STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495391	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenburnie Rehab & Nursing Center	1901 Libbie Ave Richmond, VA 23226

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide care in a dignified manner for one of eight residents in the survey sample, Resident #4.The findings include:For Resident #4 (R4) the facility staff failed to provide dignity to the resident by offering incontinence care on 10/28/25 from 10:07 a.m. through 5:30 p.m.On 10/28/25 a.m., R4 was observed without interruption from 10:07 a.m. until 5:30 p.m. During this time, R4 was sitting in her wheelchair. A staff member moved her from her room to the day room at 10:10 a.m. Following the move to the day room, the resident was moved by staff back and forth between the day room, activities room, and dining room. This observation was continuous with no interruptions. At no time did any staff member wheel the resident back to her room to provide incontinence care.On R4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/9/25, she was coded as being severely cognitively impaired for making daily decisions, having scored only two out of 15 on the BIMS (brief interview for mental status). She was coded as sometimes understanding others and as sometimes being understood by others for communication. She was coded as always incontinent of both bladder and bowel, and as requiring the assistance of staff for toileting.On 10/29/25 at 10:07 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated if she cares for a resident who is incontinent and cannot walk independently to the bathroom, she checks the resident for incontinence every hour or two. She stated that two hours is the maximum amount of time that should elapse between incontinence checks. She stated that after two hours, a resident's skin can begin to break down. She stated if a resident refuses an incontinence check, the charge nurse should be notified, and multiple attempts should be made to convince the resident to allow the care.On 10/29/25 at 10:16 a.m., CNA #2 was interviewed. She stated she is the lead CNA on the unit where R4 resides. She stated that as a lead CNA, she is responsible for making sure the floor and residents' rooms are clean and tidy. She also is responsible for doing walking rounds at the end of every shift with all the CNAs to make sure they have completed all the tasks for their shift that is ending. She explained that incontinent residents should be checked a minimum of every two hours, with some residents requiring more frequent checks. She stated that when she is responsible for caring for R4, she checks her more frequently than every two hours because the resident is not able to tell the staff if she needs incontinence care. She stated that even if R4 is in the activities room or the dining room, incontinence checks are still a priority and should be done at least every two hours.On 10/29/25 at 10:30 a.m., LPN (licensed practical nurse) #1, a unit manager, was interviewed. She stated that residents who are incontinent and require assistance should be checked every two hours. She stated that once a staff member gets to know the residents' needs better, they may check on them more frequently than every two hours. She stated a resident's skin starts to break down after two hours. LPN #1 stated that if a resident is not provided incontinence care for an extended time, the resident is not being treated with personal dignity.On 10/29/25 at 12:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations were interviewed. All three management staff members agreed that if a resident is not offered incontinence care for an extended period of time, they may suffer emotional distress and a lack of a dignified quality of life. At this time, these management staff members were informed of the concerns related to the lack of incontinence care for R4. A policy regarding treating residents with dignity was requested.No additional information was provided prior to exit.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to ensure resident rights by accommodating the needs of one of eleven residents in the survey sample, Resident #104 (R104). The findings include: The facility staff failed to ensure accommodation of needs for R104's call bell was implemented. R104 was admitted to the facility on [DATE] with diagnoses that include but are not limited to: diabetes mellitus, pressure injury and embolism.R104's most recent MDS (minimum data set) assessment, a five-day Medicare assessment, with an assessment reference date of 10/31/25, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. MDS Section G- Functional Status: coded the resident as moderate assistance with bed mobility; total dependence for transfers, dressing, hygiene and bathing. A review of MDS Section M-Skin Conditions: coded the resident as two unstageable pressure injury (PI), POA (present on admission).A review of the comprehensive care plan dated 10/29/25 revealed, FOCUS: Resident is at risk for falls related to weakness. INTERVENTIONS: place common items within reach of the resident, remind the resident to use their call light to ask for assistance with ADLS (activities of daily living).On 12/10/25 at 10:20 AM, observed the call bell in Resident 104 (R104)'s room dangling from side rail to the floor. Resident did not know where the call bell was and could not reach it. An interview was conducted on 12/10/25 at 10:25 AM with LPN (licensed practical nurse) #2, when asked where the call bell was located for R104, LPN #2 stated, it must have fallen off the bed when I was in here earlier. It was on the bed before then. The ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, and ASM #3, the vice president of operations was made aware of the finding on 12/10/25 at 4:00 PM.A review of the facility's Nurse Call System policy revealed, Inspect push button cords in all patient/public restrooms/shower rooms and verify each cord has a clip and that cord is not in contact with the floor.No further information was provided prior to exit.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interview, facility staff failed to maintain a homelike environment for one of 11 resident rooms observed, resident room [ROOM NUMBER]-B. The findings include:For resident room [ROOM NUMBER]-B, facility staff failed to maintain a section of wall in good repair. On 12/09/2025 at approximately 1:50 p.m., an observation of resident room [ROOM NUMBER]-A revealed a section of wall behind the head-of-the-bed roughly plastered, measuring approximately 15 inches wide and 36 long. Further observation revealed white plaster dust coating the top of the headboard of the bed and coating the floor under the head of the bed. Call bell within reach. On 12/10/2025 at approximately 8:05 a.m., an observation of resident room [ROOM NUMBER]-A revealed a section of wall behind the head-of-the-bed roughly plastered, measuring approximately 15 inches wide and 36 long. Further observation revealed white plaster dust coating the top of the headboard of the bed and coating the floor under the head of the bed. On 12/10/2025 at approximately 10:20 a.m., an observation of resident room [ROOM NUMBER]-A revealed a section of wall behind the head-of-the-bed roughly plastered, measuring approximately 15 inches wide and 36 long. Further observation revealed white plaster dust coating the top of the headboard of the bed and coating the floor under the head of the bed. On 12/11/2025 at approximately 1:10 p.m. an observation of R101's room and interview was conducted with OSM (other staff member) #3, maintenance director and OSM # 4, housekeeping director. When asked about the section of wall behind the head-of-the-bed roughly plastered, measuring approximately 15 inches wide and 36 long OSM #3 stated it needed to be sanded, re-mudded, sanded again and painted. When asked if it presented a homelike appearance and if the room was in good repair, he stated no. Regarding the white plaster dust observed coating the top of the headboard of the bed and coating the floor under the head of the bed, OSM #4 stated the room should not be in the condition observed. She further stated it was not clean or homelike. The facility's policy Patient Rooms Inspection documented in part, All patient rooms, beds, and bathrooms will be inspected regularly to verify operational safety and environmental safety for patients. PROCEDURE. Monthly: 2. Inspect room environment including but not limited to sprinkler heads, lights, globes, privacy curtains and tracks, wallpaper, walls, floor tile, carpet, baseboards, door, door hardware, bumper stops, and frames, ceiling tiles, toilet seats, towel bars, grab bars, furniture, windows, blinds, and all electrical appliances and/or equipment including medical devices to verify items are safe and properly maintained. 11. Replace cracked or broken wall/floor tile. On 12/10/2025 at approximately 3:55 p.m. ASM (administrative staff member) #1, interim administrator, ASM #2, director of nursing and ASM #4, vice president of operations, were made aware of the above findings. No further information was provided prior to exit.

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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 Based on clinical record review and staff interview, the facility staff failed to develop a baseline care plan for one of 11 residents in the survey sample, Resident #103. The finding include:For R103, facility staff failed to develop a baseline care plan to address the use of a C-PAP (continuous positive airway pressure) machine (1). R103 was admitted to the facility with diagnosis that included but not limited to sleep apnea (2). The MDS (minimum data set) assessment was not due at the time of the survey. The facility's admission assessment for R103 dated 12/08/2025 documented in part, Cognitively intact. Oriented to person. Oriented to place. Oriented to situation.On 12/09/2025 at approximately 2:11 p.m. an observation of R103's room revealed a C-PAP machine and mask on R103's over-the-bed table.The facility's nurse's note for R103 dated 12/08/2025 at 8:50 p.m. documented in part, Use of CPAP/BiPAP (bilevel continuous positive airway pressure): Yes.The discharge summary from (Name of Hospital) documented in part, Details of Hospital Stay. Sleep - CPAP.Review of the baseline care plan for R103 dated 12/08/2025 failed to evidence documentation for the use of a C-PAP.On 12/10/25 at 1:20 PM, an interview was conducted with LPN (licensed practical nurse) #1. Asked the purpose of the care plan, LPN #1 stated, the purpose is to make sure everyone is on the same page for the care for that resident. When asked if C-PAP should be on the care plan, LPN #1 stated, yes, it should. On 12/10/2025 at approximately 3:55 p.m. ASM (administrative staff member) #1, interim administrator, ASM #2, director of nursing and ASM #4, vice president of operations, were made aware of the above findings.No further information was provided prior to exit.References:(1) The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm. (2) Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html.

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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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement the care plan for one of eight residents in the survey sample, Resident #2.The findings include:For Resident #2 (R2), the facility staff failed to implement the resident's care plan regarding pressure injuries (1).A review of ASM (administrative staff member) #3's, the wound nurse practitioner's, progress note dated 9/18/25 revealed, in part: Date of Service: 9/16/25.Sacrum.Stage 2 (2) (present on admission). Treatment Recommendations: 1. Cleanse with wound cleanser. 2. Apply Manuka HD Super Lite (3) to base of the wound. 3. Secure with silicone bordered superabsorb. Change daily and PRN (as needed).Wound 6 Location: Right heel. Primary etiology: Pressure Ulcer/Injury. Stage/Severity: DTI (deep tissue injury) (4). Present on admission.Treatment Recommendations: 1. Cleanse with wound cleanser. 2. Apply Skin Prep to base of the wound. 3. Leave open to air. 4. Change daily and PRN.Recommend floating heels.air mattress.A review of R2's September 2025 TAR (treatment administration record) revealed no evidence that the treatment recommended by ASM #3 on 9/16/25 was implemented until 9/23/25. A review of the October 2025 revealed that an air mattress was not implemented for R2 until 10/3/25.A review of ASM #3's progress note dated 10/1/25 revealed, in part: Date of Service: 9/30/25.Wound 9. Location: Left heel. Primary Etiology: Pressure Ulcer/Injury. Stage/Severity: DTI. Wound Status: New.Recommend applying Manuka HD super lite to wound bed.A review of R2's October 2025 TAR revealed the recommended treatment to the left heel was not implemented until 10/9/25.A review of R2's care plan dated 9/12/25 and updated on 9/25/25 revealed, in part: The resident was admitted with skin impairment.Treatment as ordered. On 10/29/25 at 10:30 a.m., LPN (licensed practical nurse) #1, a unit manager, was interviewed. She stated that the care plans map out what is done to care for a resident while they are in the facility. She stated the care plan considers the resident's diagnoses, concerns, behaviors, wounds, medications, and more, and lays out the interventions the facility is taking to meet the resident's needs. She stated all staff members are responsible for implementing all elements of the resident's care plan.On 10/29/25 at 12:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.A review of the facility policy, Care Planning, revealed no information related to the importance of following a resident's care plan. No additional information was provided prior to exit.REFERENCES(1) A pressure injury (ulcer) is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/orprolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbiditiesand condition of the soft tissue. This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf.(2) Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. This injury is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .(3) Wound dressing with super-absorbent and cross-linked mesh fibers, impregnated with Manuka honey, pH of 3.0-4.5. Designed for ease of application and DAILY dressing changes for monitoring progress. Can be used in combination with other ManukaMed(R) formulations, such as ManukaPli, for optimal medical grade honey dosage with every dressing change. Reduces wound bed pH to optimize wound healing. Manuka honey released into wound bed with sustained flow, while exudate and necrotic tissue is absorbed into the dressing. Eschar and debris tissue are taken up by the mesh fiber in the dressing resulting in a clean and viable wound bed. Creates optimal wound bed healing environment and reduces or eliminates wound odor. This information is taken from the manufacturer's website https://shop.manukamed.com/products/manukamedhd-superlite?srsltid=AfmBOooPOny07IGh0wQs2X7RpZL9pJjNvbUTNCH6F7xqbY3fygSVVWL. (4) Deep tissue pressure injury remains one of the most serious forms of pressure injury. The pressure is exerted at the muscle-bone interface, but due to the resiliency of the skin, the color change is not immediate, in contrast to a bruise. The process leading to deep tissue pressure injury precedes the visible signs of purple or maroon skin by about

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to revise the care plan for three of eight residents in the survey sample, Residents #2, #1, and #3.The findings include:1. For Resident #2 (R2) the facility staff failed to revise the care plan when the resident developed pressure injuries (1).A review of R2's admission nursing assessment dated [DATE] revealed no evidence of skin impairment related to a pressure injury when the resident was admitted .A review of ASM (administrative staff member) #3's, the wound nurse practitioner's, progress note dated 9/18/25 revealed, in part: Date of Service: 9/16/25. Sacrum.Stage 2 (2) (present on admission).Treatment Recommendations: 1. Cleanse with wound cleanser. 2. Apply Manuka HD Super Lite (3) to base of the wound. 3. Secure with silicone bordered superabsorb. Change daily and PRN (as needed).Wound 6 Location: Right heel. Primary etiology: Pressure Ulcer/Injury. Stage/Severity: DTI (deep tissue injury) (4).Present on admission.Treatment Recommendations: 1. Cleanse with wound cleanser. 2. Apply Skin Prep to base of the wound. 3. Leave open to air. 4. Change daily and PRN.Recommend floating heels.air mattress.A review of ASM #3's progress note dated 10/1/25 revealed, in part: Date of Service: 9/30/25.Wound 9. Location: Left heel. Primary Etiology: Pressure Ulcer/Injury. Stage/Severity: DTI. Wound Status: New.Recommend applying Manuka HD super lite to wound bed.A review of R2's care plan dated 9/12/25 and updated on 9/25/25 revealed, in part: The resident was admitted with skin impairment.Treatment as ordered. This review revealed no evidence that the care plan was updated when the pressure injury on the left heel was identified.On 10/29/25 at 7:54 a.m., ASM #4, a regional director of clinical operations, was interviewed. She stated the care plan did not reveal any evidence of the left heel pressure injury. She stated the care plan should be updated with the presence of all current wounds.On 10/29/25 at 10:30 a.m., LPN (licensed practical nurse) #1, a unit manager, was interviewed. She stated that the care plans map out what is done to care for a resident while they are in the facility. She stated the care plan considers the resident's diagnoses, concerns, behaviors, wounds, medications, and more, and lays out the interventions the facility is taking to meet the resident's needs. She stated all floor nurses have the ability to update a resident's care plan and it is her job to make sure the updates are being completed.On 10/29/25 at 12:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.A review of the facility policy, Care Planning, revealed, in part: Care plans will be updated on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment.No additional information was provided prior to exit.REFERENCES(1) A pressure injury (ulcer) is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/orprolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbiditiesand condition of the soft tissue. This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf.(2) Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. This injury is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .(3) Wound dressing with super-absorbent and cross-linked mesh fibers, impregnated with Manuka honey, pH of 3.0-4.5. Designed for ease of application and DAILY dressing changes for monitoring progress. Can be used in combination with other ManukaMed(R) formulations, such as ManukaPli, for optimal medical grade honey dosage with every dressing change. Reduces wound bed pH to optimize wound healing. Manuka honey released into wound bed with sustained flow, while exudate and necrotic tissue is absorbed into the dressing. Eschar and debris tissue are taken up by the mesh fiber in the dressing resulting in a clean and viable wound bed. Creates optimal wound bed healing environment and reduces or eliminates wound odor. This information is taken from the manufacturer's website https://shop.manukamed.com/products/manukamedhd-superlite?srsltid=AfmBOooPOnv07IGb0wOs2X7RpZL9pJiNvbLITNCH6E7xqbY3fvgSVVWL .(4) Deep tissue pressure injury

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide ADL (activities of daily living) care to a dependent resident for one of eight residents in the survey sample, Resident #1.The findings include:For Resident #1 (R1), the facility staff failed to bathe the resident on two days in October 2025.On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/15/25, the resident was coded as being completely dependent on facility staff for bathing/showering.A review of R1's October 2025 point of care records revealed no evidence that he received a shower or a bath on 10/12/25 and 10/13/25. This review revealed no evidence that the resident refused being bathed on either of these days.On 10/29/25 at 10:07 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated she bathes every resident assigned to her each and every morning. She stated this is simply part of her job of taking care of the residents. She stated she wants to bathe every day and her residents deserve the same care she gives to herself. She stated she documents the baths she gives in the electronic medical record.On 10/29/25 at 10:16 a.m., CNA #2 was interviewed. She stated she is a lead CNA and is responsible for checking to make sure all the residents on her unit receive the care they need. She stated she bathes and dresses all residents assigned to her every day. She stated she documents the bath/shower in the electronic medical record. She stated if the bath is not documented in the record, there is no way to verify that the bath actually occurred.On 10/29/25 at 12:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.A review of the facility policy, Bathing, revealed, in part: Bathing usually occurs after breakfast or the evening meal. The person's choice of type of bath and time of day is respected when possible.No additional information was provided prior to exit.

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Glenburnie Rehab & Nursing Center	1901 Libbie Ave Richmond, VA 23226

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to implement interventions to prevent and treat pressure injuries (1) for three of eight residents in the survey sample, Residents #2, #1, and #3.The findings include:1. For Resident #2 (R2), the facility staff failed to implement the wound nurse practitioner's recommendations to treat a pressure injury (1) in a timely manner in September and October 2025.On 10/28/25 at 9:03 a.m., LPN (licensed practical nurse) #2, the facility wound nurse, was observed preparing to provide wound care to R2. As LPN #2 prepared to enter R2's room, no signage or personal protective equipment related to any sort of isolation precautions was observed in plain view. LPN #2 did not don any PPE prior to entering R2's room or providing wound care. LPN #2 sanitized her scissors and cut the dirty dressing on R2's right leg and heel. She placed the scissors on the paper shield she had lain on the bed. The dirty dressing came in direct contact with the scissors. After removing the dirty dressing from the resident's right heel, LPN #2 picked up the dirty scissors and cut the dressing on the resident's left heel. As LPN #2 worked to cleanse and replace dressings on R2's heels, LPN #2 grabbed a handful of clean gloves from the box and laid the gloves down on R2's bed linens. The bed linens contained a large number of brown flakes of dried skin from the resident's legs. LPN #2 used these gloves throughout the wound care process, including when she was placing clean dressings on the resident's heels. At one point, LPN #2 put the bottle of wound cleanser on the bed in direct contact with the dirty bed linens as described above. She later used this wound cleanser to clean R2's sacral wound.On 10/29/25 at 8:13 a.m., ASM (administrative staff member) #3, the wound nurse practitioner, and LPN #2 were observed as they prepared to enter R2's room to provide wound care. Both staff members donned isolation gowns and gloves prior to entering the resident's room. The resident's door contained signage instructing staff and visitors to observe enhanced barrier precautions when providing care to the resident involving physical contact with the resident. During the wound care observation, ASM #3 used scissors which had not been sanitized to cut the dirty dressing on R2's right heel. ASM #3 placed the scissors directly on R2's bedside table, then later picked up and used the same scissors to cut the dirty dressing on R2's left heel. R2 was asked if the facility staff had provided heel boots for her to wear while she was in bed and out of bed in her wheelchair. She stated that they did not. She explained that the staff used pillows to float her heels while she was in bed. A review of R2's admission nursing assessment dated [DATE] revealed no evidence of skin impairment related to a pressure injury when the resident was admitted .A review of ASM (administrative staff member) #3's, the wound nurse practitioner's, progress note dated 9/18/25 revealed, in part: Date of Service: 9/16/25.Sacrum.Stage 2 (3) (present on admission).Treatment Recommendations: 1. Cleanse with wound cleanser. 2. Apply Manuka HD Super Lite (4) to base of the wound. 3. Secure with silicone bordered superabsorb. Change daily and PRN (as needed).Wound 6 Location: Right heel. Primary etiology: Pressure Ulcer/Injury. Stage/Severity: DTI (deep tissue injury) (5).Present on admission.Treatment Recommendations: 1. Cleanse with wound cleanser. 2. Apply Skin Prep to base of the wound. 3. Leave open to air. 4. Change daily and PRN.Recommend floating heels.air mattress.A review of R2's September 2025 TAR (treatment administration record) revealed no evidence that the treatment recommended by ASM #3 on 9/16/25 was implemented until 9/23/25. A review of the October 2025 revealed that an air mattress was not implemented for R2 until 10/3/25.A review of ASM #3's progress note dated 10/1/25 revealed, in part: Date of Service: 9/30/25.Wound 9. Location: Left heel. Primary Etiology: Pressure Ulcer/Injury. Stage/Severity: DTI. Wound Status: New.Recommend applying Manuka HD super lite to wound bed.A review of R2's October 2025 TAR revealed the recommended treatment to the left heel was not implemented until 10/9/25.A review of R2's care plan dated 9/12/25 and updated on 9/25/25 revealed, in part: The resident was admitted with skin impairment.Treatment as ordered. This review revealed no evidence of being updated when the pressure injury on the left heel was identified.On 10/28/25 at 3:46 p.m., ASM #3 was interviewed. She stated Manuka HD is a medical grade honey fiber and she uses it to help break down tissue that is nonviable. She stated the goal is to expose as much wound tissue as available to allow healing to begin. She added that the Manuka HD also helps to keep wounds clean by preventing the discharge from turning into slough. She stated she is still learning about pressure injuries and how to stage them. She explained that when she recommends a treatment or an intervention, her intention is for the facility staff to implement what she has recommended unless the attending physician objects to it for some reason. She

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide incontinence care for one of eight residents in the survey sample, Resident #4.The findings include:For Resident #4 (R4) the facility staff failed to provide incontinence care on 10/28/25 from 10:07 a.m. through 5:30 p.m.On 10/28/25 a.m., R4 was observed without interruption from 10:07 a.m. until 5:30 p.m. During this time, R4 was sitting in her wheelchair. A staff member moved her from her room to the day room at 10:10 a.m. Following the move to the day room, the resident was moved by staff back and forth between the day room, activities room, and dining room. This observation was continuous with no interruptions. At no time did any staff member wheel the resident back to her room to provide incontinence care.On R4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/9/25, she was coded as being severely cognitively impaired for making daily decisions, having scored only two out of 15 on the BIMS (brief interview for mental status). She was coded as sometimes understanding others and as sometimes being understood by others for communication. She was coded as always incontinent of both bladder and bowel, and as requiring the assistance of staff for toileting.On 10/29/25 at 10:07 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated if she cares for a resident who is incontinent and cannot walk independently to the bathroom, she checks the resident for incontinence every hour or two. She stated that two hours is the maximum amount of time that should elapse between incontinence checks. She stated that after two hours, a resident's skin can begin to break down. She stated if a resident refuses an incontinence check, the charge nurse should be notified, and multiple attempts should be made to convince the resident to allow the care.On 10/29/25 at 10:16 a.m., CNA #2 was interviewed. She stated she is the lead CNA on the unit where R4 resides. She stated that as a lead CNA, she is responsible for making sure the floor and residents' rooms are clean and tidy. She also is responsible for doing walking rounds at the end of every shift with all the CNAs to make sure they have completed all the tasks for their shift that is ending. She explained that incontinent residents should be checked a minimum of every two hours, with some residents requiring more frequent checks. She stated that when she is responsible for caring for R4, she checks her more frequently than every two hours because the resident is not able to tell the staff if she needs incontinence care. She stated that even if R4 is in the activities room or the dining room, incontinence checks are still a priority and should be done at least every two hours.On 10/29/25 at 10:30 a.m., LPN (licensed practical nurse) #1, a unit manager, was interviewed. She stated that residents who are incontinent and require assistance should be checked every two hours. She stated that once a staff member gets to know the residents' needs better, they may check on them more frequently than every two hours. She stated a resident's skin starts to break down after two hours.On 10/29/25 at 11:59 a.m., CNA #3 was interviewed. She was assigned to care for R4 on 10/28/25 from 7:00 a.m. until 3:00 p.m. She stated she checks incontinent residents about every two hours. She stated she takes the residents to their rooms to perform the incontinence checks. She stated if a resident is left in wet or soiled incontinence briefs for a long period of time, it can lead to skin breakdown. She stated she checked R4 for incontinence multiple times on 10/28/25. After being informed of the constant observations of R4 throughout the day on 10/28/25, CNA #3 stated she actually had not taken R4 to her room to check her for incontinence at any time during her shift. She stated she walked by the resident multiple times and checked in on her throughout the shift.On 10/29/25 at 12:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations were interviewed. All three management staff members agreed that if a resident is not offered incontinence care for an extended period of time, they may suffer emotional distress and a lack of a dignified quality of life. Additionally, they agreed that a resident may also experience skin impairment after more than two or three hours in a wet or soiled incontinence brief, and that it would not feel good physically or emotionally. At this time, these management staff members were informed of the concerns related to the lack of incontinence care for R4.A review of the facility policy, Urinary Elimination, failed to reveal information related to the frequency in which incontinence care should be provided to a resident.No additional information was provided prior to exit.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide respiratory services for one of eight residents in the survey sample, Resident #1.The findings include: For Resident #1 (R1), the facility staff failed to implement a CPAP (1) device.A review of R1's hospital Discharge summary dated [DATE] revealed, in part: Acute.respiratory failure [secondary to] CHF (congestive heart failure).OSA (obstructive sleep apnea).CPAP at night.A review of R1's clinical record revealed the following progress note: 10/14/2025 11:20 Health Status Note.Note Text: Writer spoke with NP (nurse practitioner) in regards to Bipap (3) placement d/t (due to) rsd (resident) was on Cpap during stay in the hospital. NP.stated she will place and order for Bipap. Writer notified.respiratory therapist.he stated he will come to the facility and set up the machine.Further review of R1's clinical record failed to reveal any evidence that a CPAP was ever initiated for R1 during his stay at the facility.On 10/29/25 at 10:30 a.m., LPN (licensed practical nurse) #1, a unit manager, was interviewed. She stated that if a resident needs a CPAP on admission, this information is usually in the hospital discharge summary. She stated the admitting nurse should verify the order with the physician and the physician should be informed that the facility does not have CPAP machines in stock. At that time, the physician might want to put some other type of order in place until the CPAP can be obtained by the central supply clerk and provided to the resident. She stated most residents who need a CPAP have a device at home that they bring to the facility. She explained that even if the resident has a CPAP at home, it is still the facility's responsibility to provide one at the facility if the resident is unable to bring the device from their home.On 10/29/25 at 12:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A CPAP policy was requested.No additional information was provided prior to exit.REFERENCES(1) CPAP (Continuous Positive Airway Pressure) is a treatment that uses mild air pressure to keep your breathing airways open .It involves using a CPAP machine that includes a mask or other device that fits over your nose or your nose and mouth, straps to position the mask, a tube that connects the mask to the machine's motor, and a motor that blows air into the tube. CPAP is used to treat sleep-related breathing disorders including sleep apnea. This information is taken from the website https://www.nhlbi.nih.gov/health-topics/cpap.(2) Obstructive sleep apnea, also called OSA, happens when your upper airway becomes blocked many times while you sleep. The blockage can reduce or completely stop airflow. This is the most common type of sleep apnea. This information is taken from the website https://www.nhlbi.nih.gov/health/sleep-apnea.(3) Biphasic Positive Airway Pressure (BIPAP) can be described as pressure controlled ventilation in a system allowing unrestricted spontaneous breathing at any moment of the ventilatory cycle. It can also be described as a Continuous Positive Airway Pressure (CPAP) system with a time-cycled change of the applied CPAP level. This information is taken from the website https://pubmed.ncbi.nlm.nih.gov/8143712/.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to implement a complete pain program for one of eight residents in the survey sample, Resident #2.The findings include:For Resident #2 (R2), the facility staff failed to treat a resident's report of severe pain on [DATE].R2 was admitted to the facility on [DATE] with a history of fractures in the left hip, and right leg. On admission the resident was documented to have recent surgical wounds on both knees.On the following dates and times, R2 was observed in her room and was both alert and conversant: [DATE] at 1:54 p.m. and 4:19 p.m.; [DATE] a.m. at 9:03 a.m.; and [DATE] at 8:15 a.m. At each observation, the resident reported pain in her knees. She stated the staff usually treated her pain effectively, but that she had experienced severe pain once or twice that the medication did not help.A review of R2's progress notes revealed the following note dated [DATE] at 11:57 p.m.: Patient c/o (complained of) 10/10 (ten out of ten) bilat (bilateral - both left and right) knee pain and requesting prn (as needed) Oxycodone (1). This writer explained that it was no longer on her current medication list. Patient requesting MD (medical doctor) review meds and add it back if appropriate. MD Communication Book updated for this request. The nurse who wrote this note was not interviewed during the survey.Further review of R2's progress notes failed to reveal any immediate intervention by the facility staff to address R2's severe pain in both knees.A review of R2's medication orders revealed that an as needed order for Oxycodone was added to R2's medication regimen at 6:45 p.m. on [DATE]. Further review of R2's progress notes revealed no evidence that either ASM (administrative staff member) #5, the attending nurse practitioner or ASM #6, the attending physician ever was made aware of or addressed R2's specific report of severe pain on [DATE]. On [DATE] at 10:30 a.m., LPN (licensed practical nurse) #1, a unit manager, was interviewed. After reviewing R2's progress note, she stated that it was almost midnight, and the physician/NP (nurse practitioner) coming to the facility until the next morning, at the earliest. She explained that if the resident was reporting 10/10 pain, the nurse should have called the on-call physician and obtained an order for a pain medication that could be administered immediately. She stated the resident should not have been left without any medication until the resident could be seen by the physician or NP. She added: At 10/10, we need to get the on-call doctor on the phone. She could not explain why the physician/NP never addressed the 10/10 pain. She stated that even if the report of pain had been listed in the physician's book of concerns to be addressed at the next visit, this concern should have been passed along in the shift to shift nursing report.On [DATE] at 10:51 a.m., ASM #5 was interviewed. After reviewing R2's progress note, she stated she assumed the Oxycodone fell off the resident's medication list because the order expired as an as needed medication. She stated she did not remember anything being written in the physician concern book about R2 having 10/10 knee pain. She stated she would hope that the nurse would have called the physician on call to get an order for a pain medication that could be administered immediately. On [DATE] at 12:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.A review of the facility policy, Pain Management Assessments, revealed, in part: Initiate a pain assessment any time.a patient experiences pain that is not usual for the patient.No additional information was provided prior to exit. REFERENCES(1) Oxycodone is used to relieve moderate to severe pain . Oxycodone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information is taken from the website https://medlineplus.gov/druginfo/meds/a682132.html.

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or arrange emergency care by a doctor 24 hours a day. Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide 24 hour on-call physician services for one of eight residents in the survey sample, Resident #3.The findings include:For Resident #3 (R3), the facility staff failed to provide on-call physician services on 10/21/25 when a critical laboratory test result was communicated to the nursing staff.A review of R3's clinical record revealed the following progress note dated 10/21/25 at 1:10 a.m Critical lab called in from lab. Potassium 2.9 (1). Contacted on call physician to make aware. No call returned. 0145AM (1:45 a.m.) Contacted on call physician again, no returned call. 0658 (6:58 a.m.), no call returned, will have nurse follow-up with physician. On 10/29/25 at 7:54 a.m., ASM (administrative staff member) #4, the regional director of clinical operations, was interviewed. She stated the facility nurses should always be able to reach an on-call physician. She explained that if the nurses cannot reach an on-call physician in a reasonable amount of time, the medical director should be contacted.On 10/29/25 at 11:53 a.m., ASM #6, the attending physician, was interviewed. After reviewing R3's progress note, he stated that in this context, there is always a back up for the provider who is on call. He explained that the on call service has the contact information for the back up provider in case the person on call is unable to respond right away. He stated the nurse is responsible for asking the telephone on-call personnel to notify the back up person. He stated he was never aware that the resident's potassium level was 2.9. He stated the risks of low potassium include heart rhythm dysfunction and neurological fogginess. He stated he would have ordered an immediate oral supplement to be given.On 10/29/25 at 12:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A policy regarding 24 hour physician coverage was requested.No additional information was provided prior to exit.REFERENCE(1) This [laboratory] test measures the amount of potassium in the fluid portion (serum) of the blood. Potassium (K+) helps nerves and muscles communicate. It also helps move nutrients into cells and waste products out of cells.The normal range is 3.7 to 5.2 milliequivalents per liter (mEq/L) 3.70 to 5.20 millimoles per liter (millimol/L). This information is taken from the website https://medlineplus.gov/ency/article/003484.htm.

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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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interview and clinical record review it was determined that the facility staff failed to maintain a complete and accurate record for two of 11 residents in the survey sample, Residents #101 and Resident #109. The findings include:1. For Resident #101 (R101), the facility staff failed to document the eMAR (electronic medication administration record) that the medication, Protonix (1), was administered. R101 was admitted to the facility with diagnosis that included but were not limited to gastro-esophageal reflux disease (2). On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/09/2025, R101 scored 2 (two) out of 15 on the BIMS (brief interview for mental status), indicating R101 was severely impaired of cognition for making daily decisions. The physician's order for R101 documented in part, Protonix Tablet Delayed Release 40 MG (milligrams) (Pantoprazole Sodium). Give 1 (one) tablet by mouth one time a day for gastritis Order Date:10/7/2025. 0630 and 1630 (6:30 a.m. and 4:30 p.m.) The facility's nursing note for R1010 dated 12/09/2025 at 9:06 a.m. documented, Patient went upstairs for dialysis at 0420 (4:20 a.m.), she took her medication as ordered and her folder. The eMAR for R101 dated December 2025 documented the physician's order for Protonix as stated above. Further review of the eMAR revealed a blank under 12/09/2025 at 6:30 a.m. On 12/10/2025 at approximately 2:00 p.m. an interview was conducted with RN (registered nurse) #2 regarding the procedure for documenting the administration of a medication on an eMAR. she stated that when a resident's medication is administered there is a check mark for the medication under the date it was given. On 12/11/2025 at 7:46 a.m. an interview was conducted with ASM (administrative staff member) #2, director of nursing, regarding the blank on 12/09/2025 for R101's Protonix. ASM #2 stated that LPN #4 phoned her last evening about not signing the off the eMAR for the administration of R101' s Protonix. ASM #2 stated that LPN #4 told her that the Protonix was administered while R101 was waiting in the dialysis unit and forgot to sign the eMAR. She further stated that LPN #4 left a written statement this morning under the door of her office because LPN #4 was leaving out of town for vacation. ASM #2 stated that the eMAR should be signed immediately after administering the medication to the resident. On 12/11/2025 at approximately 7:30 a.m. ASM #2 provided the surveyor with a copy of the written statement by LPN #4. The written statement by LPN #4 documented in part, .I had (R101) on 12/08/25 before dialysis, her skin prep (preparation) and skin barrier were all done before dialysis during ADL (activities of daily living). At 0420 she was taken upstairs by me. At 0531 (5:31 a.m.) I took her Protonix upstairs and gave it to her while she was waiting to be seated. It was an oversight that her MARs were not signed immediately. On 12/11/2025 at approximately 2:05 p.m. ASM (administrative staff member) #1, interim administrator, ASM #2, director of nursing and ASM #4, vice president of operations, were made aware of the above findings. No further information was provided prior to exit. Reference:(1) Used to treat damage from gastroesophageal reflux disease (GERD). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601246.html. (2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. 2.Resident # 109 (R109) was admitted to the facility with diagnosis that included but were not limited to pain. On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/27/2025, R109 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R109 was cognitively intact for making daily decisions. Section J0300 Pain Presence coded R109 as not having pain in the past five days. (2) For R109, the facility staff failed to accurately document the administration of Oxycodone (1) on the Controlled Drug Administration Record dated 08/06/2025. R109 was admitted to the facility with diagnosis that included but were not limited to nerve damage. On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/27/2025, R109 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R109 was cognitively intact for making daily decisions. The physician's order for R109 documented in part, Oxycodone HCl (hydrochloride) Oral Tablet 5 (five) MG (milligrams). Give 1 (one) tablet four times a day for chronic pain management. Order Date: 7/11/2025. The eMAR (electronic medication administration record) for R109 dated August 2025 documented the physician's order as stated above. Further review of the eMAR revealed R109 received five milligrams of oxycodone on 08/06/2025 at 9:00 a.m. and 5:00 p.m. The facility's Controlled Drug Administration Record for R109 documented the physician's order for Oxycodone as stated above. Further review of the record failed to document the administration of Oxycodone on 08/06/2025 at 9:00 a.m. and 5:00 p.m. On 12/11/2025 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495391	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenburnie Rehab & Nursing Center	1901 Libbie Ave Richmond, VA 23226

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to implement infection control procedures for one of eight residents in the survey sample, Resident #2. The findings include:For Resident #2 (R2), the facility staff failed to implement enhanced barrier precautions (1) to protect residents from infection.On 10/28/25 at 9:03 a.m., LPN (licensed practical nurse) #2, the facility wound nurse, was observed preparing to provide wound care to R2. As LPN #2 prepared to enter R2's room, no signage or personal protective equipment related to any sort of isolation precautions was observed in plain view. LPN #2 did not don any PPE prior to entering R2's room or providing wound care. Further review of R2's clinical record revealed the resident had chronic wounds and a Foley catheter (2). This review revealed no orders for or evidence of enhanced barrier precautions being implemented since the resident was admitted to the facility on [DATE] (a total of 47 days).On 10/29/25 at 7:54 a.m., ASM (administrative staff member) #2, the director of nursing, and ASM #4, the regional director of clinical operations, were interviewed. ASM #2 stated enhanced barrier precautions are implemented to prevent the spread of harmful bacteria from resident to resident. ASM #4 stated enhanced barrier precautions are implemented when any resident has any kind of chronic wound and/or invasive medical device such as a Foley catheter.On 10/29/25 at 12:20 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.A review of the facility policy, Enhanced Barrier Precautions, revealed, in part: Employees providing high-contact patient care activities will follow Enhanced Barrier Precautions for patients who meet the criteria.May be indicated for patients.with chronic wounds.with indwelling medical devices.[Enhanced Barrier Precautions] require the use of gown and gloves by staff during high-contact patient care activities.[including] wound care for chronic wounds.No additional information was provided prior to exit.REFERENCES(1) Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). This information is taken from the website https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html.(2) Foley catheters are small flexible tubes inserted into the urethra to drain urine from the bladder. This information is taken from the website https://www.ncbi.nlm.nih.gov/books/NBK564404/