when rehab came to do the initial eval. They called me down to show me how to put it on. When asked how that type of information would be shared, CNA1 replied that it goes on the care plan, but was unable to locate that care guidance on the R49's care plan. 3/5/25 1130am After reviewing the care plan in R49's electronic chart but finding no reference to the boot, the care plan in R49's room was again accessed, but noted that a handwritten entry had been added, dated 2/26/25, which read Left boot to LLE when OOB. No other entries referencing the left boot were found. Review of Physician orders section of R49's paper chart revealed an ortho consult, dated 1/30/25, which recommended NWB[non-weight bearing] LLE[left lower extremity] - boot for comfort. Reviewing the Rehab section of the paper chart revealed PT eval dated 1/16/25 which documented LLE [left lower extremity] NON-WB [non-weight bearing] but omitted any reference that R49 had been admitted wearing a boot or that provided specific care guidance for this special equipment. Also found under the Rehab section of the paper chart was another ortho consult dated 2/24/25 to Start PT - WBAT with boot & walker. F/u in 1 mo. These progressive changes in weight bearing status were not noted in R49's care plan. Review of the clinical record revealed that R49 had fallen on 2/4/25 @ 7:25am, 2/8/25 02:00 am, and 2/8/25 @9:15am. Hand-written entries signed by the Unit Mgr (RN1) to the Falls section of the care plan kept in R49's room were dated 2/4/25, 2/8/25, and 2/11/25, but did not implement different fall strategies with each fall. Social Worker notes dated 1/21/25 8:23 PM documented . presents with a lot of confusion . inattention . disorganized thought process . observed to doze off during conversation as well as answer in a nonsensical way at times He is admitted as medically non-decisional per MD certification . The MDS (minimum data set) assessment dated [DATE] under Section C0500 coded R49 as being severly impaired cognitively, but the care plan noted R49 as being both Indep - decisions consistent/reasonable and Lethargic and Confused. Under the Medication section of the Care Plan, it was noted that I am not taking antipsychotics as a goal, but interventions included Because I take psychotropic drugs monitor me for sleepiness, drooling, insomnia. A review of Physician orders documented that quietiapine, a psychotropic medication, was started 1/27/25, with subsequent order changes noted 1/28/25, and 1/31/25, but no care plan updates identified targeted behaviors or non-pharmaceutical interventions The Acute Health Concerns section of R49's care plan did not have any updates to include R49's hospitalization , urinary tract infection, or suspected reoccurrence of pneumonia since R49's admission, niether were the care and immunization refusals included in this care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 9:40 am, when questioned about the intervention implemented in response to R49's falls, RN1 said, Well, he has low bed and fall mats. When it was pointed out that those interventions were already in place before the falls, RN1 replied, Well basically the plan was to increase staff monitoring. We were just trying to keep an eye out for him a little more. When further questioned on specifically what was done differently each time R49 fell to decrease the risk of reoccurrence, RN1 seemed unsure of how to answer. When asked if any attempt to support R49's apparent preference to get out of the bed, by getting him up had been attempted or if diversional activities were offered outside of his room, RN1 replied, Oh, I see, you mean the interventions should change. When comparing the care plan in the electronic health record and the copy kept in R49's room, RN1 was asked which version is most accurate and RN1 responded that the one kept in the room is a working version . which means its updated as his orders and needs change. Pointing out the lack of start dates or review dates, RN1 was asked how the goals are measurable or how effectiveness of the interventions is determined, RN1 made no verbal response, while slowly nodding head up and down and gazing at the care plan. When asked how the Baseline care plan differs from the Comprehensive Care plan, the RN1 stated that they start with the baseline and just keep adding to it, which becomes the Comprehensive Care Plan. Identifying 1/20/25 as the date of the Baseline Care Plan, RN1 had no explanation for why the CP had not been done within the first 48 hours from admission, as required. On 3/5/25 at 5:30 pm, during the end of day meeting, concerns were shared that R49's comprehensive care plan had not been adequately developed/revised to fully address R49's initial and emerging care needs or formatted with measurable objectives and interventions. On 3/6/25 at 940 am, when questioned about the history of R49's orthotic boot, RN1 responded that R49 had been admitted with the boot for the fractured left ankle, initially wearing it all the time, then only when out of bed, but is now weight bearing as tolerated. When asked to locate where that was noted in the care plan, RN1 indicated the one entry dated 2/26/25 reflecting that the boot was to be worn when out of bed. When questioned about care directives for the use of the boot prior to that date, guidance to staff on care considerations associated with the orthotics or how to secure the straps correctly, the changes in the weight bearing status, or resident focused fall interventions, RN1 confirmed that this information should've been included in the care plan. A review of the facility policy, Care / Service Plans included A comprehensive person centered care plan wll be developed by the Interdisciplinary Team and be completed within 72 hours of admission and will include measurable objectives, preferences, goals . and will address the resident's medical, nursing, mental, and psychosocial needs as identified from the resident's comprehensive assessment . any changes identified in the comprehensive care plan in the resident's goals, physical, mental, or psychosocial functioning, that was not identified in the interim care plan, will be provided to the resident and/or responsible party, if applicable . Care plans will be reviewed, revised if applicable, on an ongoing basis by the interdisciplinary team with any change in condition and after each assessment, including both comprehensive and quarterly assessments. In addition, Post-Acute residents will have their care plan reviewed weekly . all interdisciplinary team members will document any updates on care plan copy in the guest/resident suite/apartment/designated accessible location and review update with designated care associate. No other information was provided prior to exit.

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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** 41449 Based on observations, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to review and revise the care plan for three residents (Resident #5- R5, Resident #39-R39, and Resident #49-R49), in a survey sample of 33 residents. The findings included: 1. For R5, who was non-verbal and totally dependent upon facility staff for all activities of daily living, the facility staff failed to review and revise the care plan to accurately reflect the resident's needs for activity programing. On 3/3/25 in the afternoon, on 3/4/25 at 2:55 p.m., and 3/5/25 at 2:32 p.m., R5 was visited in her room. R5 was laying in her bed each of the days, was noted to be non-verbal, and didn't respond when spoken to. There was a sign in the room that indicated Keep the tv on channel 133 EWTN Religious channel. On 3/3/25 and 3/4/25, R5 was in bed without the tv on, no radio was on, and no indication of social, auditory, visual, or other sensory stimulation was observed. On 3/5/25, R5 was dressed, sitting in a wheelchair at the bedside with the television on a religious program. On 3/5/25 at 2:40 p.m., an interview was conducted with a certified nursing assistant, (CNA #1). CNA #1 reported that R5 rarely comes out of her room, but they cut her tv on for her and activities reads to her several times a week. On 3/5/25 at 3:07 p.m., an interview was conducted with the unit manager, who was a registered nurse (RN #2). RN #2 stated that R5 doesn't come out of her room much and is totally dependent on staff for all care needs to include being fed by staff. On 3/5/25 at 3:32 p.m., an interview was conducted with the activity's coordinator for the unit. The activities coordinator reported that she visits R5 almost daily. She went on to report, When the weather is nice, I take her out on the patio, I do sensory things with her, massage her hands, etc. She added that she is visited weekly on Fridays for religious prayers but is no longer able to partake in communion due to her diet. The activities coordinator confirmed that R5 is unable to pursue or initiate any leisure/stimulation programs independently. On 3/5/25, a review was conducted of R5's two most recent Minimum Data Set (MDS), (an assessment tool) with an assessment reference dates (ARD) of 1/13/25 and 10/20/24. According to both MDS assessments, it was noted that R5 had short and long-term memory impairments, severely impaired decision making, and altered level of consciousness. According to the 10/20/24 MDS, Section F indicated R5 preferred family or significant other involvement in care discussion and listening to music. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to R5's current care plan, section 12. titled, Engagement and Socialization read, I prefer to engage myself independently. I like to observe others while they are participating in activities daily. The care plan noted, I like small groups, to keep up with the news/read paper, to listen to music, to watch tv. It went on to state, Care plan Approaches: I would like to attend music programs. I would like staff to include me in small group to observe others and listen. I would like to go to Catholic Mass. On 3/6/25, the facility staff provided the surveyor with a revised copy of R5's care plan. This care plan had been revised, the revisions were initialed and dated 3/6/25. The revisions had crossed out I prefer to engage myself independently and had handwritten, I would like to be encouraged and escorted to group activities. 2. For R39, who had auditory and visual electronic monitoring within the room, the facility staff failed to revise the care plan to reflect the use of the camera. On 3/3/25, in the afternoon, while conducting a tour of the unit, the surveyor noted a sign on R39's room door that indicated electronic monitoring device is in use. On 3/4/25, a clinical record review was conducted. According to R39's care plan there was no mention of an electronic monitoring device being in use. According to an email communication within R39's clinical record, dated 1/25/25, between R39's guardian and power of attorney and the facility social worker, the family of R39 agreed that they would purchase, install and maintain the camera, the positioning of the camera as to not capture R39's care during changing [incontinence care] due to privacy concerns, and signage would be posted on the outside of the room of such monitoring. On 3/5/25 at 10:23 a.m., an interview was conducted with R39 and her private duty aide. When asked about the camera, R39 stated that she wasn't surprised to know there was a camera in the room. R39 did exhibit some confusion and was not clear on who could see the video footage from the camera or that her family had placed it in the room. R39 didn't express any concerns knowing the camera was present and in use. According to the private duty aide, the camera had video and auditory capability. The family could see the resident and talk to her through the camera device. The private duty aide went on to say that she provides R39's care such as toileting and changing clothes in the bathroom, where the camera cannot see, for privacy. The private duty aide reported that the family had put the camera in place about 2-3 weeks ago because they no longer provide a private duty aide overnight and are concerned about the resident getting up and falling. On 3/5/25 at 10:37 a.m., an interview was conducted with a certified nursing assistant (CNA #2). CNA #2 reported that the camera had been placed in the room by the family about a month ago. CNA #2 stated that the facility's administration was aware of it being present and the family was told it couldn't be positioned where it could see into the bathroom. 3. For Resident #49 (R49), facility staff failed to review and update the comprehensive care plan to reflect the use of an orthotic boot and omitted changes in weight bearing status. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 9:50 am, resident was observed sitting in a wheelchair beside his bed, wearing a large black molded plastic boot that encased his left foot, from the toes to just below the knee. Also present was R49's significant other/POA. When asked about care satisfaction, R49 nodded his head and looked at his significant other who replied, Yes, I believe that they do a good job here, much better than where he's been before . but I know one thing that they could do better. They really need to make sure everyone knows how to fasten his boot properly. The staff mean well, but they really [NAME] those straps. Everyone does it differently. Even PT has exclaimed at finding the boot with the straps so messed up. Noting a printed paper sign on the wall that read Left boot to LLE [left lower extremity/leg] when OOB [out of bed], R49's significant other said, Yes, PT put that sign up, but I wrote out what the abbreviations meant in pen because some of the staff didn't know. When asked how the staff knows how to properly apply the orthotic, R49's significant other said, Well, they look at that care plan book over there. So, it's probably in there. When asked if he had received a copy of any of the care plan, R49 started to shake his head No, but looked again to his significant other, who responded, Nope. I just look at that one over there [indicating the care plan binder behind the door] from time to time, but the print is so tiny. Actually, when he was first admitted , he had to wear the boot all the time, but his last ortho appt was good news. The fracture is healing so now he can bear weight when using the walker, but that's really only with PT. When asked if there had been a different sign on the wall then, R's significant other replied, No, they put that sign up when he no longer had to keep the boot on all the time. R49's significant other joined this surveyor in review of the care plan, but no reference was found to the orthotic boot. A later review of the printed care plan kept in R49's room revealed that it had been initiated 1/20/25 and was dated 2/13/25, but none of the goals had individual dates that reflected when they had begun or when the review was due. A few pages had manual entries, but there were no entries or updates that reflected the use of an orthotic boot. Under the Skin Integrity section of this care plan, the only care concern listed was Infections of the foot, with general interventions that included Inspect pressure areas related to splints/brace/immobilizer/cast/ Prosthesis during routine care and report concerns. There was no specific guidance to staff on how the boot should be applied or the special care considerations associated with the use of the orthotic boot. 3/5/25 930 am, an interview was conducted with the licensed practical nurse (LPN3) working on R49's hall. When questioned about care planning, LPN3 replied, We constantly add & update until the next care plan time, when all those handwritten updates are entered into the electronic care plan. Then we do everything together . notify the NP or doctor of a decline or special equipment needs. When asked how special equipment needs are handled, LPN3 replied, They are referred to therapy and then they say what equipment they can use. When asked how new orders or special care needs are communicated to staff, LPN3 stated, That happens during the Daily Huddle at the beginning of each shift. We give a report to the incoming staff of what happened on our shift. As requested, LPN3 retrieved the Huddle binder and pointed out that each person signs off that they attended. Observing that the most recent shift sheet was dated 2/4/25, LPN3 was questioned and confirmed that 2/4/25 was likely the last date the sheet was completed, as she stated that they had not signed a sheet that morning. When asked how staff coming in late or for a split shift would get the needed care report, as the topics listed on the sheet were only general and there was no resident specific information, LPN3 replied, I get a much better report here than the last place I worked. It's really good communication, but I hadn't thought about that. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/5/25 10:20am certified nursing assistant #1 (CNA1) working on R49's hall. When asked about the boot that R49 wears, CNA1 said, When he first came, he wore the boot all the time. Then, it changed to when he gets out of bed. When asked how changes in care are communicated, CNA1said, When something changes, its supposed to go on the care plan. We keep them in each room, behind the door. When asked if she had ever seen any instructions on the right way to secure R49's boot, CNA1 said, No, but there's a sign on the wall. When pointing out that the sign tells 'when,' not 'how', CNA1 agreed and replied, I was working when rehab came to do the initial eval. They called me down to show me how to put it on. When asked how that type of information would be shared, CNA1 replied that it goes on the care plan, but was unable to locate any care guidance regarding the left boot on the R49's care plan. On 3/5/25 at 1130am, after reviewing the care plan in R49's electronic chart but finding no reference to the boot, the care plan in R49's room was again accessed, but noted that a handwritten entry had been added, dated 2/26/25, which read Left boot to LLE when OOB. No other entries referencing the left boot were found. Review of the Physician orders section of R49's paper chart revealed an ortho consult, dated 1/30/25, which recommended NWB[non-weight bearing] LLE [left lower extremity] - boot for comfort but this specialized care guidance was not reflected in the care plan. Reviewing the Rehab section of the paper chart revealed PT eval dated 1/16/25 which documented LLE [left lower extremity] NON-WB [non-weight bearing] but omitted any reference that R49 had been admitted wearing a boot or that provided specific care guidance for this special equipment. Also found under the Rehab section of the paper chart was another ortho consult dated 2/24/25 to Start PT - WBAT with boot & walker. F/u in 1 mo. These changes in weight-bearing status were also not reflected in R49's care plan. On 3/5/25 at 5:13 p.m., the facility's management team, to include but not limited to, the facility administrator and director of nursing were made aware of the above concerns regarding R5 and R29's care plans, not being reviewed and revised as noted above. The facility's staff was also informed of the findings that R49 was admitted wearing an orthotic boot, which had never been included in the care plan since admission, as well as other notable omissions. This has resulted in concerns that the comprehensive care plan had not been adequately developed/revised to fully address R49's initial and emerging care needs. On 3/6/25 at 8:42 a.m., an interview was conducted with a licensed practical nurse (LPN #3). LPN #3 explained that the care plan is . individualized about the care of a resident. Whatever they need should be in the care plan, it is what we follow to take care of them. On 3/6/25 at 8:47 a.m., an interview was conducted with the assistant director of nursing, who is a registered nurse (RN #2). RN #2 stated that the purpose of the care plan is to . provide individualized care for our residents. It should have everything the resident needs in the care plan, how often, etc. The care plan guides the staff of how to take care of the residents, that's why it is in the resident room, so they can look through it to see what type of assistance they need. When asked if she would expect electronic monitoring to be indicated in the care plan, RN #2 said, Yes, we want to make sure it is not positioned to see care, for privacy, and in the bathroom. It [the care plan] should say she has it. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 940 am, when questioned about the history of R49's orthotic boot, the unit manager (RN1) for that wing responded that R49 had been admitted with the boot for the fractured left ankle, initially wearing it all the time, then only when out of bed, but is now weight bearing as tolerated with PT. When asked to locate where that was noted in the care plan, RN1 indicated the one entry dated 2/26/25 that reflected that the boot was to be worn when out of bed. When questioned about care directives for the use of the boot prior to that date, guidance to staff on care considerations associated with the orthotics or how to secure the straps correctly, and the changes in the weight bearing status, RN1 confirmed that this information should've been included in the care plan. The facility policy titled; Care/Service Plans was reviewed. The policy read in part, . 3. A comprehensive person-centered care plan will be developed by the Interdisciplinary Team and be completed within 72 hours of admission and will include measurable objectives, preferences, goals, any specialized services as a result of the PASARR evaluation, resident's discharge plan and will address the resident's medical, nursing, mental and psychosocial needs as identified from the resident's comprehensive assessment. 4. Any changes identified in the comprehensive care plan in the resident's goal, physical, mental, or psychosocial functioning, that was not identified in the interim care plan, will be provided into the resident and/or responsible party, if applicable . 8. Care plans will be reviewed, revised if applicable, on an ongoing basis by the interdisciplinary team with any change in condition and after each assessment, including both comprehensive and quarterly review assessments . In addition, Post-Acute residents will have their care plan reviewed weekly . all interdisciplinary team members will document any updates on care plan copy in the guest/resident suite/apartment/designated accessible location and review update with designated care associate. No additional information was provided.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 49456 Based on resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to follow professional standards of nursing practice for one resident, Resident #104 (R104), out of a survey sample of 11 residents. The findings included: The staff failed to notify the physician when a medication was not available. On 5/13/25 at 2:30 p.m., an interview was conducted with R104. During the tour of the nursing unit, R104 was interviewed by request. R104 stated that she was prescribed a prn (as needed) cough medicine that she could have every six hours if needed. R104 said, I got a dose of the cough medicine during the night but when I asked for a dose this morning, I was told by the nurse there was no more here; it would need to be ordered. R104 stated she asked the nurse to check in the stat (immediate) box and R104 said, The nurse was not even aware of a stat box where you can get medications from if needed. Reportedly, R104 was told that the medication was supposed to be here by 8:00 a.m., and then the time was changed to arrive at noon. R104 said, Here it is 2:30 p.m., and still no cough medicine. R104 stated she had called her pulmonologist (lung specialist) and said, My pulmonologist wants me to go out to the emergency room to get a CT scan and be treated for my cough, since the facility cannot treat me. R104 stated that she had called her pulmonologist, was waiting to be dressed, and then she was calling 911 (emergency number) herself. On 5/13/25 at 3:00 p.m., an interview was conducted with a licensed practical nurse, LPN#2. WHen questioned about the cough medicaine, LPN#2 said, [R104's name redacted] cough medicine was not here because the medicine ran out. LPN#2 stated the third shift nurse reported to her the cough medicine was out and had been ordered. LPN#2 said, I called the pharmacy, and it was supposed to be here by noon today, but it still is not here. LPN#2 stated that the physician was not notified of the cough medicine being unavailable because it was a PRN medicine. LPN#2 said, When out of a prn, I don't notify the doctor about that. R104's clinical record was reviewed. R104 had a prn order for `dextromethorphan-guaifenesin 10mg-100mg/5 ml oral liquid for cough as needed every six hours. On 5/13/25 at 8:32 p.m., a progress note was written by LPN#2, which read in part, The night nurse informed this writer that the resident's prn cough medication was out of stock. The writer contacted the pharmacy twice [pharmacy staff names redacted] both of whom confirmed that the order had been received and was being processed. LPN#2 had a progress note that documented that R104 was transferred to the hospital at 3:30 p.m. The medication administration record was reviewed, and no prn cough medicine had been administered prior to R104 going out to the emergency room . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility documentation was conducted. The policy Medication Administration, Receipt, Storage and Disposal read in part, when a licensed nurse or CMA/CMT determines that an ordered medication is unavailable, the following steps are initiated: if medication has not been ordered, fax request immediately and ensure request has STAT written on the top. Call the pharmacy and let them know which medication is needed as soon as possible. I medication is not available in the Omnicell machine, provider is notified and EMR [electronic medical record] will reflect conversation with the provider. Provider may ask nurse for alternative medications available in the Omnicell and provide a one time for an alternative to cover until medication is received for skilled/long term care residents only. On 5/14/25 at 4:00 p.m., an end of the day meeting was conducted with the administrator and corporate staff, during which the above findings were discussed. No additional information was provided prior to the exit conference.

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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. 49456 Based on resident interviews, staff interviews, clinical record review and facility documentation review, the facility staff failed to assess resident, communicate with the provider, and ensure quality of care for one resident, R#104 (R104), out of a survey sample of 11 residents. The findings included: The staff failed to assess R104 prior to being sent out to the emergency room , failed to communicate with the physician before 911 was called by R104, and failed to review the emergency room report for new orders. On 5/13/25 at 2:30 p.m., R104 stated that she had called her pulmonologist (lung specialist) and said, My pulmonologist wants me to go out to the emergency room to get a CT scan and be treated for my cough, since the facility cannot treat me. R104 stated that she had called her pulmonologist and was waiting to be dressed and then she was calling 911 (emergency number) herself. The resident stated that her vital signs were not being checked, and no one had listened to her lung sounds. R104 said, When my oxygen levels are checked, I have to ask for it to be done. On 5/13/25 at 3:00 p.m., an interview was conducted with a licensed practical nurse, LPN#2. LPN#2 stated that she was aware that R104 had called her pulmonologist, and that she had given the number to R104. LPN#2 said, I didn't speak with the doctor. LPN#2 was aware that R104 was going to call 911 and that R104 stated to her that the pulmonologist I that she goes to the emergency room for evaluation. LPN#2 said, It was not the normal way for the residents to call the doctor or to call 911. I would call 911 if I felt she needed to go to the emergency room . LPN#2 stated that the physician was not notified of the cough medicine being unavailable because it was a PRN medicine. LPN#2 stated that R104 vital signs was obtained because she was going out to the emergency room . LPN#2 stated that R104's transfer packet was completed and given to the emergency medical staff. On 5/14/25 at 9:10 a.m., an interview was conducted with the clinical manager, registered nurse (RN#1). RN#1 stated the nurses should review the report from the emergency room and if anything was new or changes to notify the provider. LPN#2 showed the new order for cough medicine to RN#1 that was approved by the nurse practitioner (NP). RN#1 asked it the NP was going to order the prednisone and then she said, Never mind she will get me to call [R104's name redacted] pulmonologist about that. On 5/14/25 at 5:22 p.m., an interview was conducted with the NP. The NP stated, These instructions from the emergency room were not discharge orders. The emergency room s paperwork states to ask your doctor about these medications. When asked if she was R104's provider, the NP said, Umm hmm. The NP was asked if she was aware that R104 had called the pulmonologist and 911 herself and the NP replied, Umm hmm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 6:30 p.m., an interview was conducted with LPN#2. When asked if the NP had seen R104 today, LPN#2 said, She did not see the resident today and only sees them if the nurse has a concern. When shown the emergency room report, LPN#2 stated these orders was new orders and that she was going to review the orders with the NP. Although the report from the hospital emergency room was placed in the miscellanous section of the resident's hard chart, but the staff was not aware of the new orders that were in the emergency room report. On 5/15/25 at 9:25 a.m., an interview was conducted with the regional director of clinical of operations, who stated that R104's lung sounds, skin assessment, medication review, coughing and shortness of breath were assessed last night by two nurses. The regional of clinical operations stated that the risk versus the benefits of the nasal cannula to be worn correctly was discussed with R104. The ADON reported having a clinical note in the chart about the assessments and about the education given to R104. The regional director of clinical of operations stated that the expectations of the staff were to assess prior to going out to the emergency room , staff were expected to speak to the doctor, and the provider was to physically see the resident within 24 hours of returning from the emergency room (ER) visit. The regional director of clinical operations said, The provider wouldn't write a note if she didn't see her and the provider is aware and knows the expectation of resident to be seen within 24 hours after an ER visit. The regional director of clinical operations was shown the provider's note where no physical exam was recorded. A clinical record review was conducted. R104 clinical notes had vital signs recorded the day she went out to the emergency room . When R104 returned from the emergency room no assessment was recorded for R104. On 5/14/25, a clinical note was written about R104 being on antibiotic and prednisone for upper respiratory infection but no vital signs were recorded in the note. A provider's note was reviewed during the clinical record review. The NP was in the facility and wrote a progress note addressing the ER (emergency room) visit, which only had medical history, surgical history, hospitalization , family history, social history and a list of medication. There was no physical exam in the NP's note. On 5/14/25 at 4:00 p.m., an end of the day meeting was conducted with the administrator and corporate staff, during which the above findings were discussed. No additional information was provided prior to the exit conference.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to implement interventions to prevent the development of a pressure ulcer for one resident, Resident #1 (R1) of 33 residents in the survey sample, which resulted in a facility acquired wound that was identified at the advanced stage 3, constituting harm. The findings included: According to the clinical record, R1 was admitted to the facility on [DATE]. Diagnoses for R1 included but are not limited to muscle weakness, osteoarthritis, venous insufficiency, dementia, and lack of coordination. R1's Significant Change Minimum Data Set (an assessment tool), dated 1/11/2025, coded R1 with severe cognitive impairment, limited range of motion to left side, impaired mobility, and urinary & fecal incontinence. This assessment also coded R1 as dependent for turning & repositioning, while coding that R1 required maximal assistance for transferring. Although this assessment identified the presence of a stage 3 wound, there were no diagnosis coded to identify the specific wound location or type. On 3/3/25 at 3:00 p.m., a tour of unit 300 was conducted. During the tour, R1 was observed reclining in bed watching her television, which was mounted on the opposite wall in her room. On 3/4/25 at approximately 1:45 p.m., an interview was conducted with R1. R1 was laying on her back in bed with her head elevated, watching television. During the interview, R1 said, I have a wound on my butt that hurts sometimes. R1 was not able to recall how long she has had this wound. R1 said, I stay in the bed too much. They say they will get me up but never do. On 3/5/25 at approximately 8:50 a.m., an interview was conducted with LPN#3 (LPN3). During the interview, LPN3 stated that skin assessments were completed twice weekly. LPN3 stated, When a pressure wound heals, the skin is tender, and we order a protective dressing to be used. LPN3 said, We turn and reposition the resident [R1] every two hours and use the preventive treatment dressing until we feel the skin is stronger. LPN3 stated that R1 sometimes refused to get out of bed and that R1 did not like being transferred using a Hoyer lift. There was no documentation in the nurses notes or care plan about R1 refusing to get out of the bed or not liking to be transferred with the Hoyer lift. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/5/25 at approximately 10:00 a.m., a clinical record review was conducted. A wound assessment dated [DATE], documented that R1 had a facility acquired, stage 2 pressure wound on the sacrum. On 9/11/24, a wound assessment was completed, which read in part, . wound bed not visible. Started on 3/20/24, a physician's order for optifoam dressing to the sacrum 3 times a week & as needed was documented as active until 11/13/24. On 9/20/24, a physician's order was written for a protective dressing which read, Clean sacrum wound with wound cleanser, pat dry, cover with opt-view transparent dressing with hydro-core. Change dressing every six days. On 10/9/24, a wound assessment noted the facility acquired sacral wound was healed. On 11/21/24 a wound assessment read in part, .acquired since admission . coccyx -reopened wound . stage 3. The documented measurements were 1.0 cm length x 0.8 cm width x 2.0 cm depth, with 2. 0 cm depth tunneling between 12 and 3 o'clock. The assessment also noted that the wound bed had moderate serous-sanguineous (thin, yellow fluid with a pink or red tinge) drainage and a mild odor. A review of R1's Treatment Administration Record (TAR) revealed that the optifoam dressing 3 times a week, which started on 3/20/24, was documented as completed until 11/13/25. The TAR also revealed that the optiview dressing treatment every 6 days to the healed sacral area was also documented weekly since 10/9/24. R1's care plan interventions included an alternating pressure mattress and gel cushion to wheelchair, but there were no new preventative measures implemented from 10/9/24, when the sacral wound healed, despite R1 being documented as high risk for skin breakdown, nor was there any change in the treatment in response to the new coccyx wound that was identified on 11/21/24. On 3/5/25 at approximately 11:45 a.m., an observation was conducted of the treatment to R1's stage 3 coccyx wound. R1 was observed reclining on her back watching television and required total assistance of two nursing staff to turn her onto her side for the wound care. R1 was not able to assist with this repositioning and appeared ridged throughout, with arms clenched at her sides, but tolerated it well. A licensed practical nurse, LPN#4 (LPN4), was observed performing the wound care for R1. Once exposed, R1's coccyx wound was a full thickness, with obvious depth, and pink, beefy tissue, but no foul odor was noted. The wound also had rolled edges, and lateral space underneath the skin, into which gauze dressing had been packed. The old dressing and wound packing were saturated with drainage. Also visible was healed scar tissue on the sacral area. On 3/5/25 at 4:30 p.m., R1 was again observed reclining on her back, in bed, watching television. On 3/5/25 at approximately 5:00 p.m., an end of day meeting was conducted with the director of nursing, administrator, the unit manager and assistant director of nursing. The surveyor discussed the concerns of R1's stage 2 sacral wound that was documented as having healed on 10/9/2024, and then on 11/21/24 a new wound was identified to the coccyx at a stage 3, instead of the acceptable stage 1. The facility was asked to provide any documentation regarding R1's pressure wounds, to include preventative measures and interventions. On 3/6/25 at 8:50 a.m., an observation was made of R1 laying on her back, with the head of the bed elevated, sleeping. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/6/25 at approximately 11:00 a.m., the facility provided a copy of an email from the registered dietician, dated 3/6/25, which appeared to be excerpts from the dietician's progress notes regarding R1. The email read in part, 9/29/24, follow-up d/t [due to] skin status . Seen during wound rounds for healing stage 2 sacral wound 0.5x0.5cm . The email also included the dietician's note, dated 11/14/24, which read in part, stage 2 sacral wound which is improving, but the nurses' clinical notes previously reviewed documented that the stage 2 sacral wound had healed on 10/9/24. A review of the email included the dietician's documentation dated 11/20/24 - 12/16/24, 11/28/24, and 11/29/24, but there was no mention of the stage 3 coccyx wound, which had first been identified on 11/21/24. Also included in this email was a dietician's note dated 12/19/24, which read in part, Skin: seen by wound team 12/17/24 for sacral stage 3 wound 4cmx4cmx3.5cm, tunneling: 9-12pm 3 cm, 12-3pm 2.5cm, Oval shaped . Left buttock stage 2: 0.5cmx0.8cm, Oval shaped . recommend Juven twice daily and active liquid protein 30 ml twice daily . for wound healing. No documentation, including skin assessments, treatments, or physician orders, was provided that addressed the stage 2 wound to the left buttock. On 3/6/25 at approximately 11:15 a.m., the facility provided skin assessments for review. The skin assessments completed on 11/8/24 indicated no skin impairments. The next skin assessment wasn't completed until 11/25/24 and had a circle on the sacral area, without any labeling or description of a wound. On 11/28/24, the skin assessment was completed and had an arrow pointing to the coccyx area with only pressure wound and treatment in progress noted on the assessment. On 3/6/25 at approximately 11:45 a.m., an interview was conducted with the administrator and the director of nursing. The director of nursing (DON) stated that she had a QAPI action plan that she wanted me to review. The plan was developed on 1/10/25, almost two months after R1 acquired the coccyx wound on 11/21/24. The listed interventions included staff education on pressure injury prevention, a skin sweep to all SNF [skilled nursing facility] residents, and audits. The action completed date was blank, and the Action Completed date was blank. The surveyor informed the DON and administrator that the survey team would review the information and that there was potential for harm. On 3/6/25 at approximately 11:55 a.m., a review of the facility policy titled, Skin Integrity Program, and it read in part, .prevention and management of alterations in skin integrity, including pressure injuries is a priority for the community. The approach to the management of pressure injuries and prevention will be consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers/injury from developing. This policy also defined an avoidable wound as . resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors, define and implement interventions that are consistent with the resident's needs, resident goals, and professional standards of practice, and evaluate the impact of the interventions or revise the interventions as appropriate. No additional information was provided prior to exit conference.

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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. 49456 Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to implement interventions to prevent accidents from falls for one resident, Resident #106 (R106) out of a survey of 11 residents. The findings included: On 5/14/25 at 8:30 AM, a clinical record review was conducted, which included the comprehensive care plan. The review revealed that R106 had a fall on 4/29/25, while trying to transfer from wheelchair to bed without assistance. The staff documented a care plan intervention that he was reeducated and was to call for assistance. The record documented another fall on 5/6/25, while he was trying to transfer from the wheelchair to the bed without assistance. The staff again documented that R106 was reeducated on using the call light and to follow him to assist with his needs. The interventions that staff wrote for these falls were interventions that were already in place from previous falls. There was no other entries to indicate that R106 had new interventions put in place to effectively address the required fall prevention, following these two falls. On 5/14/25 an interview was conducted with the assisted director of nursing (ADON). The ADON said, [R106's name redacted] was confused and had to have things repeated over and over. He had to be reminded because he forgets. During the interview, the ADON presented a copy of the care plan interventions for R106. On the copy presented by the ADON, an entry had been made for 4/29/25. When asked if this intervention was completed on 4/29/25, the ADON said, Yes. Later review of this copy version presented by the ADON revealed an entry for 4/29/25 which read staff will assist residents during transfer at night and currently on maintenance for therapy. When compared to the original care plan, these added interventions were not on the original care plan, which had been obtained this morning. On 5/15/24, an interview was conducted with the regional director of clinical operations (RDCO), who said, You were correct that the fall interventions were duplicated for the falls on 4/29/25 and 5/6/25, those interventions were already in place. The RDCO stated that a root cause analysis was completed and they determined that R106's falls had occured after his meals. the RDCO stated that no new interventions were implemented at the time of the falls. The RDCO stated that the new intervention being implemented now was to assist R106 back in his room after meals and offer him assistance to lay back down. The RDCO stated they had started in-services with nurses on the new intervention for R106. The facility documentation was reviewed. The policy Fall Management read in part, .review care/service plan for appropriateness of approaches and/or modify/add approaches if necessary. DON and/or designee will report fall trends and any action plans developed to keep guest/residents safe from falls and/or decrease frequency of falls during monthly QAPI process. An end-of-day meeting was conducted with the administrator and corporate staff. During this meeting, the above concerns were shared that fall prevention/interventions had not been appropriately implemented to reduce accident risk for R106. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided prior to the exit conference

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 41449 Based on observation, resident and family interview, facility staff interview, clinical record review, and facility documentation review, the facility staff failed to implement nutritional interventions to maintain the resident's nutritional status and weight, for one resident (Resident #101- R101) in a survey sample of eleven residents. The findings included: For R101, who had experienced a significant weight loss, the facility staff failed to provide the resident with nutritional interventions identified/implemented to prevent further weight loss. On 5/13/25, a clinical record review was conducted of R101's chart, to include the current care plan, which was kept in the resident's room. According to the care plan, R101 was noted in the nutritional care plan to have interventions of .super soup in a mug at lunch/dinner, and super mashed potatoes at lunch/dinner. Offer magic cup at dinner . According to the weights recorded in R101's chart, on 3/5/25, R101 weighed 146. 90 lbs. R101 gained weight and on 3/19/25 had a weight of 154 lbs. On 4/2/25, R101's weight was noted to have been 145.40 lbs. The most recent weight for R101 was recorded on 5/7/25 at 142.40 lbs. From 3/19/25-4/2/25, R101 experienced a weight loss of 5.58%. From 3/19/25-5/7/25, R101 had a weight loss of 7. 58%. On 5/13/25 at 5:28 p.m., observations were conducted of R101. R101 was interviewed, while the spouse was at the bedside, but was noted with significant cognitive impairments. R101 was observed lying in bed, with her evening meal sitting on the over bed table. The meal consisted of a bowl of soup that was not served in a mug and there was no indication if it was super soup. There were no potatoes on the meal tray and there was no magic cup on the tray. According to the meal ticket, there was no indication that R101 was to have super soup in a mug or the super potatoes. The meal ticket did read, note: no magic cup. On 5/13/25 at 5:30 p.m., an interview was conducted with R101's spouse who was sitting in the chair in the room. The spouse was asked about the meal and reported that the soup is served in a mug only 1/3 of the time. The spouse of R101 also stated, Sometimes I'm asked to fill out a menu but only get it about 1/3 of the time and it isn't what I have filled out. It looks like they don't read it. On 5/13/25 at 5:47 p.m., the surveyor asked a certified nursing assistant, CNA #1, to accompany the surveyor to R101's room. CNA #1 reviewed R101's care plan and confirmed that the soup should be super soup served in a mug, and that super potatoes should have been provided, along with a magic cup. CNA #1 stated expressed inability to identify if R101's soup was super soup or not, noting that it was in a bowl versus mug, which made it difficult for R101 to feed to herself lying in bed. CNA#1 also confirmed that there were no potatoes or magic cup provided on the tray. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Weight Management, with a version date of 06/2021, was reviewed. The policy read in part, . Residents will have their weight and height measured and recorded routinely to provide a measure of assessment of resident nutritional status . Significant weight change- As defined in RAI Manual is any unplanned weight change of 5% change over 1 month, 7.5% over 3 months or 10% change over the past 6 months . 11. Guests/residents with a significant weight change should be discussed in High-Risk Rounds/Utilization Review. 12. When a significant weight change is identified, the guest/resident plan of care will be reviewed, evaluated and revised, as applicable, to reflect interventions to support the guest/resident goals and preferences after medical consideration and interdisciplinary discussion . On 5/14/25 at 4 p.m., during an end of day meeting, the facility's administration and corporate staff were made aware of the above findings. On 5/15/25 at 8:40 a.m., an interview was conducted with the dietary manager. When asked about supplements and nutritional interventions for residents with weight loss, the dietary manager stated that they have a daily detail sheet that lists the needed supplements, and that list is printed daily for the dietary staff to know what to prepare for each resident. The dietary manager stated that after being made aware of the concerns regarding R101, they reviewed the information and noted that magic cup was not on the detailed sheet, but it has now been updated. When asked about the super soup and super potatoes, the dietary manager explained that it is made by adding skim milk and powdered milk, adding that the soup would be thinner than the usual soup consistency. The dietary manager was unable to confirm if R101's soup on 5/13/25 was super soup or not. On 5/15/25 at 9:18 a.m., the facility's Regional Director of Clinical Operations (RDCO) met with the survey team and stated, The dietician interviewed the resident yesterday and she [R101] said she doesn't want the super soup anymore. We discontinued that. She still wants the super mashed potatoes and likes ice cream versus the magic cup. When asked if orders are written for such items, the RDCO stated, No, we don't write orders, we put it in the care plan and in the dining details and we have updated that. The RDCO also provided the survey team with the dietician's notes and commented that they educated the dietician on not determining weight loss based on weights obtained during a prior stay, because the dietician had referenced and trended weights prior to R101 being hospitalized on a few occasions. According to the progress notes, the registered dietician (RD) made entries in R101's chart on 3/14/25, 3/17/25, 3/25/25, 5/2/25, and 5/14/25. The note, dated 3/14/25, read in part, . Resident's husband (POA) requests 3/13 diet order be changed to mechanical soft ground . Resident came back from most recent hospital stay on a regular diet on 3/3 but was subsequently downgraded to purred diet since she was chewing for a long time before swallowing and seemed to get fatigued before finishing her meal . Discussed with husband that resident is likely not meeting estimated needs and offering Ensure Plus three times daily after meals as tolerated . Continue to offer fortified foods as previously ordered. Continue to monitor PO [by mouth] intake, diet texture tolerance, and weekly weights and provide encouragement and assist at meals as needed . On 3/17/25, the RD documented, . Reports resident ate ~50% at lunch and dinner on 3/16. Had episode of nausea and spit-up on 3/17 in AM and did not eat breakfast but was able to consume ensure. Weight 3/12 150.3 # increased from 146.9 # on 3/5 however resident still triggers for 18% weight loss at 90 days. Continue to offer fortified foods at ordered at all meals [sic]. Continue to offer Ensure three times daily after meals . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/25, the RD's progress note read in part, . Weight 3/19 154#, 3/12 150.3#, 3/5 146.9#, 2/19 157#, 12/19 180.8# indicating slight increase in past week, slight loss at 30 days, and 14.4% significant weight loss at 180 days. Continue to offer fortified foods at ordered at all meals [sic] . Resident was on Remeron in Feb but not currently ordered. Will inquire with NP about possibility of re-starting . On 5/14/25 at approximately 11:15 a.m., the dietary manager provided the surveyor with a copy of R101's diet order information that was in place from 3/3/25-5/13/25, which noted, Preferences: Breakfast: Smoothie, Lunch: Super soup in mug, smoothie, super mased w/gravy, Dinner: super soup in mug, smoothie, super mashed w/gravy, magic cup. On 5/14/25, the diet order changed and noted: Preferences: Breakfast: Smoothie, Lunch: super mashed w/gravy, Dinner: super mashed w/gravy. On 5/14/25, the RD made an entry into R101's chart at 9:09 p.m., that read, Nutrition note follow-up due to food preferences. Resident receiving hospice care. Tolerating mechanical soft ground diet. Discussion held with resident today to clarify smoothie, super soup, ice cream, and super mashed potatoes preferences. Resident prefers to not have super soup but would like to continue smoothie at breakfast and super mashed potatoes at lunch and dinner and would like to have regular ice cream. Food preference report and care plan book updated to reflect resident preferences. Reviewed resident's food preferences for breakfast on 5/14 and communicated with dining team . No additional information was provided.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure appropriate dementia care was in place for one resident (Resident #9-R9), in a survey sample of 33 residents. The findings included: For R9, who had dementia, the facility staff failed to develop resident specific interventions and identify target behaviors to ensure the resident received appropriate treatment to maintain the resident's highest practicable well-being. On 3/4/25 and 3/5/25, R9 was observed attending group activities and eating meals in the dining room. R9 was noted to be calm, engaged and no behaviors noted. On 3/5/25, a clinical record review was conducted. This review revealed that R9 was admitted to the facility on [DATE] from assisted living, where her spouse was also a resident. R9's diagnosis included, but were not limited to unspecified dementia, unspecified severity, without behaviors/psych/mood/anxiety; unspecified dementia with behavioral disturbance; and dementia in other disorder classified elsewhere, severe, with other behavioral disturbance. According to R9's care plan, the only mention that the resident had behaviors was in section 10. Medications that read in part, . I am taking anti-psychotics: yes. These are the 'actions/expressions' I exhibit/exhibited to support use of anti-psychotic: yelling at staff and trying to hit, Prior to beginning and/or administering antipsychotic medications please try the following approaches: calm quiet surroundings . The care plan approaches included to monitor for side effects, monitoring by the mental health MD/NP [physician and/or nurse practitioner], nursing to monitor for side effects, and administer medications as prescribed. The care plan did identify any target behaviors for R9, and interventions facility staff were to employ when those behaviors were being displayed. There was a care plan in section 4. titled, Safety and Exploring that indicated R9 will be able to explore my neighborhood and will be safe while exploring. The care plan approaches included, I will need nursing staff and my family to help me follow the LOA [leave of absence] policy when traveling out around the campus and off of the campus, I will need an escort when leaving [the unit's name redacted], Observe for changes in my cognition, mood, actions and expressions and notify wellness team if changes are noted. According to R9's nursing notes, since admission, the only noted behavior was wandering on and off the unit. She had one instance of refusing a shower but did accept a bed bath. The notes indicated R9 attended various activities, ate meals in the dining room, etc. According to the physician progress notes, R9 was seen by the medical provider on 12/17/24, 1/14/25, 2/3/25, 2/10/25, and 2/18/25, who noted no changes in behavior. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Psychiatric-Mental Health Nurse Practitioner (PMHNP), saw R9 on 12/3/24, 12/16/24, and 2/5/25. Each of those notes noted no behavioral changes or target behaviors facility staff were to monitor for. On 3/5/25 at 2:45 p.m., an interview was conducted with the unit manager, who was a registered nurse (RN #2). RN #2 was asked about R9 and any behaviors she displayed. RN #2 reported that she does yell out during care and will get anxious about care. Any kind of behaviors that nursing is notified to, will be documented in the clinical notes. On 3/5/25 at 4:15 p.m., the Director of nursing was notified that R9 had no documentation of any behaviors other than wandering and that may have been attributed to being a new admission to the unit and looking for her husband who resided on the unit with her prior to her admission to this nursing unit. On 3/6/25, the director of nursing provided the surveyor with where the certified nursing assistants document and answer the questions: Were any negative/disruptive actions or expressions displayed? Is the resident exploring their environment? Did the action/expression interfere with the resident's activities or socialization? Did the actions/expression interfere with the resident's care? Interventions tried: Did the resident try to leave the neighborhood/building? Were there other actions or expressions not directed towards others? (i.e. hitting/scratching self, pacing, rummaging, public sexual acts, smearing/throwing food/waste, screaming, disruptive sounds, repetitive calling out without defined need), Outcome of intervention, were physical actions directed towards others? Were there verbal expressions directed towards others? and at whom did the resident direct their actions/expressions? There were four documented occurrences of R9 having behaviors that interfered with care. There were no associated nursing progress notes to give details of R9's behaviors. Review of the facility policy titled; Psychoactive Medications was conducted. The policy read in part, .1. All psychoactive medication orders will contain supporting documentation to define specific goals of treatment. The minimum documentation required includes a specific diagnosis or condition, if known, OR a specific target behavior. Any medication used to manage behavior will include provider documentation of target symptoms or behaviors in the clinical record and the documentation will be sufficient to demonstrate the said behaviors are a. [NAME] or dangerous to self or others; or b. extremely disturbing to the resident or other staff; c. Interfere significantly with care delivery causing adverse outcomes . On 3/5/25, during an end of day meeting, the above information to include the lack of identification of target behaviors and resident specific interventions for staff to employ. On 3/5/25 and 3/6/25, the facility was asked to provide their policies regarding dementia care/services. The policy was not received prior to conclusion of the survey. No additional information was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49456 Based on resident interviews, staff interviews, clinical record review and facility documentation review, the facility staff failed to ensure medication was available for one resident, Resident #104 (R104) out of a survey of 11 residents. The findings included The staff failed to keep cough medication in stock to be available for the residents. On 5/13/25 at 2:30 p.m., an interview was conducted with R104. During the tour of the nursing unit R104 was interviewed by request. R104 stated that she was prescribed a prn (as needed) cough medicine that she could have every six hours if needed. R104 said, I got a dose of the cough medicine during the night but when I asked for a dose this morning, I was told by the nurse there was no more here it would need to be ordered. R104 stated she asked the nurse to check in the stat (immediate) box and R104 said, The nurse was not even aware of a stat box where you can get medications from if needed. R104 stated that she was told that the medication was supposed to be here by 8:00 a.m., and then the time was changed to arrive at noon. R104 said, Here it is 2:30 p.m., and still no cough medicine. On 5/13/25 at 3:00 p.m., an interview was conducted with a licensed practical nurse, LPN#2. LPN#2 said, [R104's name redacted] cough medicine was not here because the medicine ran out. LPN#2 stated the third shift nurse reported to her the cough medicine was out and had been ordered. LPN#2 said, I called the pharmacy, and it was supposed to be here by noon today, but it still is not here. LPN#2 stated that the physician was not notified of the cough medicine being unavailable because it was a PRN medicine. LPN#2 said, When out of a prn medicine, I don't notify doctor about that. R104's clinical record was reviewed. R104 had a prn order for dextromethorphan-guaifenesin 10mg-100mg/5 ml oral liquid for cough as needed every six hours. On 5/13/25 at 8:32 p.m., a progress note was documented by LPN#2, which read in part, The night nurse informed this writer that the resident's prn cough medication was out of stock. The writer contacted the pharmacy twice [pharmacy staff names redacted] both of whom confirmed that the order had been received and was being processed. LPN#2 documented a progress note that R104 was transferred to the hospital at 3:30 p.m. on 3/24/25. The medication administration record was reviewed, and no prn cough medicine had been administered prior to R104 going out to the emergency room . A review of facility documentation was conducted. The policy Medication Administration, Receipt, Storage and Disposal read in part, .when a licensed nurse or CMA/CMT determines that an ordered medication is unavailable, the following steps are initiated: if medication has not been ordered, fax request immediately and ensure request has STAT written on the top. Call the pharmacy and let them know which medication is needed as soon as possible. If medication is not available in the Omnicell machine, provider is notified and EMR [electronic medical record] will reflect conversation with the provider. Provider may ask nurses for alternative medications available in the Omnicell and provide a one time for an alternative to cover until medication is received for skilled/long term care residents only. (continued on next page)

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Greenspring Village	7470 Spring Village Dr Springfield, VA 22150

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 4:00 p.m., an end of the day meeting was conducted with the administrator and corporate staff and the above concerns were discussed. No additional information was provided prior to the exit conference.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on staff interview, clinical record review and facility documentation review the facility staff failed to respond to medication reviews in a timely manner for three residents Resident #6 (R6), Resident #9 (R9) and Resident #31 (R31) out of a survey sample of 33 residents. The findings included: 1. The facility staff failed to review and respond to pharmacy consults in a timely manner. R6 was admitted to the facility on [DATE]. Diagnoses for R6 included but are not limited to unspecified psychosis, bipolar disorder and anxiety disorder. R6's Quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/11/2025 coded R6 with no cognitive impairment. On 3/5/25 at approximately at 9:00 a.m. an interview was conducted with the registered nurse, RN#1 (RN1). RN1 stated that the pharmacy consult information is month to month and should be reviewed within 10 days of the review from the pharmacy. RN1 stated that the nurse practitioners and physicians was in the facility several times weekly. On 3/5/25 at approximately at 10:00 a.m. an interview was conducted with the director of nursing (DON). The DON stated that the pharmacy regimen reviews was supposed to be completed within 30 days of the date of the review. The DON stated that the unit managers were responsible to review the pharmacy regimen after the physician and to make sure the review was completed On 3/5/25 at approximately at 11:30 a.m. a clinical record review was conducted. On 3/14/24 a pharmacy consultation was not signed by the physician or by the DON for a gradual dose reduction of four central nervous system active medications. On 6/18/24 a pharmacy consultation for two of R6's inhalers was not dated by the physician or signed by the DON. On 6/18/24 a pharmacy consultation for a gradual dose reduction for Buspar, Xanax and Depakote were recommended and, was not addressed until 10/8/24 by the physician. On 11/12/24 a pharmacy consultation was completed to monitor R6's orthostatic hypotension due to her antipsychotic medication and this recommendation was not addressed by the physician until 12/23/24, and no rationale was given for the decline. 2. The facility staff failed to review and respond to pharmacy consults in a timely manner. R31 was admitted to the facility on [DATE]. Diagnoses for R31 included but are not limited to unspecified dementia, major depressive disorder and delusional disorders. R31's Annual Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 12/20/24 coded R31 with severe cognitive impairment. On 3/5/25 at approximately at 9:00 a.m. an interview was conducted with the registered nurse, RN#1 (RN1). RN1 stated that the pharmacy consult information is month to month and should be reviewed within 10 days of the review from the pharmacy. RN1 stated that the nurse practitioners and physicians was in the facility several times weekly. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/25 at approximately at 10:00 a.m. an interview was conducted with the director of nursing (DON). The DON stated that the pharmacy regimen reviews was supposed to be completed within 30 days of the date of the review. The DON stated that the unit managers were responsible to review the pharmacy regimen after the physician and to make sure the review was completed. On 3/5/25 at approximately at 11:30 a.m. a clinical record review was conducted. On 1/23/25 a gradual dose reduction (GDR) was recommended for R6 trazodone and sertraline. The pharmacy consultation report was addressed on 3/4/25 and had no rationale for why the GDR was not being completed. On 6/18/24 a recommendation from the pharmacy was to taper Seroquel to 12.5 mg every other day for 14 days then discontinuing on a trial basis and the physician declined and recommended, psych to evaluate, on 10/8/24. On 3/6/25 a review of facility documentation was conducted. The facility document titled, Timeliness of Medication Regimen Review (MRR) Reports, and read in part, .the attending physician is expected to review and sign the residents individual MRR and document that he/she has reviewed the pharmacist's identified irregularities prior to the pharmacy consultants next scheduled visit/typically within 30 days. On 3/5/25 at approximately at 5:00 p.m. an end of day meeting was conducted with the director of nursing, the administrator, the assistant administrator and assistant director of nursing. The above concerns were discussed. No additional information was provided prior to exit conference. 41449 3. For Resident #9 (R9), the facility staff failed to respond to a medication regime review (MRR) and recommendation from the pharmacist in a timely manner and failed to give rationale for the decisions selected. On 3/5/25 at 9 a.m., a clinical record review was conducted of R9's chart. This review revealed one MRR dated 12/20/24. This review noted that R9 was on an opioid Tramadol Hydrochloride in combination with a medication that may increase adverse effects, Quetiapine Fumarate. Recommendation: Please consider avoiding or minimizing concomitant use, perhaps tapering Quetiapine. The physician noted, I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: which was blank and gave no rationale. On 3/5/25, the surveyor requested a copy of R9's MRR's and was provided MRR's dated 11/22/24, 1/23/25, and 2/20/25, which were not in the resident's clinical record. Review of these MRR's revealed that on 11/22/24, the pharmacist noted that R9 had a diagnosis of diabetes and made the recommendation to monitor A1C [lab work]. The doctor declined this recommendation on 3/5/25 and noted HBA1C [hemoglobin A1C] was done on 2/5/25. R9 had two MRRs dated 1/23/25. Each signed by different providers, but the printed name remained as one provider with no correction. One MRR was signed 3/4/25 and the other was dated 3/5/25. Both providers declined the recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/25 at 2:45 p.m., an interview was conducted with the unit manager, who was a registered nurse (RN #2). When asked about the medication regime reviews, and the delay in getting them addressed, she stated, I don't know why it took her so long to come in and sign it, I know they have been requesting for her to come and sign it. When asked why the printed physician name was not changed, when a different provider was addressing the recommendation, RN #2 said, Normally when I get it, I will cross out the printed doctor name and put [Psychiatric nurse practitioner's name redacted] name on it. On 3/5/25 at 4:13 p.m., the surveyor conducted a phone interview with the psychiatric nurse practitioner that had declined the gradual dose reduction recommendation. The provider was asked why it took so long for her to respond to the pharmacy recommendation and she stated she had just received the document. On 3/5/25, the facility administration was asked to provide their policy regarding MRR's. The facility provided a policy titled, 9.1 Medication Regimen Review, with a review date of 6/1/24. The document read in part, 1. The consultant pharmacist will conduct MRRs if required under a Pharmacy Consultant Agreement and will make recommendations based on the information made available in the residents' health record . 8. The consultant pharmacist will provide the resident's MRRs to facility identified personnel who will ensure that the attending physician, medical director, director of nursing and other necessary facility staff receive the recommendations . 9. Facility should encourage physician/prescriber or other responsible parties receiving MRR and the director of nursing to act upon the recommendations contained in the MRR. 9.1 For those issues that require physician/prescriber intervention, facility should encourage physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected, as outlined in the State Operations Manual Appendix PP [regulation set] . 12. If an irregularity is not time-sensitive but should be addressed before the consultant pharmacist's next monthly MRR, the facility staff and the consultant pharmacist will confer on the timeliness of attending physician/prescriber responses to identified irregularities based on the specific resident's clinical condition . On 3/5/25 at approximately 5:15 p.m., during an end of day meeting, the facility administrator and director of nursing, along with other management level staff, were made aware of the above findings. No additional information was provided.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 21875 Based on observation, staff interview and clinical record review, the facility staff failed to ensure a medication error rate of less than 5 percent. There were three errors in 29 opportunities resulting in a medication error rate of 10.3%. The findings include: 1. Resident #33 (R33) was administered a dose of extended-release morphine when the physician's order required immediate release. A medication pass observation was conducted on 3/4/25 at 8:09 a.m. with licensed practical nurse (LPN) #1 administering medications to R33. Included in the medications administered to R33 was morphine 15 mg (milligrams) extended-release. R33's clinical record documented a physician's order dated 2/2/25 for morphine 15 mg immediate release tablets two times per day for pain management. On 3/4/25 at 9:00 a.m., LPN #1 was interviewed about the morphine administered to R33. LPN #1 reviewed R33's clinical record and stated the current morphine order listed immediate release and not extended-release. LPN #1 reviewed R33's medication supply from the locked storage and stated the medication she gave was extended release. LPN #1 stated she was not sure why she administered extended-release when the order stated immediate release. On 3/4/25 at 10:56 a.m., the assistant director of nursing (RN #1) was interviewed about the medication error with R33's morphine. RN #1 stated the nurse administering the medication should have recognized the discrepancy and clarified the order prior to administering the medication. This finding was reviewed with the administrator, director of nursing and assistant administrators during a meeting on 3/4/25 at 5:15 p.m. with no further information presented prior to the end of the survey. 41449 2. For Resident #49 (R49), the facility failed to administer medications appropriately, resulting in two medication errors. On 3/4/25 at 8:24 a.m., observations were conducted of licensed practical nurse (LPN #4) administering medications for R49. It was noted that in R49's room was a sign that indicated the resident had swallowing problems and pills must be crushed finely. LPN #4 was observed to preparing R49's medications, which included Vitron-C [Vitamin C with Iron] 65/125 mg tablet. Upon R49 attempting to swallow the pill whole, the resident asked the nurse if it could be crushed. LPN #4 retrieved the pill from the resident, reviewed the card of medication. When asked, LPN #4 said she was looking to see if it that medication could be crushed and then proceeded to crush the medication. LPN #4 then administered R49 the Vitron-C at 8:50 a.m. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following the administration, the surveyor asked LPN #4 to pull the card of medication again. The label was read, and the surveyor pointed out that the pharmacy label indicated, Do not crush. It also indicated that the medication was to be given on an empty stomach and said, give 1 hour before food or 2-3 hours after food. The nurse stated, he hasn't eaten yet. Upon exiting the room, breakfast was actively being served in the dining room and at 9 a.m., R49's breakfast was provided to him in his room. According to R49's physician orders, it noted that Vitron-C 65 mg iron-125 mg tablet, delayed release (1) tablet, delayed release (enteric coated) oral, every one day starting 2/27/2025. 3. For Resident #21 (R21), the facility staff failed to administer medication on an empty stomach as indicated. On 3/4/25 at 9:16 a.m., LPN #4 was observed during the administration of medications to R21. Resident #21 had Vitron- C 65/125 mg Delayed Release due to be given as well. LPN #4 said, I don't want to do the same thing again and held the medication, since R21 was sitting at the breakfast table eating at the time of medication administration. On 3/4/25 at 12:15 p.m., LPN #4 notified the surveyor she was ready to administer R21's Vitron-C. The surveyor observed the medication card, which indicated to give on an empty stomach, 1 hour before food or 2-3 hours after food. The administration of the Vitron-C to R21 was observed and as the surveyor exited the room, noted that residents were in the dining room and staff were preparing to serve the lunch meal. According to R21's physician orders, it noted that Vitron-C 65 mg iron, 125 mg tablet, delayed release (1) tablet, delayed release (enteric coated) oral, every one day starting 10/26/2024. On 3/4/25 at 2:03 p.m., a telephone call was placed the facility's registered pharmacist/pharmacy consultant. The pharmacist was asked about the administration of Vitron-C. The pharmacist stated, you shouldn't crust it according to the manufacturer's recommendation and it should be taken on an empty stomach, 1 hour before or 2 hours after meals. When asked why, the pharmacist said, You can release all of the drug at once and increase side effects. When asked what the side effects are, the pharmacist said, more constipation, diarrhea, upset stomach. On 3/4/25 at approximately 3 p.m., the director of nursing provided the surveyor with an email that the pharmacist had sent in follow-up to the phone call with the surveyor. It read in part, Vitron C, take this medication by mouth, usually once daily or as directed by your doctor. This medication is best taken on an empty stomach 1 hour before or 2 hours after meals . Do not crush or chew the tablets. Doing so can release all of the drug at once, increasing the risk of side effects . The facility's policy titled, Medication Administration, Receipt, Storage & Disposal was reviewed. It read in part, . 4. Trained staff designated to administer medications will verify that he/she is administering medications using the 5 Rights of Medication Administration/Assistance and are documented immediately following completion of task for each resident. I. Right resident, II. Right medication, III. Right dose, IV. Right time, V. Right route . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at approximately 5:15 p.m., during an end of day meeting, the facility administration, to include, but not limited to the administrator and director of nursing, were made aware of the above findings. No additional information was provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21875 Based on observation, staff interview and facility document review, the facility staff failed to prepare food in a sanitary manner in the main kitchen. The findings include: A scoop was observed stored in the bulk flour supply. Stainless serving pans were stored nested and wet. On 3/3/25 at 2:18 p.m., an initial inspection of the kitchen was conducted accompanied by the executive chef (other staff #1), certified dietary manager (other staff #2) and assistant general dietary manager (other staff #3). During this inspection, a scoop was observed stored inside the bulk flour bin, resting in the flour. The executive chef stated at this time that the scoop was not supposed to be positioned in the flour and that the scoop was to be removed from inside the flour bin and cleaned after each use. A rack of ready-to-use serving pans were inspected. Eight large stainless serving pans were nested with water droplets noted along the rims of the pans. The certified dietary manager stated the pans were supposed to be air dried prior to stacking/nesting. A dry rack was observed available for pan storage. The facility's policy titled SOP (Standard Operating Procedure) Food/Non-Food Storage (revised 4/24) documented, .Food is stored in compliance with applicable federal, state and local regulations regarding sanitary storage conditions .Dry, bulk foods, such as flour, sugar, and rice will be labeled and stored in metal or plastic containers with tight fitting lids. Scoops for dispensing these items will be stored separately in a holder . The facility's policy titled Dishwashing Operation (revised 4/24) documented, .Proper infection control techniques will be followed when washing dishes, utensils and other food service equipment .All items will be air dried (no towel dried equipment or utensils) to prevent wet nesting or contamination . These findings were reviewed with the administrator, director of nursing and assistant administrators during a meeting on 3/4/25 at 5:15 p.m. with no further information presented prior to the end of the survey.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for two residents (Resident #108 and Resident #101), in a survey sample of 11 residents. The findings included: 1. For Resident #108 (R108) the facility medical provider failed to complete and accurately document in the clinical record the resident's CPR (Cardiopulmonary resuscitation) wishes and left the information blank. On [DATE], a clinical record review was conducted of R108's chart. This review revealed that R108 signed and executed a durable do not resuscitate (DNR) on [DATE]. On [DATE] the medical provider/doctor completed a Code Status Discussion form and indicated that R108's wishes were for Code B, DNR, but hospitalize. On [DATE], the doctor initiated a National POLST Form: A Portable Medical Order. The POLST form had R108's name, date of birth, gender, R108's signature and the signature of the doctor. Sections A-D, where R108's cardiopulmonary resuscitation orders, initial treatment orders, additional orders or instructions, and medically assisted nutrition wishes would have been documented, were all blank. On [DATE] at 11:05 a.m., an interview was conducted with a licensed practical nurse (LPN #3). LPN #3 was asked to review R108's chart and indicate how she would respond if the resident was identified to be in cardiopulmonary arrest. LPN #3 stated she would have to talk with the doctor to get clarification since the form dated [DATE] was blank and didn't indicate the resident's wishes. LPN #3 went on to say, In this case I would have to do CPR because this form is blank. On [DATE] at 3:31 p.m., an interview was conducted with one of the medical doctors (MD) that works at the facility caring for residents to include R108. The MD was asked about residents' advanced directives and code status. The MD stated that in Virginia they want the POLST form completed to document the residents' wishes and if a resident is going to be resuscitated or not. The MD reviewed the POLST form for R108 and confirmed that the residents' wishes were blank, and the form was not completed. The doctor stated, I think this is incomplete. The doctor was asked what the facility staff are to do when a resident is in an emergency and in need of CPR and the form is incomplete. The doctor said, When it is not complete, they can ask that question and the nurse would call us or call the family. A DNR can be revoked at any time . During the above conversation with the doctor, when asked if, during a cardiopulmonary arrest, the time it takes for staff to call the doctor, is critical? The doctor stated that during an event of CPR, timing is critical, but it is unlikely that it goes that far, and said, Generally, when we see a patient is sick, they call before it gets to that point. Usually, events are evolving but timing is critical. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, titled Advance Directives, with a version date of ,d+[DATE], was provided to the survey team. Review of this document noted that it read in part, .Staff support Residents' rights to execute Advance Directives regarding their health care . The physician order (including the MOLST/POLST) is the source document that drives the care of the resident . Definitions . MOLST/POLST: Medical/Physician's Orders for Life Sustaining Treatment. Includes active enduring medical orders which directs end of life treatment . Procedure . 5. If advance directive documents (including MOLST and POLST forms) are updated or modified, copies of the documents will be provided to the community finance Office and the designated individual at EHMG (typically the medical center social worker or the practice administrator) in order for the documents to be entered into the resident's designated record set and EMR [electronic medical record] . According to the facility policy titled, Designation of Code Status, which read in part, . For communities with an endorsed POLST/MOLST program in effect, medical interventions and life sustaining procedures and preferences regarding life sustaining treatment will be documented on a state approved form, which acts as an active order and takes the place of code status orders . On [DATE] at 4 p.m., during an end of day meeting, the facility's management team and corporate staff were made aware of the above concerns. On [DATE] at 9:18 a.m., the Regional Director of Clinical Operations (RDCO) met with the survey team and said, Last night, we contacted the responsible party [for R108] and she is coming in today to discuss it, and we will have the provider complete the POLST form. The RDCO also indicated that education had been conducted with all the medical providers about completing the POLST form completely and accurately to reflect resident's wishes. No additional information was provided. 2. For Resident #101 (R101), the facility staff failed to maintain a complete clinical record to include the hospice plan of care. On [DATE] and [DATE], a clinical record review was conducted of R101's chart. Clinical documentation included a physician order, dated [DATE], to admit to hospice. There was no care plan or documentation to indicate what care and services hospice would provide to R101 within the clinical record or care plan. On [DATE], the facility administration was asked to provide the hospice plan of care. On [DATE] at 9:18 a.m., the Regional Director of Clinical Operations stated to the surveyor that they had not been able to find the hospice care plan and had reached out to have hospice fax the care plan. On [DATE] at 9:49 a.m., the facility provided a copy of the hospice care plan to the survey team. No additional information was provided.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41449 Based on observation, staff interviews and clinical record review, the facility's quality assessment and assurance program failed to implement appropriate plans of action to correct identified quality deficiencies previously cited, having the potential to affect residents on two of the two nursing units. The findings included: The facility's quality assessment and assurance program failed to implement appropriate plans of action to correct quality deficiencies previously identified by the state survey agency and remained out of compliance during a revisit survey. During a survey conducted 3/3/25-3/6/25, the facility was identified and cited for several quality deficiencies which included, development and implementation of comprehensive resident centered care plans, failure to review and revise care plans, timely completion of drug regime reviews, unnecessary psychotropic medications, food storage, and COVID-19 immunizations. Following the survey, the facility submitted an approved plan of corrective action that included they would complete audits to identify other residents affected by the deficient practice and make corrective actions to bring the facility into compliance with the regulatory requirements. The facility alleged they would be completed with their approved plan of correction and be in regulatory compliance by 4/20/25. During this re-visit survey conducted 5/13/25-5/15/25, the survey team identified that the facility's quality assurance program had failed to implement a plan of correction to sustain ongoing compliance as continued deficient practice was identified in the same areas noted above. On 5/13/25, the facility staff failed to implement the comprehensive care plan and provide nutritional interventions for Resident #101, who had experienced a significant weight loss of 7.58 % in less than two months. The facility staff also had in the comprehensive care plan that the level of assistance needed with eating, Activity did not occur. According to the quality assessment and assurance committee's plan of correction developed it read, DON [director of nursing] or designee will audit 100% of SN [skilled nursing] residents care plan to ensure care plan has person-centered, comprehensive approaches with measurable, objectives and timeframes. Any discrepancies will be corrected promptly. SDC [staff development coordinator] or designee will educate all SN nurses and interdisciplinary team (IDT) on the facility policy for person-centered and accurate comprehensive care plan approaches for all residents. The DON or designee will review all new admissions to ensure baseline care plans are comprehensive, have specific measurable goals and outcomes and appropriate prevention strategies. These audits will occur weekly for one (1) month and monthly for two (2) months. Audit findings will be reported to the QAPI committee monthly for review, additional audits and education may be determined based on findings (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/25, the survey team identified the facility remained out of compliance involving residents #101 (R101) and resident #106 (R106), the facility staff failed to review and revise the care plans to reflect the resident's current needs. R101 had developed blanchable redness to the sacral area that they had implemented a preventative treatment for and implemented an air mattress that was not reflected in the care plan. R101 had a change in condition that required the order and implementation of oxygen continuously, which the care plan did not include. For R106, who had cognitive impairments and several falls, the facility staff failed to review and revise the care plan with interventions to prevent reoccurrence. According to the facility's submitted and approved corrective action plan indicated they were going to audit 100% of all residents' care plans, provide staff education and conduct audits to ensure ongoing compliance. They were going to conduct weekly audits for one month, then monthly for two months and be reported to the quality assurance committee. For resident #111 (R111) a medication regime review (MRR) was completed 3/13/25, by the pharmacist. The pharmacist made recommendations to the provider to conduct gradual dose reductions of two psychotropic medications that the resident had been on for nine and ten months with no attempted reductions. The recommendation was not responded to until 5/2/25, at which time the provider signed agreeing to the recommendation to conduct dose reductions of the two psychotropic medications but only wrote orders for one reduction. The delayed response to the recommendation resulted in R111 receiving psychotropics without the required gradual dose reductions or documentation of why it was contraindicated, which constituted unnecessary psychotropic medications. During the previous survey, the facility had been identified to have been out of compliance for the same regulations of not responding timely to medication regime reviews and unnecessary psychotropic medications. The facility implemented a plan of correction that included a review of 100% of the MRR's completed to ensure they were addressed timely. Education was provided to the medical providers and clinical managers. To ensure ongoing compliance audits were going to be conducted weekly for one month, then monthly for two months and findings would be reported to the quality assurance and performance improvement committee. During the survey conducted in March 2025, the tour of the kitchen revealed scoops being stored in bulk food items and pans wet nesting. During the kitchen tour conducted on 5/13/25, the same observations were again noted. According to the action plan that the facility submitted and indicated would be completed by 4/20/25, they indicated: The general manager (GM) has removed the scoop from the flour dispenser and discarded the remaining flour. The GM has also removed and re-sanitized the wet pans, then allowed them to air dry prior to storage. The GM will complete a 100% audit of all dry bulk food storage containers ensure areas of non-compliance are adequately addressed. The GM or designee will audit 100% of the ready-to-use serving pans to ensure proper storage. Any concerns will be addressed promptly. The GM will provide education to all SN Dining staff regarding proper storage of food and proper sanitation and storage of materials. The GM or designee will perform audits of the dry storage and pan storage areas to ensure items are stored and dried appropriately. These audits will occur weekly for one (1) month and monthly for two (2) months. Audit findings will be reported to the QAPI committee monthly for review, additional audits and education may be determined based on findings. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the annual recertification survey conducted March 2025, the facility was identified to have not offered a resident the COVID-19 vaccine. As their plan of correction, they indicated they an audit was conducted of all residents to ensure if they were not up to date, they were offered vaccines, and it was appropriately documented in the clinical record. On 5/14/25, the survey team identified that that Resident #106 had declined the vaccine but was given the vaccine despite the declination. The facility had alleged they were going to conduct audits to maintain ongoing compliance. When the facility administration was made aware of this by the survey team, they conducted an internal investigation and had not identified this concern prior. On 5/15/25 at 9:18 a.m., during a meeting with the Regional Director of Clinical Operations (RDCO), she explained that following the notification by the survey team of the findings on the evening of 5/14/25, they had implemented quality assurance and performance improvement plans for each of the area's identified and initiated staff education. The RDCO explained that everything we did we put a QAPI plan in place to make sure we are monitoring to sustain and solve this. That's the most important thing, is that we sustain the correction. The RDCO explained that the role of QAPI is, When we identify a problem we come together as a team and plan action steps and develop a goal of intent of what we are doing. We evaluate the outcome, meet weekly or monthly to review audits and determine if the action items are working or not. When asked what the failure was in the previous plan for them to have not maintained compliance for so many areas identified deficient in less than a month after they alleged, they were in compliance, the RDCO gave no clear explanation. The RDCO did provide the survey team with copies of Quality Care Action/Performance Improvement plans following the survey team's findings being shared on 5/14/25. The plans provided had Plan Development Date of 5/14/25 and 5/15/25. On 5/15/25 at 10:18 a.m., a meeting was held with the facility administrator and the quality assurance program was reviewed. The administrator indicated that the QA committee meets monthly and reviews the data from the prior month. The administrator explained that in the March 2025 QA meeting, data from February was reviewed. With regards to the survey conducted in March 2025 and the findings of the inspection the administrator said we discussed it outside of QAPI, in April when we submitted it [the plan of correction] they were involved in that during the April 29th meeting. We discussed the citations, what plan we were implementing, etc. During the above meeting the surveyor explained that in reviewing the facility's audits conducted, it identified on-going compliance concerns, and that correction had not been sustained. When the administrator was asked if the audits had been reviewed with the QA committee, she indicated they would be reviewed during the meeting held at the end of May. When asked if anyone is reviewing the audits and had identified that they had not achieved ongoing compliance, the administrator stated again that this will be reviewed in our May QAPI, but we do a daily meeting involving the administrator, Director of nursing, clinical members and discuss this daily. She went on to state that they had not identified the ongoing non-compliance. The administrator was then shown some of the audits that indicated ongoing compliance issues. The administrator was also shown some of the medication regime reviews conducted 3/14/25, that the provider signed and dated as being reviewed prior to it being conducted on 3/7/25, but the orders were not noted until 4/29/25. The audits for unnecessary psychotropic medications were conducted prior to their date of completion and there was no evidence of any monitoring following 4/20/25. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Quality Assurance Performance Improvement (QA/PI) Plan policy with a version date of 04/025 [sic], was reviewed. The policy read in part, The community will develop, implement and maintain an effective, comprehensive and data-driven QAPI program focused on outcomes of care and quality of life. The community will establish and maintain a QAPI Committee to oversee the QAPI process . How the QAPI Plan Will Address Key Issues: Departments in the Continuing Care will be involved in the development and execution of Quality Assurance Performance Improvement activities. The QAPI process will: . Develop and execute correction action or performance improvement activities . The above findings were discussed with the facility administrator on 5/15/25. No additional information was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49456 Based on observation, staff interview, and facility documentation, the facility staff failed to follow infection control standards during medication administration and failed to demonstrate proper use of transmission-based precautions on one of two units. The findings included: 1. The staff failed to wear the appropriate personal protective equipment (PPE) that was required for contact precautions before entering the resident room. On 5/13/25 at 2:00 p.m., a tour of the 200-healthcare unit was conducted. During the tour, a physical therapist aide, other staff #2 (OS2), was observed coming out of a resident's room into the hallway and grabbing a gown out of the PPE cart sitting outside the residents room. OS2 was not wearing any PPE when she came out of the resident's room to get the gown out of the PPE cart and was not wearing any PPE when she reentered the resident's room. On 5/13/25 at 2:10 p.m., an interview was conducted with a physical therapist, other staff #1 (OS1). OS1 was asked about the precautions directed by the sign on the resident's door. OS1 stated that it was for contact precautions. When questioned further, OS1 stated that the gown and gloves were to be on when you enter the room and was to be removed prior to coming out of the room. On 5/13/25 at 2:20 p.m., the director of nursing was sitting in the hallway by the elevator and said, They did not get the contact PPE right. The DON was informed that staff was observed entering the restricted room without having the PPE on that was required for contact precautions. The facility documentation was reviewed. The policy, titled Infection Prevention and Control Preventing Transmission of Infectious Agents, read in part, .staff will follow appropriate precautions in order to prevent the transmission of infectious agents. Implemented precautions will be in accordance with CDC [center of disease control] guidance and will follow a least restrictive possible approach. An end-of-day meeting was held with the administrator and the corporate staff, during which they were made aware of the above concerns. No additional information was provided prior to exit conference. 41449 2. During medication administration, the nurse (licensed practical nurse #4- LPN #4) failed to follow standard infection control practices by not wearing gloves, touching multiple surfaces with contaminated the gloves, and then directly handling the medications with contaminated gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 8:31 a.m., LPN #4 was observed to prepare and administer medications to a resident on the 200 unit. LPN #4 donned gloves and with her gloved hands took a set of keys from her pocket, opened the medication cabinet located in the resident's room, removed the medication package cards, and returned to the medication cart, touching the medication cart, computer, computer mouse, etc. LPN #4 was then observed removing/popping medications from the package cards directly into her gloved hands and then placed the pills into a medication cup, which were then administered to the resident. Following the above observations of LPN #4 preparing and administering the above medications, the surveyor asked LPN #4 about wearing gloves during medication administration. LPN #4 stated that she usually wears gloves because they don't want to chance touching a resident's medication. The surveyor discussed the observation of LPN #4 touching multiple surfaces with her gloved hands and then handling the pills with her gloved hands. LPN #4 expressed understanding the findings of infection control breaches. A review of the facility policy, titled Medication Administration, Receipt, Storage & Disposal, with a version date of 10/2023, was conducted. The policy read in part, . Medications are administered in accordance with Nursing Standards of practice and state law . No other information within the policy addressed the wearing of gloves during medication administration. On 5/14/25 at 4 p.m., during an end of day meeting, the facility administration and corporate staff were made aware of the above findings. The Regional Director of Clinical Operations (RDCO) confirmed that the expectation is for staff not to wear gloves during medication administration. On 5/15/25 at 9:18 a.m., the RDCO provided the survey team with evidence that they had initiated staff training to not wear gloves during medication administration. No additional information was provided.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49622 Based on staff interview, clinical record review, and facility document review, the facility staff failed to offer a pneumococcal vaccine in accordance with nationally recognized standards for (1) one of (5) five sampled residents reviewed for immunizations (Resident #1). The findings included: For Resident #1, the facility staff failed to offer the resident a pneumococcal conjugate vaccine 20 (PCV20) or a pneumococcal conjugate vaccine 21 (PCV21) at least one year after the pneumococcal conjugate vaccine 13 (PCV13) was administered. Resident #1's diagnosis list indicated diagnoses, which included, but not limited to Muscle Weakness, Dementia, Hypertensive Heart Disease, Anxiety Disorder, Occlusion and Stenosis of Bilateral Carotid Arteries, and Chronic Kidney Disease-Stage 2. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/11/25, assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. Resident #1 was over the age of [AGE] years when admitted to the facility. Surveyor reviewed Resident #1's pneumococcal vaccination history, and it revealed the resident received PCV13 pneumococcal vaccine on 12/7/20, there was no evidence the resident was offered a PCV20 or PCV21 at least one year after the administration of the PCV13. The Centers for Disease Control and Prevention (CDC) guideline titled, Recommended Adult Immunization Schedule for Ages [AGE] years or Older dated 12/28/23 read in part that adults aged [AGE] years or older who have previously received a dose of PCV13, should receive one dose of PCV20 or PCV21 at least one year after administration of PCV13. On 3/5/25 at 10:04 AM, surveyor met with the Infection Preventionist (IP) and discussed Resident #1's pneumococcal vaccination status. The IP stated she would look at the immunizations and follow-up with surveyor. At 2:10 PM, IP stated no evidence of Resident #1 being offered any other pneumococcal vaccine other than PCV13 on 12/7/20 could be located. This concern was discussed at the end of day meeting on 3/5/25 at 5:05 PM with assistant administrator #2, administrator, director of nursing, assistant administrator #4, assistant director of nursing, and clinical manager. Surveyor requested and received the facility policy titled, Infection Prevention and Control Preventing Transmission of Infectious Agents with a version date of 10/2022, that read in part, .Resident Pneumococcal vaccine history will be obtained and vaccines offered, per CDC guidelines on vaccine administration . (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to the exit on 3/6/25.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 49622 Based on staff interview, clinical record review, and facility document review, the facility staff failed to offer updated COVID-19 vaccines for (1) one of (5) five sampled residents reviewed for immunizations (Resident #15). The findings included: For Resident #15, the facility staff failed to offer the resident an updated 2023-2024 formula COVID-19 vaccine and an updated 2024-2025 formula COVID-19 vaccine. Resident #15's diagnosis list indicated diagnoses, which included, but not limited to Parkinson's Disease with Dyskinesia with Fluctuations, Muscle Weakness, Repeated Falls, Cognitive Communication Deficit, Glaucoma, Hypertension, Diabetes Mellitus-Type 2, Dementia, and Atrial Fibrillation. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/10/25 assigned the resident a brief interview for mental status (BIMS) summary score of 9 out of 15 for cognitive abilities indicating the resident was moderately impaired in cognition. A review of Resident #15's COVID-19 vaccination record revealed resident received a COVID-19 vaccination on 10/7/22. Surveyor was unable to locate evidence of the resident being offered an updated 2023-2024 formula COVID-19 vaccine or an updated 2024-2025 formula COVID-19 vaccine. On 3/5/25 at 10:04 AM, surveyor met with the Infection Preventionist (IP) and discussed Resident #15's COVID-19 vaccination status. The IP stated she would look at the immunizations and follow-up with surveyor. At 2:10 PM, IP stated no evidence of Resident #15 being offered updated COVID-19 vaccines could be located. The IP agreed Resident #15 should have been offered updated COVID-19 vaccines. This concern was discussed at the end of day meeting on 3/5/25 at 5:05 PM with assistant administrator #2, administrator, director of nursing, assistant administrator #4, assistant director of nursing, and clinical manager. Surveyor requested and received the facility policy titled, Infection Prevention and Control Preventing Transmission of Infectious Agents with a version date of 10/2022, that read in part, .Resident .COVID-19 vaccination history will be obtained and documented. The COVID-19 vaccine will be offered and administered based on CDC (centers for disease control) guidelines for vaccination . No further information regarding this concern was presented to the survey team prior to the exit on 3/6/25.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 21875 Based on observation, staff interview and facility document review, the facility staff failed to maintain the walk-in freezer in proper working order. The seal on the freezer door was in disrepair and had been in this condition for over seven months. The findings include: On 3/3/25 at 2:29 p.m., accompanied by the certified dietary manager (other staff #2), assistant general dietary manager (other staff #3) and the executive chef (other staff #1), the walk-in freezer was inspected. There was heavy frozen condensation observed across the ceiling of the freezer. Frozen condensation was observed on the fan grates positioned along the ceiling on the right wall of the freezer. Fine ice shavings were noted in the freezer floor. There was no observed contamination of food/product packaging, and the freezer temperature was acceptable. The certified dietary manager and executive chef were interviewed at this time about the condensation. The certified dietary manager stated there had been an issue with condensation on and off for months and that kitchen staff scraped/removed the condensation at least weekly. The certified dietary manager stated that work orders were written, and maintenance worked on the freezer, but the condensation problem had not been resolved. The certified dietary manager stated the freezer was old and in need of repair. The executive chef stated the freezer door was difficult to latch and that staff were reminded to use effort to be sure the door was latched when close. The executive chef stated the condensation had been an ongoing problem for months. On 3/4/25 at 3:07 p.m., the maintenance supervisor (other staff #5) and maintenance mechanic (other staff #4) were interviewed about the freezer condensation. The maintenance mechanic stated the door seal on the freezer was bad. The maintenance mechanic stated an outside vendor assessed the condensation issue and determined the freezer door needed replacement. The maintenance supervisor stated the freezer door did not latch unless closed tightly with manual effort because the door seal was in disrepair. The maintenance supervisor stated the outside vendor provided a quote to fix the freezer door months ago, but the door had not yet been replaced. When asked when the door was expected to be repaired, the maintenance supervisor stated, That's above my pay grade. The maintenance supervisor presented an outside vendor quote regarding the freezer dated 7/31/24 stating, During our visit on 7/19/24, the technician found the walk-in door need to be replaced . This finding was reviewed with the administrator, director of nursing and assistant administrators during a meeting on 3/4/25 at 5:15 p.m.