STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amelia Rehabilitation and Healthcare Center	8830 Virginia Street Amelia, VA 23002

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to protect the resident's right to be free from financial exploitation for one resident (Resident #2) in a survey sample of fourteen residents. The findings included:On 5/14/26 at approximately 2:45 PM, an interview was conducted with Resident #2 (R2) in his room. When asked about an incident involving money being taken from him, R2 did reported that a staff member had taken money using his debit card, but she no longer worked there. R2 asked the surveyor to talk with the activities director and was reluctant to discuss the incident in detail. On 5/14/26, through staff interviews, it was determined that the activities director was not working that day and was not available for interview. On 5/14/26 a clinical record review was conducted of R2's chart. This review revealed R2 had diagnosis that included, but were not limited to cerebral palsy, major depressive disorder, contracture of the muscle, generalized anxiety disorder, and insomnia. According to R2's most recent minimum data set (an assessment) with an assessment reference date of 2/21/26, R2 was coded as having a brief interview for mental status score of 15 of 15, indicating he was cognitively intact. According to the clinical record there was no documentation of the incident/financial exploitation other than a progress note dated 5/11/26 that read, Resident received his direct express card, Resident requested for SS [social services] to help him, set up a new pin. SS assisted resident with setting up a new pin. Resident has his card and all mail that came with it. On 5/15/26 at 11:43 AM, a telephone interview was conducted with the facility's Activity Director (AD). The AD reported that ON Monday, May 4, [R2's name redacted] came to my office and asked me to check the balance on his debit card, he does this all the time. I dial the numbers for him and put it on speaker phone. When I checked his balance was low, he said something doesn't make sense and I asked if he wanted to listen to the transactions and he said yes. We listened to the transactions that told the dollar amount of each transaction; I wrote them down. One was a $604 ATM [automated teller machine] withdrawal. He hadn't been anywhere, so we selected the option for the details. It said it was an ATM transaction made on 5/1/26 at the [grocery store name redacted] in [city name redacted]. I realized something was going on and reported it to the administrator. I called my staff and [Activities Assistant #1's name redacted] asked if she knew anything about it, she said she didn't know anything about it. The Administrator asked her to come back out here and talk to her before starting work. She told the Administrator she didn't know anything about it, but when the police went and talked to her [Activities Assistant #1] she confessed she took the card, got the money out of the ATM, and we fired her. During the above interview, the AD was asked how someone would have gotten access to the debit card and she reported, His card lived in the lock box in my office. When asked why and if she kept anyone else's debit card, the AD said, No and stated that R2 was a special case, before I was the activity director thee one before me helped him with setting it up and he asked them to keep it. I inherited the lock box with the card in it; he is his own RP so after this we gave it to him. The AD went on to report, Apparently Monday when trying to figure out what was going on, [the activity assistant #1's name redacted] came after everyone got off and went to his room and got him to write a statement and gave it to the Administrator. She [the Activity Assistant #1] was arrested with a felony. On 5/15/26 at 2:01 PM, an interview was conducted with the (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Business Office Manager (BOM). When asked to discuss what she knew about R2's debit card being used by a staff member, the BOM said, All I know is they had contacted the administrator when they realized something did not add up with his debit card. I was not involved in the investigation. I handle the resident trust account, and he didn't have one at the time. When asked how it came to be that the activities department had R2's debit card, the BOM said, that had been in place for years. The BOM went on to report when they found out R2's debit card was compromised, they assisted R2 to cancel the card and a new card has been received and is now in R2's possession. The BOM went on to report that they have ordered a secured lock box for R2 to be able to keep the card and any other important items in. On 5/15/26 at 2:13 PM, an interview was conducted with the Social Services director (SSD). When asked to discuss what she knew about the incident involving R2, the SSD said, I wasn't with him when he first found out the information. I did talk with him afterwards and of course he was upset; we took the steps and called the police, and, in the end, he got his money back and was very happy about that. The SSD reported not really having any knowledge of how residents' money or bank cards are handled and stated she would need to talk with the business office manager. On 5/15/26 at 2:19 PM, an interview was conducted with the facility Administrator. The Administrator said, It was on the 4th day of May, the activities director came in here and said she had an issue with one of the resident's funds being accessed and we felt like it was taken, so I had some very basic information at that time. I instructed her [Activities Director] to take the lock box and put it in the business office. His card and any other contents were to be counted off with the Business Office Manager. When asked if it was common practice for activities to keep resident's bank cards, the Administrator said, It has been in this instance, it had been the practice that this resident needed assistant to access his funds and order things. During the above interview, the Administrator went on to report that So then she [Activity's Director] said she had talked to two of her assistants and was waiting to hear back from two more. She had left messages. I immediately called the other two and left messages for them as well. I interviewed the resident and he was a little confused about the money, was unsure if someone had taken it out, I asked if he wanted me to the call the police and he just kept saying he trusted [Activity's Director's name redacted]. I let him know no one was in trouble, we just had to protect his funds. We [activity's director and Administrator] left at 5:30 PM, agreed that if we heard from the other two assistants, we would let the others know. I spoke with one of them and she said she hadn't done it, didn't know who did, and didn't suspect anyone. [Activity's Director's name redacted] texted and said she talked with the [activities assistant #1's name redacted] who said she remembered she did it, we agreed that was sort of strange that you don't remember when asked the first time. She was scheduled to work the next day, so we told her to come in at 8AM to meet with me. I rolled up at 7:30 AM and she was coming into the building. I grabbed the Director of Nursing (DON) and we interviewed her. She (Activity Assistant #1) said ?yeah, I probably shouldn't have done it.' I didn't know she had spent the money. I told her she was suspended, we had her give a statement and she gave me what [R2's name redacted] had written out. The Administrator provided the surveyor with a file of the investigation conducted by the facility. Within the file was a statement from R2 that read, I sent [activity assistant #1's name redacted] to go out to send money, which was signed by R2. There was also a statement from the activity assistant #1 who wrote, On May 1st, Friday I was asked to go see [R2's name redacted]. When I came to his room he asked me to go to the atm. I went on my lunch break and got the money for him to mail off to someone. I had him sign a paper saying he let me go. On 5/15/26, a follow-up interview was conducted with the facility Administrator about the statement written by R2 that was in the facility investigation file. The Administrator reported that after they all left work for the day, the Activity Assistant #1 returned to the facility and coerced R2 into writing that document. The nurse saw her in the room and found it suspicious given the time of day and asked the employee to leave the facility. Also within the file was a statement from a certified nursing assistant who stated, that R2 reported, I'm so pissed right now. someone who works here stole $600 from my card at the ATM. R2 also reported that he was scared (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	he would get kicked out if he reported it. According to the facility submitted documents, R2's misappropriated funds were returned to him and there was a copy of a check made payable to the resident in the amount of $600 in the file. The facility conducted an audit to ensure no other residents were affected, re-educated all facility staff on the abuse policy, conducted a root cause analysis, implemented that all financial items were relocated to the business office and access was restricted and a sign-in/sign-out dual control process was implemented. The Administrator was asked why the resident was only reimbursed $600 versus the $604 that was debited from his account. The Administrator reported that the police had arranged for the resident to be re-paid, and she thought it was the employee's stepfather who provided the reimbursement of the funds. The Administrator and the Regional Director of Clinical Services (RDCS) stated the $4 was the ATM fee and they hadn't thought of it. The RDCS went and gave R2 the $4. The facility's undated policy titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation was received and reviewed. The policy read in part, . The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation. On 5/15/26 at 4:15 PM, after consulting with the state agency supervisory team, immediate jeopardy (IJ) was identified regarding financial exploitation, which began on 5/2/26. The facility administrator was provided a copy of the Immediate Jeopardy (IJ) template. The facility had self-identified the non-compliance and implemented a full plan of correction and achieved past non-compliance with a compliance date of 5/11/26. Following the removal of IJ the scope and severity was lowered to a level two isolated. No additional information was provided.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to take measures to protect the resident from an alleged perpertrator who financially abused the resident while an investigation was being conducted for one resident (Resident #2-R2) in a survey sample of 14 residents. The findings included:On 5/14/26 in the afternoon, an interview was conducted with R2. R2 reported that his debit card was taken and money was removed from his bank account in the amount of $604. R2 said he had gotten his money back. On 5/14/26, the administrator provided the survey team with the facility's investigation file of the incident. Within the file was a signed statement from R2 that indicated he had asked the activity assistant to get money from his account. On 5/15/26 at 2:19 PM during an interview with the facility administrator, the statement referenced above was questioned. The administrator stated that after the investigation was initated and the activity assistant was suspended. That evening, on 5/4/26, after the adminstrative staff had left the facility, the employee returned to the facility and had the resident sign that statement. The facility administrator confirmed that facility's abuse policy indicates that staff involved or suspected of abuse are to be removed from the facility until the investigation is complete to protect the resident. According to the facility's abuse policy titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation read in part, . v. Protection: The facility will protect residents from harm during an investigation . On 5/15/26, during an end of day meeting, the facility administrator was made aware of the above findings. No additional information was provided.

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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** Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to develop and implement a comprehensive resident centered care plan for two of fourteen residents (Resident #1-R1 and Resident #11-R11). The findings included: 1. For Resident #11 (R11), the facility staff failed to develop a comprehensive care plan to include the residents' desire and wishes to be a Do Not Resuscitate. On [DATE], during a clinical record review, it was noted that R11 had a physician order dated [DATE] that indicated a Do Not Resuscitate code status. Within the clinical record R11 had a signed Durable Do Not Resuscitate form on file that had been executed on [DATE], prior to admission. Review of R11's care plan there was no evidence of the request for any advance directives or code status (wishes in the event of a cardiopulmonary arrest) event. On [DATE] at 2:01 PM, an interview was conducted with the care plan coordinator (CPC). When asked about care plans, the CPC stated that the care plan is a resident specific document used by all staff to let them know what care the resident needs and how to provide for their needs. When asked if their code status was something that would be in the care plan, the CPC said, yes. On [DATE], during an end of day meeting, the above findings were reviewed with the facility administrator and director of nursing. No additional information was provided. 2. For Resident #1, the facility failed to implement comprehensive care plan on resident's advance directive for full code status. Per clinical record review, a progress note dated [DATE], R1 was observed not breathing and without a heartbeat. A review of R1's care plan revealed the care plan focus, Mr. [name redacted] R1 has advanced directives: Full Code, Date Initiated: [DATE], Revision on: [DATE], Cancelled Date: [DATE] with interventions to include Perform CPR (cardiopulmonary resuscitation). Notify physician of any change. The facility nurse failed to implement R1's care plan for Full Code by not initiating cardiopulmonary resuscitation upon finding R1 not breathing and without a heartbeat despite R1 having a Full Code status. Resident #1 was originally admitted [DATE] and re-admitted [DATE] after a hospitalization for evaluation and treatment of sepsis secondary to a urinary tract infection. Diagnoses included but are not limited to hypertension, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, pulmonary emphysema, anemia, chronic obstructive pulmonary disease and Alzheimer's disease. A clinical record review revealed nurse progress note by RN#1(Registered Nurse) dated [DATE] at 7:42AM revealed, This RN was called to residents (R1) room. Resident (R1) noted to be lying in bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No heart or breath sounds at this time. Resident (R1) warm and clammy to touch. LPN #1 [name redacted] notified and is contacting resident family and (name redacted) Nurse Practitioner (NP). A progress note documented dated [DATE] at 7:45 AM by LPN#1 (Licensed Practical Nurse), read in part, Writer notified NP, [name redacted] and (RP) Responsible Party, [name redacted] of resident (R1) expiring. RP requested that Funeral Home be notified and that resident (R1) would have family coming to facility prior to funeral home picking him up. Certified nursing assistants in complete post-mortem care. Writer has notified funeral home and of the personal request that writer notify them after family leaves. A progress note (discharge summary) documented by the NP (Nurse Practitioner) dated [DATE] at 8:00 AM, read in part Patient was found by RN#1(Registered Nurse) at 7:42 AM with no heartbeat or breath sounds. This NP was notified at 7:44 AM that patient was pronounced deceased . Progress notes also revealed R1 with code status, FULL CODE. On [DATE] at 9:35 AM, the NP was interviewed on incident with R1 observed not breathing and without a heartbeat and stated, the nurse called me that morning to inform me that Mr. (name redacted) R1 had expired. I had him on my list to discuss his code status with his family, but this happened before I got around to it. On [DATE] at 11:47 AM, an interview was conducted with RN#1. According to RN#1, she was rounding with the Wound Nurse Practitioner when two of the certified nursing assistants came looking for me so I could pronounce Mr. [name redacted] R1. I went to get my stethoscope, LPN#1 told me Mr. (name redacted) R1 did not have heartbeat or breath sounds, I pronounced him, I checked his pulse and breathing and pronounced him. That is typically our protocol. Normally I would know their code status. I took her (LPN#1's) word for it that he was a DNR (Do Not Resuscitate). I did not know until I was called into the office that he was a Full Code. I think I had one other time to pronounce death of a resident. I am the facility's wound nurse and as wound nurse, I would check the resident's code status for those residents I see. When asked if she thought the resident's wishes were honored, she responded, No, not if his wishes were for a FULL CODE and we did not do anything for him. I did not get report that morning as I was doing wounds, I only get report if a resident has a fall or new admission. I have been employed here since [DATE] and the other resident I pronounced was a resident receiving hospice services. When asked what the facility had done since this event she stated, They re-educated all of us on our responsibility to know and honor the resident's right for advanced directives to include code status, they implemented a DNR binder which is at each nurse's station and where to locate the resident's code status like on the resident dashboard in computer record system and to report during shift report, especially for fragile residents or those with change in condition. On [DATE] at 1:35 PM, a telephone interview was conducted with (Licensed Practical Nurse) LPN#1 who was the nurse on duty [DATE] caring for Resident #1. LPN#1 when asked about R1 not breathing and without a heartbeat on [DATE], she responded, The aides called me to R1's room, I could see he was not breathing, I checked him to see if he had a pulse and he did not have a heartbeat. I told the aides to get the RN (registered nurse) as I am an LPN and could not pronounce death. I did not check his code status, I don't know why, I just didn't - he wasn't breathing and he did not have a heartbeat, so I asked them to get the RN to pronounce him, and no, I did not start CPR. When asked if 911 was called or if anyone asked what R1's code status was she responded No, I have beat myself up over this, they suspended me immediately and I just came back yesterday [DATE]. I have been a nurse for 28 years and have never had a write-up or any disciplinary actions against me. I am just so torn up (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	over this. They re-educated me and everyone else on our responsibility to honor the residents' right for advanced directive and code status, so now I know how to check the code status, it is on the resident's dashboard in the computer chart and in the DNR (Do Not Resuscitate) binder at the nurse's station. I just don't know why I didn't think about his code status. On [DATE] at 2:00 PM, an interview was conducted with C.N.A #5 who was one of the C.N.A.'s on duty with R1 on [DATE]. According to C.N.A#5 when she entered R1's room after report that morning he didn't look right so looked closer and did not see him breathing, I went to get the nurse and Miss [name redacted] LPN#1 came and checked his pulse on his neck and wrist and looked at his breathing and told me to go get Miss[name redacted] RN#1 because she needed an RN to pronounce him. So C.N.A. #5 and I went to find Miss [name redacted] RN#1. When asked if anyone called 911 or attempted CPR, she said, No. On [DATE], during a telephone interview with LPN#1, she was asked what the care plan purpose was. She responded, the care plan tells us what the resident's needs are and what the staff should be doing to address those needs. When asked if Mr. [Name redacted] R1's care plan was carried out as he had a care plan focus for Full Code status with an intervention to perform CPR, she stated, we did not follow his care plan.

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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. Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to review and revise the care plan for one resident (Resident #8-R8) in a survey sample of 14 residents. The findings included:For R8, the facility staff failed to review and revise the care plan to include the resident's code status of a DNR (do not resuscitate). On 5/14/26, during a clinical record review it was noted that R8 had a physician order dated 2/19/26, that read Do Not Resuscitate DNR. In the miscellaneous tab of the chart was a Durable Do Not Resuscitate signed and dated 2/19/26. According to R8's care plan a focus area initiated 1/22/26 that was revised on 3/23/26 read, [R8's name redacted] has exercised the right to self-determination. [R8's name redacted] has decided after informed decision making to be: Full Code. On 5/14/26 at 2:01 PM, an interview was conducted with the care plan coordinator (CPC). When asked about the purpose of a care plan, the CPC said, that is something that is developed and used by everyone on the interdisciplinary team. It is used as a guide to show what care to provide to the residents. It gives you a quick picture of the resident. Information included is ADL's (activities of daily living- bathing, dressing, toileting, etc.), if on any particular medication, if have any infections, activities, nutrition, and if there is anything more resident specific that require interventions. When asked if they have advance directives, does that go on the care plan? The CPC said, Yes. When asked, if they change code status, do you expect that change to be on care plan? The CPC said yes, anyone can update but here social services is responsible.On 5/14/26, during an end of day meeting the above findings were reviewed the facility administrator, director of nursing and regional director. No additional information was provided.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and clinical record review, the facility staff failed to ensure that basic life support, including cardio-pulmonary resuscitation (CPR), was initiated to a resident. This resulted in a failure to adhere to the resident's specific advance directive and code status for one of 14 residents in the survey sample, Resident #1 (R1).Findings included:On the morning of [DATE], R1 was observed not breathing and without a heartbeat. The facility nurse failed to initiate cardiopulmonary resuscitation despite R1 having a Full Code status.Resident #1 was originally admitted [DATE] and re-admitted [DATE] after a hospitalization for evaluation and treatment of sepsis secondary to a urinary tract infection. Diagnoses included but are not limited to hypertension, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, pulmonary emphysema, anemia, chronic obstructive pulmonary disease and Alzheimer's disease.A clinical record review revealed nurse progress note by RN#1(Registered Nurse) dated [DATE] at 7:42AM revealed, This RN was called to residents (R1) room. Resident (R1) noted to be lying in bed. No heart or breath sounds at this time. Resident (R1) warm and clammy to touch. LPN #1 (name redacted) notified and is contacting resident family and (name redacted) Nurse Practitioner (NP).A progress note documented dated [DATE] at 7:45 AM by LPN#1 (Licensed Practical Nurse), read in part, Writer notified NP, (name redacted) and (RP) Responsible Party, (name redacted) of resident (R1) expiring. RP requested that (name redacted) Funeral Home be notified and that resident (R1) would have family coming to facility prior to funeral home picking him up. Certified nursing assistants in complete post-mortem care. Writer has notified funeral home and of the personal request that writer notify them after family leaves.A progress note (discharge summary) documented by the NP (Nurse Practitioner) dated [DATE] at 8:00 AM, read in part Patient was found by RN1(Registered Nurse) at 7:42 AM with no heartbeat or breath sounds. This NP was notified at 7:44 AM that patient was pronounced deceased . Progress notes also revealed R1 with code status, FULL CODE.A review of R1's care plan revealed care plan focus for, Mr. (name redacted) R1 has advanced directives: Full Code, Date Initiated: [DATE], Revision on: [DATE], Cancelled Date: [DATE] with interventions to include Perform CPR. Notify physician of any change.A review of R1's physician orders for code status revealed a Full Code order dated [DATE], discontinued [DATE] and re-instated and signed by nurse practitioner on [DATE].On [DATE] at 9:35 AM, the NP was interviewed on incident with R1 observed not breathing and without a heartbeat and stated, the nurse called me that morning to inform me that Mr. (name redacted) R1 had expired. I had him on my list to discuss his code status with his family but this happened before I got around to it.On [DATE] at 11:47 AM, an interview was conducted with RN1. According to RN#1, she was rounding with the Wound Nurse Practitioner when two of the certified nursing assistants came looking for me so I could pronounce Mr. (name redacted) R1. I went to get my stethoscope, LPN#1 told me Mr. (name redacted) R1 did not have heartbeat or breath sounds, I pronounced him, I checked his pulse and breathing and pronounced him. That is typically our protocol. Normally I would know their code status. I took her (LPN#1's) word for it that he was a DNR (Do Not Resuscitate). I did not know until I was called into the office that he was a Full Code. I think I had one other time to pronounce death of a resident. I am the facility's wound nurse and as wound nurse, I would check the resident's code status for those residents I see. When asked if she thought the resident's wishes were honored, she responded, No, not if his wishes were for a FULL CODE and we did not do anything for him. I did not get report that morning as I was doing wounds, I only get report if a resident has a fall or new admission. I have been employed here since [DATE] and the other resident I pronounced was a resident receiving hospice services. When asked what the facility had done since this event she stated, They re-educated all of us on our responsibility to know and honor the resident's right for advanced directives to include code status, they implemented a DNR binder which is at each nurse's (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	station and where to locate the resident's code status like on the resident dashboard in computer record system and to report during shift report, especially for fragile residents or those with change in condition.On [DATE] at 1:35 PM, a telephone interview was conducted with (Licensed Practical Nurse) LPN#1 who was the nurse on duty [DATE] caring for Resident #1. LPN#1 when asked about R1 not breathing and without a heartbeat on [DATE], she responded, The certified nursing assistants called me to R1's room, I could see he was not breathing, I checked him to see if he had a pulse and he did not have a heartbeat. I told the aides to get the RN (registered nurse) as I am an LPN and could not pronounce death. I did not check his code status, I don't know why, I just didn't - he wasn't breathing and he did not have a heartbeat, so I asked them to get the RN to pronounce him, and no, I did not start CPR. When asked if 911 was called or if anyone asked what R1's code status was she responded No, I have beat myself up over this, they suspended me immediately and I just came back yesterday [DATE]. I have been a nurse for 28 years and have never had a write-up or any disciplinary actions against me. I am just so torn up over this. They re-educated me and everyone else on our responsibility to honor the residents' right for advanced directive and code status, so now I know how to check the code status, it is on the resident's dashboard in the computer chart and in the DNR (Do Not Resuscitate) binder at the nurse's station. I just don't know why I didn't think about his code status.On [DATE] at 2:00 PM, an interview was conducted with C.N.A #5 who was one of the C.N.A.'s on duty with R1 on [DATE]. According to C.N.A#5 when she entered R1's room after report that morning he didn't look right so looked closer and did not see him breathing, I went to get the nurse and Miss (name redacted) LPN#1 came and checked his pulse on his neck and wrist and looked at his breathing and told me to go get Miss (name redacted) RN#1 because she needed an RN to pronounce him. So C.N.A. #5 and I went to find Miss (name redacted) RN#1. When asked if anyone called 911 or attempted CPR, she said, No. The facility returned to substantial compliance on [DATE] after implementing the following corrective actions:Corrective action for the Affected ResidentThe incident was investigated by the Director of Nursing and Administrator. The residents' record was reviewed and confirmed to reflect Full Code status. The physician and responsible party were notified. The nurse involved received corrective action, retraining and competency. An interdisciplinary review was completed.Identification of Other ResidentsA 100% audit of all residents was completed to verify accuracy of code status orders across documentation. Both goldenrod binders were audited by the Director of Nursing for accuracy. Any discrepancies were corrected immediately. Staff were re-educated on verification of code status during emergencies. Nursing CPR (cardiopulmonary resuscitation) audit was completed to ensure all certification s are current.Systemic ChangesPolicies were reviewed and revised, if indicated, to require verification of code status at key care points and prior to emergencies. Code status is now clearly displayed in the medical record and care tools. Staff received education and completed a code blue drill on [DATE]. Emergency protocols now include a mandatory verification step during the admission process and code blue drills will be completed on all shifts monthly x 3, then quarterly. Education and CPR competency skills will be added to the new hire orientation process.MonitoringThe Director of Nursing will conduct weekly audits for 4 (four) weeks, then monthly for 3 (three) months to ensure all new admission code status is entered into the resident record upon admission, and MOCK code drills will be completed monthly x 3 (three) months, then ongoing on a quarterly basis. The Director of Nursing/Designee will interview 5 (five) nurses weekly x 4 (four) weeks, then monthly x 2 (two) months to ensure nurses know how to determine code status. Results will be reviewed through QAPI (Quality Assurance Performance Improvement, non-compliance will result in corrective action.Date of ComplianceCompliance was achieved on [DATE] when audits, education, and system changes were completed.On [DATE], the survey team verified all components of the Immediate Jeopardy (IJ) by:1. Verifying corrective action for LPN#1 and RN#1to confirm re-education, retraining and competency on CPR skills and verification of residents' code status. Verified current CPR (cardiopulmonary resuscitation) certification for LPN#1 and RN#1.2. Five resident charts were reviewed to verify code status order matched care plan and code status was (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	displayed on the resident dashboard. Verification that goldenrod binders were at each nursing station and reviewed code status for five residents in the binders.3. Reviewed education attendance sheets and interviewed licensed nurses, certified nursing assistants and therapy staff on what steps to take when they observe a resident who is not breathing and without a heartbeat. All confirmed they had received additional education since [DATE] incident and were able to articulate actions and where to locate the resident's code status. Reviewed attendance sheets on code blue drills that included nursing staff, activities, social services, business office manager, human resources, admissions staff, dietary and environmental staff dated [DATE]. The surveyor verified CPR and AED (automated external device) skills checklists were completed on all licensed nurses.4. Reviewed facility polices used in the staff's re-education: Do Not Resuscitate Order, Advance Directives, Emergency Procedure- Cardiopulmonary Resuscitation, and Compliance with Reporting Allegations of Abuse/Neglect.The survey team accepted the facility's past non-compliance on [DATE], no plan of correction is required.On [DATE] during the end of day meeting, the above findings were reviewed with the Administrator, Director of Nursing and Regional Director of Clinical Services, including the [NAME] President of Operations and Chief Clinical Nursing Officer via telephone conference. No further information was provided.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on staff interviews and facility document review, the facility failed to ensure RN (registered nurse) coverage included 8 (eight) consecutive hours for 2 (two) days of the past 30 (thirty) days on 2 (two) of 2 (two) units, (4/24/26, 4/30/26).Findings included:A review of staffing records was completed for the period of 4/14/26 through 5/14/26 revealing 4/24/26 had no RN coverage and 4/30/26 revealing 7.62 hours RN coverage.On 5/15/26, an interview was conducted with the Administrator, Director of Nursing and the Regional Director of Clinical Services who confirmed that 8 (eight) consecutive hours of RN coverage was a requirement and they strived to comply. The staffing sheets were reviewed with the facility management team noting no RN coverage for 4/24/26 and 4/30/26 without 8 (eight) consecutive hours.No further information was provided.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on staff interview and facility documentation review, the facility staff failed to ensure all staff received mandatory training on effective communication for six of six employees reviewed for training (RN #1, LPN #6, CNA #5, 6, 7, and 8). The findings included:On 5/14/26, as part of the extended survey review a sample of six employees were selected for review of training. The facility administrator was given the list of six employees and asked to provide their training records. On 5/15/26, the training records revealed that none of the six sampled employees (registered nurse #1, licensed practical nurse #6, and certified nursing assistants #5, 6, 7, and 8) had received training on effective communication. On 5/15/26, the above findings were reviewed with the facility's administrator, director of nursing (DON), and regional director of operations. On 5/15/26 at 2:06 PM, an interview was conducted with the DON and Regional Director, when asked how they identify training needs of staff they reported that based on policies and sometimes just talking to people or employees. When asked about training on effective communication, they reported that is not a topic included within their training program. The above findings were reviewed with the administrator, DON and regional director of operations. No additional information was provided.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on staff interview and facility documentation review, the facility staff failed to ensure part of the facility's Quality Assurance and Performance Improvement (QAPI) program included training to facility staff on the program elements and goals for six of six employees reviewed (licensed practical nurse #6- LPN 6, registered nurse #1-RN 1, and certified nursing assistants #5, 6, 7, and 8). The findings included:On 5/14/26 during an extended survey review of staff training a sample of six employees was selected for review. The facility administrator was asked to provide evidence of each employees training. Review of the employee training records for LPN #6, RN #1, and CNA #5, CNA #6, CNA #7, and CNA #8, none of the employees had received training on the facility's quality assurance program elements and goals. On 5/15/26 at 2:06 PM, during an interview with the facility's director of nursing (DON) and regional director, the above findings were reviewed. They confirmed that their training program did not include training on the QAPI program. No additional information was provided.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on staff interview and staff record review, the facility staff failed to ensure two of six employees had trianing on infection control (certified nursing assistants #6 and #8). The findings included:On 5/14/26 as part of the extended survey, a sample of six employees was selected for review of training requirements. The facility administrator was asked to provide evidence of each employees training. Review of the employee training records for CNA #6 and CNA #8, revealed no evidence of infection control training having been received. On 5/15/26 at 2:06 PM, during an interview with the facility's director of nursing (DON) and regional director, the above findings were reviewed. They confirmed that all staff should have training on infection control. No additional information was provided.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on staff interview and staff record reviews, the facility staff failed to ensure that staff were trained in compliance and ethics for two of six staff sampled (Certified nursing assistant #7- CNA 7 and certified nursing assistant #8- CNA 8). The findings included:On 5/14/26 as part of the extended survey, a sample of six employees was selected for review of training requirements. The facility administrator was asked to provide evidence of each employees training. Review of the employee training records for CNA #7 and CNA #8, revealed no evidence of compliance and ethics having been received. On 5/15/26 at 2:06 PM, during an interview with the facility's director of nursing (DON) and regional director, the above findings were reviewed. They confirmed that all staff should have training on compliance and ethics. No additional information was provided.