STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495406	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Wybe and Marietje Kroontje Health Care Center	1000 Litton Lane Blacksburg, VA 24060

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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to assess the resident for risk of entrapment and attempt to use appropriate alternatives prior to the installation of a side rail and failed to ensure correct installation to assess for the seven zones of entrapment when side rails were added and/or bed components were changed for 6 of 26 sampled residents (Resident #41, Resident #5, Resident #1, Resident #3, Resident #25, and Resident #57). At the time of the survey, the facility staff member responsible for the installation and maintenance of side rails did not have the knowledge to ensure appropriate safety measurements of the seven zones of entrapment risk. The facility failed to ensure side rails were assessed for entrapment risk when installed on a bed or bed components were replaced. At the time of the survey, of a census of 53 residents, 34 residents had at least one side rail attached to the bed. The facility's failure to assess for bed rail entrapment risk and ensure safe installation created a likelihood of serious injury, harm, impairment, or death. Entrapment can result in asphyxiation, suffocation or fatal injury. Given that 34 of 53 residents had side rails in use the deficient practice was pattern and placed residents at immediate risk. This resulted in the identification of immediate jeopardy and substandard quality of care for Resident #41 and all facility residents with a side rail in place. The survey team informed the facility on 4/09/26 at 1:45 PM of the Immediate Jeopardy situation regarding Resident #41 and the staff member responsible for assessing entrapment risk lacked the knowledge to measure the seven zones of entrapment risk. The scope and severity were originally cited at Level IV pattern. On 4/10/26 at 3:00 PM, the Immediate Jeopardy was removed and lowered to a Level II pattern. The findings included:A facility policy entitled Bed Rail Use with an approved date of 03/30/2023 read in part, It is the policy of (name of facility omitted) to identify and reduce safety risks and hazards commonly associated with bed rail use. A dual approach will be used to achieve sustainable quality outcomes, including 1) regular bed maintenance and 2) Individual bed rail evaluations for use. In response to the requirement of providing for a safe, clean, comfortable, and homelike environment, the facility's regular maintenance program will include bi-yearly inspections of all bed systems (e.g. rails, frames, mattresses, and operational components) to ensure they are clean, comfortable and safe. The facility will also ensure individual resident bed rail evaluations are performed on a regular basis for residents who utilize bed rails. Individual bed rail evaluations will include data collection analysis and determination of potential alternatives to bed rail use. When bed rails are deemed necessary and appropriate, the facility will provide education to the resident or resident's representative pertaining to the risk and benefits of bed rail use. The facility's priority is to ensure safe and appropriate bed rail use. The bed rail use policy will be reviewed annually or more frequently as needed and will be integrated into the facility Quality Assurance and Performance Improvement program (QAPI). The policy included a section on page 2 of the document entitled, Overview of the U.S. Food and Drug Administration's Potential Zones of Bed Entrapment which describes the 7 zones to be measured and includes the accompanying acceptable measurements. On (continued on next page)

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

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

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	page 3 of the policy, under the heading entitled Training Components the document read in part, The Director of Nursing (DON)and Maintenance Director (MD) (or qualified designees) cooperatively will be responsible for completion of bed inspections bi-annually and as needed. Under the heading, Procedure the document read, Facility staff will receive education as follows: *All employees will receive education on this policy *Education will occur during orientation and ongoing programs *Staff will be taught the risk factors for entrapment and other safety hazards related to bed systems (e.g. bed rails, frames, and mattresses) *Identification of risks and benefits pertaining to bed rails *Procedure for reporting and management of potential safety risks associated with bed rails, frames, or mattresses *The FDA's potential zones of entrapment *Staff should report any actual or potential risk to their immediate supervisor *Educational resources will include, but are not limited to: 1)The FDA's potential zones for entrapment, and the CMS State Operational Manual, Appendix PP. On page 4 under the heading, Resident Assessment the document reads in part, c. Assess the resident to identify appropriate alternative prior to installing bed rails d. Assess the resident for risk of entrapment from bed rails prior to installation. 1. For resident #41 the facility staff failed to assess the resident for entrapment and failed to attempt alternatives to side rails prior to the installation of bilateral one-half (1/2) side rails to the resident's bed. The Resident Face Sheet revealed the facility admitted resident #41 on 07/06/2024. According to the Resident Face Sheet the resident had a medical history that included the diagnoses of dementia with anxiety, repeated falls, muscle weakness, unspecified abnormalities of gait and mobility and generalized idiopathic epilepsy and epileptic syndromes. The quarterly minimum data set (MDS) assessment with an assessment reference date of 03/30/2026 assigned resident #41 a brief interview for mental status (BIMS) score of 8 which indicated moderate cognitive impairment. The MDS also indicated the resident required supervision to touching assistance for transfers and going from lying to sitting on the side of the bed but was independent with rolling left and right in bed. Resident #41's care plan included a problem statement dated 07/18/2024 that read, I require assistance with my ADL's [activities of daily living] related to my decreased mobility, muscle weakness, and dementia. I am mobile in my wheelchair. I am able to feed myself once I am set up. My level of assistance needed to complete my ADL's highly fluctuates related to my mood, cognition, and impulsiveness at times, I often appear independent and I do things for myself although, I am not always safe to do things on my own. I also require a much higher level of care at times related to my mood, cognition fluctuation to complete my tasks safely. Please anticipate my needs, cue and assist me as needed. I at times prefer a bed bath instead of a shower. The approaches included bed rails as ordered. The use or need for the bed rails was not specified anywhere on the care plan. The Physician's Order Report included an order dated 12/04/2024 that read, May use bed rails to assist with mobility and transfers. Special Instructions: Assistive device. A document entitled, Negotiated Risk Agreement and Release was reviewed. The document was signed by resident #41's power of attorney on 07/06/2024. The document read in part, Resident/Family desire or preference: Have the bed/side rail available for use to aid in bed mobility. Possible consequence of desire or preference: Risk of possible entrapment between side rail and mattress which can also lead to other concerns like asphyxiation. Alternative approaches to minimize risk: Resident is encouraged to use call light to ask for assistance as needed; staff round per (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	company protocol (every 2 hours) and in between as needed by resident. Agreed course of action: Have bed rails available for resident use in bed mobility. The Negotiated Risk Agreement and Release did not indicate that an entrapment risk assessment was conducted or specify the type of side rails to be installed. A document entitled, Side Rail Use and Risk Observation dated 07/06/2024 was reviewed. Under Side Rail Type the document stated the type of side rails being evaluated for use were quarter length. Under Reason for use the document read, Resident has medical symptoms for use of side rail(s). The medical symptom listed was, Weakness, decreased ROM (range of motion)- used for bed positioning and restricts movement for safety. There is no space on the form to indicate risk for entrapment was assessed. A facility document that the staff identified as a Work Order was reviewed. The work order was dated 10/06/2024 and stated under comments, Need bedrails installed please. Under notes, placed rails on bed. The note was signed by the Maintenance Director. The room number for the work to be done was listed as 312A, which is resident #41's current room assignment. There was no mention of an entrapment assessment or bed safety inspection being carried out. The facility staff were unable to provide a work order for resident #41's admission in July 2024. A facility document entitled Bed Entrapment Inspection was reviewed. The document was dated 07/18/2025. The form indicated that a contracted vendor had checked each bed in the facility, including all seven entrapment zones on that date. The form did not indicate or specify what type of rails were in place at the time of the inspection. A facility document with no date or title was provided by the Administrator who stated it was the Bed Entrapment Inspection for July 2024. The Administrator stated the inspection was done on 07/24/2024 and provided a Bed Entrapment Inspection FDA Requirements sticker that was dated 07/24/2024. On 04/07/2026 resident #41 was not in the room during the initial tour. The bed had one-half (1/2) rails bilaterally and both rails were in the up position. On 04/08/2026 at 10:35 AM resident #41 was observed lying in bed. The left side of the bed had the bed rail up, but the right rail was not up. During a conversation, resident #41 sat up on the right side of the bed independently, stood and sat in the wheelchair that was by the bed, also independently. During an interview on 04/09/2026 at 10:00 the Compliance Director was asked what alternatives were used for resident #41 prior to the installation of bed rails. The Compliance Director referred to page 2 of the Side Rail Use and Risk Observation document under the section that read, Select other methods used besides bed rail(s). Low bed was marked. The Compliance Director stated, That is what we use this section for. When it was pointed out that the bed rails were applied the same day the resident was admitted to the facility they stated, The family asked for the side rails. When asked if they could verify that there was an entrapment risk assessment done they referred to the Negotiated Risk Agreement and Release document. During an interview on 04/09/2026 at 10:37 AM the survey team asked the Director of Nursing (DON) to come to resident #41's room. The resident was not in the room, and both side rails were up. In the room, the DON was asked if the rails were quarter or half rails. The DON stated, Those are half rails. The right one is a little different and not quite as long, but I think it is too long to be a quarter. The (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	DON stated that maintenance applies and removes side rails as needed/ordered and should be ensuring the safety of the bed as far as entrapment risk is concerned. On 04/08/2026 at 12:00 PM during an interview in resident #41's room, the Maintenance Director stated he is not familiar with the seven zones of entrapment risk, I just know to measure here and here pointing to zones 6 (between the end of the rail and the side edge of the headboard) and 7 (between the head or foot board and the end of the mattress). The Maintenance Director went on to say that they had been employed at the facility for five years and only measures when a work order is submitted for side rails. When asked if a mattress gets switched out or a resident is moved to another room with a different bed whether new measurements are obtained, the Maintenance Director stated, I only do it if I have a work order. I base everything I do on those work orders and I'll be honest; I don't get work orders like I should. The Maintenance Director stated that a contracted vendor comes in annually and does bed safety checks on all the beds. He has a big tool, like a head that he uses to check for entrapment with all the side rails. I asked for one of those tools, but they are like $2,000.00 so they said no. I just use my tape measure. When asked if resident #41's bed and side rails had been inspected prior to being installed, the Maintenance Director stated, I didn't know she had side rails until now. When asked if the rails on resident #41's bed were quarter rails or half rails the Maintenance Director stated, Those are half rails. When asked if the facility could provide any evidence that resident #41's bed was assessed for safety when the bed rails were applied on 07/06/2024, the Maintenance Director stated, I don't have anything else on it. On 04/09/2026 at 1:45 PM the survey team notified the Administrator and DON of the Immediate Jeopardy situation involving resident #41 and the facility's failure to assess the resident for the risk of entrapment from bed rails prior to installation and failure to attempt to use appropriate alternatives prior to the installation of side rails. The Administrator and DON were also notified that the facility Maintenance Director was unaware of the seven zones of entrapment risk and demonstrated that he only measures from the top of the upper side rail to the headboard and checked for a gap between the mattress and footboard. The Maintenance Director stated he had not received education or training regarding the seven zones of entrapment during his five years in the position. On 04/09/2026 at 5:49 PM the Administrator presented the following Immediate Jeopardy removal plan: Resident #41 was assessed for appropriate use of side rails, bed safety and entrapment. Residents with side rails have potential to be affected. Maintenance Director has been re-educated regarding the seven zones for entrapment risk and a proper inspection process. Type of side rails to be noted on inspection if applicable. All current working nurses to be educated immediately and all other nurses to be educated their next scheduled shift. Nurses to be educated on bed safety, risk of entrapment and use of the Side Rail and Entrapment Risk Assessment Form. Director of Nursing/designee will assess the residents for bed safety and will complete an audit on all residents using the Side Rail and Entrapment Risk Assessment form and the 7 Zone Bed Entrapment form. All new admissions, readmissions and a resident with new side rails will be assessed as well. Maintenance will note on all work orders for bed rails that bed rails were installed, note type of side rail and all 7 entrapment pass. Director of Nursing/designee will complete an audit on all residents with side rails to ensure 7 zone inspections is good every other week x 4 weeks and every month x 3. Results of the observations will (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	be reported to the QAPI committee for review, analysis and recommendations. Date of completion 04/09/2026 at 19:00 (7:00 PM). On 04/09/2026 at 6:16 PM the survey team notified the facility staff that the Immediate Jeopardy removal plan had been accepted. On 04/10/2026 at 2:02 PM the survey team met with the Maintenance Director and Administrator. When asked if he had received education regarding checking bed/side rail safety in order to clear the education part of the Immediate Jeopardy, the Maintenance Director stated he had not been educated. When asked the last time he received education regarding bed/side rails, he said (Name of Administrator omitted) said I signed something a while back, but I only know about the headboard and the footboard and I can put extenders in, I know about the electrical too. I learned all that from (name of vendor omitted). I don't know about the zones, (name of vendor) doesn't check zones he is just so good and so knowledgeable he knows, he can tell by looking at a bed if it's safe. The only thing I do is if I have a work order but we're always watching it. The Maintenance Director was asked again if he had training yesterday or today and he stated, No, I signed something and saw those pictures, but I can't do it by looking at a picture one time. I base everything on work orders, and I can do what I showed you the other day with head and foot boards. If I don't know what I'm doing, I'm putting the residents at risk. On 04/10/2026 at 2:40 PM, the survey team observed DON and the Director of Staff Development educate the maintenance assistant on bed rail safety and measuring the 7 zones of entrapment. The maintenance assistant demonstrated and voiced understanding. The facility staff presented credible evidence that the removal plan had been implemented, including staff education as outlined in the removal plan. Interviews with staff verified education as outlined in the removal plan. The survey team audited the Side Rail and Entrapment Risk Assessment form and the 7-Zone Bed Entrapment forms for each resident with siderails with no concerns identified. On 04/10/2026 at 3:00 PM, the survey team met with the Administrator, DON, Director of Compliance and Director of Staff Development and informed them the Immediate Jeopardy had been cleared. 2. For Resident #5, the facility staff failed to attempt the use of appropriate alternatives, failed to assess the resident for risk of entrapment prior to installation of bilateral one-half side rails, and failed to ensure correct installation of the side rails to prevent an entrapment risk. A Resident Face Sheet indicated the facility admitted Resident #5 on 10/07/25. According to the Resident Face Sheet, the resident had a medical history that included chronic respiratory failure with hypoxia, epilepsy, generalized muscle weakness, and history of traumatic brain injury. A quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/30/26 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating Resident #5 was cognitively intact. The MDS also indicated the resident was independent in rolling left and right in bed and moving from lying to sitting on the side of the bed. On 4/09/26 at 8:40 AM, Resident #5 was sitting on the edge of her bed with bilateral one-half side (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	rails attached to the bed and in the upright position. Resident #5 stated she liked having the side rails and used them to get in and out of bed. A provider order dated 10/07/25, the first day of admission, specified Resident #5 may use bed rails to assist with mobility and transfers. The provider order did not specify the type of side rails to be used. Resident #5's current comprehensive person-centered care plan included a problem area indicating the resident took medication for epilepsy, approaches included but were not limited to monitor for signs and symptoms of seizures such as jerking movements of arms and legs. Resident #5's care plan also indicated the resident required assistance with bed mobility with an approach dated 10/15/25 that she may have bed rails as ordered/indicated. The care plan did not specify the type of side rails to be used. Resident #5's clinical record included a [facility name omitted] Side Rail Use and Risk Observation dated 10/07/25 at 10:21 AM which indicated the resident was evaluated for the use of bilateral quarter length side rails due to the resident or legal representative request for side rails. The form indicated the resident was able to ask for assistance to raise and lower side rails and used side rails with bed mobility and getting out of bed. The form included a section to select other methods used besides side rails and call light in reach was checked. Resident #5's clinical record included a document titled Negotiated Risk Agreement and Release signed by the resident on 10/07/25. This document indicated Resident #5 desires to have the bed/side rail available for use to aid in bed mobility. The document included possible consequences of the risk of possible entrapment between side rail and mattress which could also lead to other concerns like asphyxiation. Alternative approaches to minimize risk include resident is encouraged to use call light to ask for assistance as needed and staff round per company protocol (every two hours) and in between as needed by resident. The Negotiated Risk Agreement and Release did not indicate that an entrapment risk assessment was conducted. Resident #5's clinical record included no evidence of alternatives being attempted prior to the installation of side rails. Resident #5's clinical record also failed to include evidence of assessment of the resident's entrapment risk related to her height, weight, and medical history which included a diagnosis of epilepsy prior to or following the installation of side rails. An additional Side Rail Use and Risk Assessment was completed on 3/27/26 which also indicated the resident was evaluated for the use of bilateral quarter-length side rails. This form also did not include assessment of the resident's entrapment risk. A facility document titled, Bed Entrapment Inspection dated 7/18/25 was reviewed. This form indicated that a contracted vendor performed an entrapment inspection, including all seven zones on that day. This inspection was completed approximately 11 weeks prior to Resident #5's admission to the facility on [DATE]. Upon observation on 4/09/26, Resident #5's bed had a bed inspection sticker with the assigned bed number #150. According to the 7/18/25 Bed Entrapment Inspection. Bed #150 was in room [ROOM NUMBER] at that time and had an air mattress and side rails in place. The form did not indicate the (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	type of bed rails present at the time of the inspection. Resident #5 does not currently reside in room [ROOM NUMBER] and according to the resident census list, she has never resided in room [ROOM NUMBER]. Resident #5 does not have an air mattress on the bed. Resident #5 has resided in four different rooms while a resident of the facility. The Administrator provided a work order dated 12/30/25, under the comments, There needs to be one bed rail taken to room [ROOM NUMBER] was documented and under the notes, Bed rail replaced. Resident resided in room [ROOM NUMBER] from 12/27/25 through 12/31/25. There was no other work orders provided regarding side rails for Resident #5. During an interview on 4/09/2026 at 10:37 AM, the Director of Nursing (DON) stated maintenance applies and removes side rails as needed/ordered and should be ensuring the safety of the bed as far as entrapment risk is concerned. On 4/08/2026 at 12:00 PM during an interview, the Maintenance Director stated he was not familiar with the seven zones of entrapment risk, I just know to measure here and here pointing to zones six (6) (between the end of the rail and the side edge of the headboard) and seven (7) (between the head or foot board and the end of the mattress). The Maintenance Director went on to say that they had been employed at the facility for five years and only measured when a work order was submitted for side rails. When asked if a mattress gets switched out or a resident is moved to another room with a different bed whether new measurements are obtained, the Maintenance Director stated, I only do it if I have a work order. I base everything I do on those work orders and I'll be honest; I don't get work orders like I should. The Maintenance Director stated that a contracted vendor comes in annually and does bed safety checks on all the beds. He has a big tool, like a head that he uses to check for entrapment with all the side rails. I asked for one of those tools, but they are like $2,000.00 so they said no. I just use my tape measure. During an interview on 4/10/26 at 2:02 PM, the Maintenance Director stated when nursing calls or puts in a work order for side rails he installs the rails on the bed and measured from the top of the side rail to the headboard only. When asked if he was aware of measuring the seven zones of entrapment, he stated No, I don't know the seven zones. He stated the only training he had received in his five years of employment regarding side rails was from the contractor who comes annually and measures the beds who showed him how to measure the space between the side rail and the headboard and the gap between the mattress and the footboard. The Maintenance Director stated that if he did not know what he was doing, he was putting the residents at risk. When discussing bed identification numbers, the Maintenance Director agreed the beds may have different numbers assigned on each annual bed inspection because the annual assessment was done by room number and a sticker was applied to the bed. The Maintenance Director agreed beds may have different numbers than what is on the last facility bed entrapment inspection completed in July 2025 as it was inspected by room number and then a bed sticker number was placed on the bed. During a meeting with the Administrator, Director of Compliance, and the DON on 4/13/26 at 4:38 PM, the concern of staff failing to attempt the use of alternatives, assess Resident #5 for risk of entrapment, ensure correct installation of side rails to prevent an entrapment risk, ensure the medical provider order specifies the type of side rails, and ensure the installed side rails are correct according to the side rail evaluation was discussed. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	No further information regarding this concern was presented to the survey team prior to the exit conference on 4/13/26. 3. For Resident #1, the facility staff failed to provide evidence that appropriate alternatives were attempted prior to the installation of bilateral half (1/2)-side rails and the facility staff failed to assess for entrapment risks in the seven entrapment zones associated with the utilization of bilateral one-half (1/2) side rails. Resident #1's diagnosis list indicated diagnoses that included, but were not limited to, sepsis, acute and subacute infective endocarditis, encounter for surgical aftercare following surgery on the circulatory system-pacemaker, type 2 diabetes mellitus, acute respiratory failure with hypoxia, and atrial fibrillation. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/3/26 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. Section GG (Functional Abilities) coded the resident as being partial/moderate assist (helper does less than half the effort) for the ability to roll from lying on back to left and right side and moving from lying on back to sitting on the side of the bed. On 4/7/26 at 12:20 PM, observed and interviewed Resident #1. Bilateral 1/2 side rails were noted in the upright position on the resident's bed. Resident #1 stated the side rails do not move, but the bed moves up and down. A review of the medical provider orders disclosed an order with a start date of 2/25/26 which read in part, .May use bedrails to assist with mobility and transfers.Special Instructions: Assistive Device. A review of Resident #1's comprehensive person-centered care plan disclosed a focus with a start date of 2/16/26 which read in part, .need assistance with activities of daily living (ADLs).have a diagnosis of.physical disability, and recent cardiovascular surgery.have left lower extremity hemiparesis/hemiplegia related to prior stroke.use a rollator for mobility.transfer.out of bed without assistance. An intervention associated with the focus read in part, .May have bed rails as ordered/indicated. A review of a Side Rail Use and Risk Observation assessment dated [DATE] was coded to reflect the resident had quarter (1/4) side rails used for .medical symptoms of paralysis and weakness. Factors impacting the use of side rails was coded as .resident requires assistance with transfers.other methods used besides side rails.low bed. (bed place in lowest position).This device is an enabler to promote resident mobility, positioning, and independence. The assessment was coded in the care plan for side rail use section as .N/A – no longer needed. Further review of the side rail assessment and Resident #1's clinical record produced no evidence of alternatives being attempted prior to the utilization of side rails for the resident and produced no evidence of assessment for side rail entrapment risks. On 4/8/26 at 9:26 AM, the maintenance director (MD) was interviewed and observed the side rails on Resident #1's bed. The MD stated the side rails were considered full-size side rails and the rails only move up and down. MD demonstrated the movement of the side rail on the right side of the bed by lifting a small metal bar from the outside of the bed attached to the side rail. The MD flipped the metal (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	bar outward and upward and lowered the side rail down. The side rail did not move from side-to-side. Resident #1 was present in the room at the time of the demonstration and stated they did not realize the side rails moved up and down. Resident #1 stated it was difficult at times to get in and out of bed because they had to get into bed below the side rail and then try pulling themselves up into the bed. Requested and received manufacturers specifications for the side rails utilized by the facility. A review of the information concluded the side rails on Resident #1's bed were 1/2 side rails. Requested and received the most recent facility bed entrapment inspection. The inspection was completed on 7/18/25, prior to the admission of Resident #1 and there was no evidence to confirm if the same bed and/or mattress were currently in place in Resident #1's room. This concern was discussed at the end of day meeting on 4/8/26 at 5:00 PM with the Administrator, Compliance Director, Director of nursing, MDS Coordinator, and Assistant Director of Nursing. On 4/9/26 at 10:33 AM, Resident #1 was interviewed and stated movement was not hindered by the 1/2 side rails on the bed and the side rails were needed at the beginning of their admission to the facility following surgery. Resident #1 stated that they lowered the side rails last evening (4/8/26) and it was easier to get in and out of bed. On 4/9/26 at 10:37 AM, the Director of nursing (DON) observed Resident #1's side rails and agreed the side rails were 1/2 side rails. The DON stated they are looking into updating the side rails and stated the side rails enhance a resident's mobility and independence. The benefits and risks are discussed with the resident and family, and they sign a negotiated risk agreement. Requested and received a Nego

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 and clinical record review, the facility staff failed to revise and/or reassess the effectiveness of the interventions of the comprehensive person-centered activity care plan to meet the needs of facility residents. The findings included:A review of the clinical records for the current sampled facility residents did not disclose activity progress notes for resident quarterly care plan reviews. On 4/8/26 at 9:10 AM, the activity director (AD) was interviewed and asked if a quarterly activity progress note or activity assessment is completed for each resident. The AD stated they do a care plan note. The activity assistant (AA) agreed that a quarterly activity progress note is completed with review of the resident care plans. A review of the activity care plan progress notes for the current sampled facility residents disclosed the start date of the initial care plan, the last reviewed/revised date of the activity care plan, and the activity care plan focus, goal, and interventions. The note did not disclose information about revisions to the activity care plan or the effectiveness of the activity interventions. On 4/8/26 at 2:46 PM, the AD was asked how a resident's progress in activities is followed and how the effectiveness of the activity care plan goals and interventions are measured as no activity quarterly progress notes could be located in the residents' clinical records. The AD stated adjustments to the residents' activity care plans are made as needed. The AD agreed that quarterly activity progress notes are not completed for the residents of the facility and there is no activity assessment to utilize. A printed copy of Section F (Preferences for Customary Routine and Activities) from the MDS (minimum data set) is used for admission assessments and the residents' interests are written on this paper at the time of the initial activity assessment. This concern was discussed at the end of day meeting on 4/8/26 at 5:00 PM with the administrator, compliance director, director of nursing, MDS coordinator, and assistant director of nursing. Requested, but did not receive a facility policy for activity assessments and/or activity progress notes. On 4/8/26 at 1:56 PM, the administrator stated the facility utilizes the regulations for guidance. No further information was provided prior to exit on 4/13/26.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to develop a comprehensive person-centered activity care plan to address the resident's activity preferences, interests, and psychosocial needs for (5) five of (26) twenty-six current sampled residents, Resident #1, Resident #2, Resident #19, Resident #25, and Resident #7. The findings included: 1. For Resident #1 the facility staff failed to develop a comprehensive person-centered activity care plan to address the resident's activity preferences, interests, and psychosocial needs. Resident #1's diagnosis list indicated diagnoses that included, but were not limited to, sepsis, acute and subacute infective endocarditis, encounter for surgical aftercare following surgery on the circulatory system-pacemaker, type 2 diabetes mellitus, acute respiratory failure with hypoxia, and atrial fibrillation. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/3/26 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of the comprehensive care plan disclosed a focus with a start date of 2/20/26 and a reviewed/revised date of 3/3/26, which read in part, .Activities.concerned about being able to participate in activity programs that meet.leisure needs and wants. The goal associated with the focus read in part, .would like to choose which activity programs to participate in through.next review. The one intervention associated with the focus read in part, .Please place a large monthly calendar in.room. On 4/8/26 at 2:46 PM, the activity director (AD) was interviewed and stated they make adjustments to the care plan as needed. The AD stated they do not have an activity assessment, and they utilize a copy of Section F (from the MDS) and write the resident's interests on the paper at the time of assessment. A review of an admission MDS dated [DATE] Section F (Preferences for Customary Routine and Activities) F0500 disclosed it was very important for Resident #1 to keep up with the news and participate in favorite activities. It was somewhat important for the resident to go outside in nice weather. On 4/8/26 at 4:15 PM, the AD was interviewed and agreed the activity care plan for Resident #1 was not person-centered/individualized. This concern was discussed on 4/10/26 at 4:16 PM at the end of day meeting with the administrator, president/chief executive officer, director of nursing, and compliance director. Requested and received a facility policy titled, Comprehensive Care Plans with an implementation date of 9/26/24, which read in part, .A resident centered care plan will be developed for each resident with goals to meet the resident's.social.and psychological needs.3. A care plan team, in coordination with the resident and their representative, develops and maintains a resident centered comprehensive care plan for each resident.4. The comprehensive care plan is designed to.a. incorporate identified needs.c. Build on the resident's strengths.d. Reflect the goals and objectives in measured outcomes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit on 4/13/26. 2. For Resident #2 the facility staff failed to develop a comprehensive person-centered activity care plan to address the resident's activity preferences, interests, and psychosocial needs. Resident #2's diagnosis list indicated diagnoses that included, but were not limited to, dementia, anxiety disorder, obsessive-compulsive disorder, and depression-severe with psychotic disturbance. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/2/26 assigned the resident a brief interview for mental status (BIMS) summary score of 99 indicating the resident was unable to complete the interview. Further review of Section C (Cognitive Patterns) disclosed the resident had short and long-term memory problems, and moderate impairment in daily decision making. A review of the comprehensive care plan disclosed a focus with a start date of 6/28/24 and a reviewed/revised date of 3/3/26, which read in part, .Activities.enjoy bird watching.like to watch TV.visit with friends and family.quietly socialize.usually decline coming to activities. A goal associated with the focus read in part, .would like to choose which activity programs to participate in through.next review. Interventions associated with the focus read in part, .accept.right to decline.praise involvement.provide 1 on 1 sessions in.room.please place a large monthly calendar in.room. On 4/8/26 at 2:46 PM, the activity director (AD) was interviewed and stated they make adjustments to the care plan as needed. The AD stated they do not have an activity assessment, and they utilize a copy of Section F (from the MDS) and write the resident's interests on the paper at the time of assessment. A review of the most recent comprehensive MDS assessment dated [DATE] containing Section F (Preferences for Customary Routine and Activities) F0500 (Interview for Activity Preferences) was coded to reflect the following activities were somewhat important to Resident #2, having books/newspapers/magazines to read, being around animals, going outside in nice weather, and participation in religious services or practices. On 4/8/26 at 4:15 PM, the AD was interviewed and agreed the activity care plan for Resident #2 was not person-centered/individualized. This concern was discussed on 4/10/26 at 4:16 PM at the end of day meeting with the administrator, president/chief executive officer, director of nursing, and compliance director. Requested and received a facility policy titled, Comprehensive Care Plans with an implementation date of 9/26/24, which read in part, .A resident centered care plan will be developed for each resident with goals to meet the resident's.social.and psychological needs.3. A care plan team, in coordination with the resident and their representative, develops and maintains a resident centered comprehensive care plan for each resident.4. The comprehensive care plan is designed to.a. incorporate identified needs.c. Build on the resident's strengths.d. Reflect the goals and objectives in measured outcomes. No further information was provided prior to exit on 4/13/26. 3. For Resident #19 the facility staff failed to develop a comprehensive person-centered activity care (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plan to address the resident's activity preferences, interests, and psychosocial needs. Resident #19's diagnosis list indicated diagnoses that included but were not limited to vascular dementia-severe, cerebrovascular disease, chronic kidney disease-stage 3 (three), Alzheimer's Disease, and cerebral infarction. The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 4/1/26, was coded in Section C (Cognitive Patterns), to reflect the resident as being rarely/never understood with short and long-term memory problems, and severe impairment in decision making, indicating the resident was severely impaired in cognition. A review of Section F (Preferences for Customary Routine and Activities) F0500 (Interview for Activity Preferences) was coded with (9) No response or non-responsive. F0600 (Daily and Activity Preferences Primary Respondent) was coded as (9) Interview could not be completed by resident or family/significant other. A review of the comprehensive care plan disclosed a focus with a start date of 6/6/25 and a reviewed/revised date of 4/2/26, which read in part, .Activities.enjoy listening to music.likes to have snacks between meals. A goal associated with the focus read in part, .would like to choose which activity programs to participate in through.next review. One intervention was associated with the focus which read in part, .Please place large monthly calendar in.room. On 4/8/26 at 2:46 PM, the activity director (AD) was interviewed and stated they make adjustments to the care plan as needed. The AD stated they do not have an activity assessment, and they utilize a copy of Section F (from the MDS) and write the resident's interests on the paper at the time of assessment. On 4/8/26 at 4:15 PM, the AD was interviewed and agreed some of the activity care plans are not person-centered/individualized. This concern was discussed on 4/10/26 at 4:16 PM at the end of day meeting with the administrator, president/chief executive officer, director of nursing, and compliance director. Requested and received a facility policy titled, Comprehensive Care Plans with an implementation date of 9/26/24, which read in part, .A resident centered care plan will be developed for each resident with goals to meet the resident's.social.and psychological needs.3. A care plan team, in coordination with the resident and their representative, develops and maintains a resident centered comprehensive care plan for each resident.4. The comprehensive care plan is designed to.a. incorporate identified needs.c. Build on the resident's strengths.d. Reflect the goals and objectives in measured outcomes. No further information was provided prior to exit on 4/13/26. 4. For Resident #25 the facility staff failed to develop a comprehensive person-centered activity care plan to address the resident's activity preferences, interests, and psychosocial needs. Resident #25's diagnosis list indicated diagnoses that included, but were not limited to, vascular dementia with other behavioral disturbance, neurocognitive disorder with Lewy Bodies Dementia, dementia, anxiety disorder, depression, and cognitive communication deficit. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/6/26 was coded in Section C (Cognitive Patterns), to reflect the resident as being rarely/never understood with short and long-term memory problems, and severe impairment in decision making, indicating the resident was severely impaired in cognition. A review of the comprehensive care plan disclosed a focus with a start date of 1/6/26 and a reviewed/revised date of 4/7/26, which read in part, .Activities.concerned about being able to participate in activity programs that meet.leisure needs and wants. The goal associated with the focus read in part, .would like to choose which activity programs to participate in through.next review. The one intervention associated with the focus read in part, .Please place a large monthly calendar in.room. On 4/8/26 at 2:46 PM, the activity director (AD) was interviewed and stated they make adjustments to the care plan as needed. The AD stated they do not have an activity assessment, and they utilize a copy of Section F (from the MDS) and write the resident's interests on the paper at the time of assessment. On 4/8/26 at 4:15 PM, the AD was interviewed and agreed the activity care plan for Resident #25 was not person-centered/individualized. This concern was discussed on 4/10/26 at 4:16 PM at the end of day meeting with the administrator, president/chief executive officer, director of nursing, and compliance director. Requested and received a facility policy titled, Comprehensive Care Plans with an implementation date of 9/26/24, which read in part, .A resident centered care plan will be developed for each resident with goals to meet the resident's.social.and psychological needs.3. A care plan team, in coordination with the resident and their representative, develops and maintains a resident centered comprehensive care plan for each resident.4. The comprehensive care plan is designed to.a. incorporate identified needs.c. Build on the resident's strengths.d. Reflect the goals and objectives in measured outcomes. No further information was provided prior to exit on 4/13/26. 5. For resident #7 the facility staff failed to develop a person-centered comprehensive care plan for activity preferences. A facility policy entitled, Comprehensive Care Plans and with an implementation date of 9/26/24 read in part, A resident centered care plan will be developed for each resident with goals to meet the resident's medical, nursing, mental, social, nutritional and psychological needs. Under the heading Policy item #5 read, The resident's comprehensive care plan is developed within seven (7) days of the completed resident's comprehensive assessment (MDS). A Resident Face Sheet revealed the facility admitted resident #7 on 03/03/2026. According to the face sheet the resident had a medical history that included Alzheimer's, Parkinson's, generalized anxiety, major depressive disorder and post-traumatic stress disorder. An admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/10/2026 and a completed date of 03/16/2026 revealed that resident #7 had a brief interview for mental status (BIMS) score of 9 indicating moderate cognitive impairment. The MDS revealed that resident #7 felt listening to music, being around animals or pets, participating in groups and going outside for fresh air was very important. Having access to books and keeping up with the news was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	marked as somewhat important. 04/08/2026 10:21 AM Resident #7 was observed sitting in the day room or common area along with a large group of other residents and some staff members. Resident #7 was in a wheelchair with eyes closed, not engaged with the group. The resident was at a table with back turned to the main group participating in story time. At 11:20 AM resident #7 was observed sitting in the same location. A group of residents were involved in an exercise program but resident #7 was not engaged but again sitting facing an opposite direction as the rest of the group and seemed unaware that an activity was happening. On 04/08/2026 at 4:15 PM the survey team met with the Activities Director. When asked whether the activity care plan for resident #7 was individualized and person-centered the Activity Director stated, No, it isn't. On 04/10/2026 at 4:16 PM the survey team met with the Administrator, Director of Nursing, and Director of Compliance. This concern was reviewed with them at that time. No further information was provided to the survey team prior to the exit conference.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure completion of monthly medication regimen reviews for 5 of 26 sampled resident, Resident #9, #39, #41, #8, and #2. The findings included: 1.For resident #9 the facility staff failed to ensure a monthly drug regimen review was completed by a pharmacist for May 2025. A facility policy entitled Drug Regimen Review (DRR) with an implementation date of 9/25/25 specified, A consultant pharmacist shall conduct a drug regimen review for each resident monthly in the Cove (long-term care center). Item 2. Under the heading Policy read in part, Purpose of the review: The review aims to ensure the safe and effective use of medications by: Identifying potential drug-drug or drug-food interactions. Verifying those medications are prescribed and administered as ordered by the attending physician. Confirming that medications are administered at the correct time, in the appropriate dose, and in the correct dosage form. Monitoring for signs and symptoms of adverse drug reactions or interactions. Detecting any medication or documentation errors. The Resident Face Sheet for resident #9 revealed the facility admitted the resident on 4/19/25. According to the document the resident had a medical history that included diagnoses of major depressive disorder, generalized anxiety disorder, hypertension and chronic kidney disease. A quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/9/26 revealed resident #9 had a brief interview for mental status score (BIMS) of 15, which indicated the resident has intact cognition. During review of the clinical record there was no drug regimen review for May 2025 observed. On 4/10/26 at 4:17 PM the survey team met with the Director of Nursing (DON), Administrator and Director of Compliance. This concern was discussed with them at that time. The DON stated, That was about the time we switched pharmacies and that was part of the reason why we switched. The DON confirmed that there was no evidence of a drug regimen review being done in May 2025. No further information was provided to the survey team prior to the exit conference on 4/13/26. 2.For resident #39, the facility staff failed to ensure a monthly drug regimen review was completed by a pharmacist for the month of May 2025. The Resident Face Sheet for resident #39 revealed the facility admitted the resident on 6/2/22. According to the document the resident had a medical history that included diagnoses of chronic systolic heart failure, chronic obstructive pulmonary disease, hypertension, bipolar disorder, psychotic disturbance, mood disturbance and anxiety. A quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/6/26 revealed resident #39 had a brief interview for mental status score (BIMS) of 10, which indicated the resident had moderate cognitive impairment. During review of the clinical record there was no drug regimen review for May 2025 observed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/10/2026 4:05 PM the Administrator was interviewed and stated there were no drug regimen reviews for last May 2025 and said the facility did switch to another pharmacy. On 4/10/26 at 4:17 PM the survey team met with the Director of Nursing (DON), Administrator and Director of Compliance. This concern was discussed with them at that time. The DON stated, That was about the time we switched pharmacies and that was part of the reason why we switched. The DON also confirmed that there was no evidence of a drug regimen review being done in May 2025. No further information was provided to the survey team prior to the exit conference on 4/13/26. 3.For resident #41 the facility staff failed to ensure a monthly drug regimen review was completed by a pharmacist for May 2025. The Resident Face Sheet for resident #41 revealed the facility admitted the resident on 7/6/24. According to the document the resident had a medical history that included diagnoses of dementia, anxiety, schizophrenia, schizoaffective disorder, major depressive disorder and generalized idiopathic epilepsy. A quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/30/26 revealed resident #41 had a brief interview for mental status score (BIMS) of 8 out of 15, which indicated the resident had moderate cognitive impairment. During review of the clinical record there was no drug regimen review for May 2025 located. On 4/10/26 at 4:17 PM the survey team met with the Director of Nursing (DON), Administrator and Director of Compliance. This concern was discussed with them at that time. The DON stated, That was about the time we switched pharmacies and that was part of the reason why we switched. The DON confirmed that there was no evidence of a drug regimen review being done in May 2025. No further information was provided to the survey team prior to the exit conference on 4/13/26. 4. For Resident #8, the facility staff failed to ensure a monthly drug regimen review was completed by a licensed pharmacist for the month of May 2025. A facility policy titled, Drug Regimen Review (DRR), implemented on 9/25/25, specified, A consultant pharmacist shall conduct a drug regimen review (DRR) for each resident monthly in the Cove [long-term care center]. The Resident Face Sheet indicated the facility admitted Resident #8 on 11/22/20. According to the Resident Face Sheet, the resident had a medical history that included Alzheimer's Disease, major depressive disorder, generalized anxiety disorder, and psychophysiologic insomnia. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/02/26, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) summary score of 10 out of 15 indicating the resident was moderately cognitively impaired. A review of Resident #8's clinical record failed to reveal a drug regimen review for the month of May 2025. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/13/26 at 9:21 AM, the Compliance Director stated there was no May 2025 drug regimen review for Resident #8. She further stated the facility switched pharmacies during this time and the new pharmacy started in June 2025. On 4/13/26 at 4:38 PM, the concern of Resident #8's monthly drug regimen review not being completed in May 2025 was discussed with the Administrator, Director of Compliance, and the Director of Nursing. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/13/26. 5. For Resident #2 the facility staff failed to ensure a monthly medication regimen review (MRR) was completed for the months of May 2025 and October 2025. Resident #2's diagnosis list indicated diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, atherosclerosis of coronary artery, dementia, anxiety disorder, obsessive-compulsive disorder, and depression-severe with psychotic disturbance. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/2/26 assigned the resident a brief interview for mental status (BIMS) summary score of 99 indicating the resident was unable to complete the interview. Further review of Section C (Cognitive Patterns) disclosed the resident had short and long-term memory problems, and moderate impairment in daily decision making. A review of Resident #2's MRRs did not disclose MRRs were completed for May 2025 and October 2025. Requested evidence of completion of MRRs for May and October 2025. On 4/13/26 at 10:09 AM, the compliance director (CD) was interviewed and stated a new pharmacy was obtained and did not start pharmacy reviews until June 2025, and agreed there was no evidence that a MRR was completed for May 2025. The CD stated October 2025 did not pull into the new pharmacy until November 2025 and agreed there was no evidence the pharmacy review was completed for October 2025. This concern was discussed at the pre-exit meeting on 4/13/26 at 4:38 PM with the administrator, director of nursing, and compliance director. Requested and received a facility policy titled, Drug Regimen Review with an implementation date of 9/25/25 which read in part, .A consultant pharmacist shall conduct a drug regimen review for each resident monthly. No further information was provided prior to exit on 4/13/26.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on staff interview and facility document review, the facility staff failed to provide evidence of staff training that outlines and informs staff of the elements and goals of the facility's Quality Assurance and Performance Improvement (QAPI) program for four of four sampled staff members, Certified Nursing Assistant (CNA) #3, Registered Nurse (RN) #1, Dining Server #1, and the facility Maintenance Director. The findings included: A facility policy titled, Quality Assurance and Performance Improvement (QAPI), reviewed 1/29/26, specified All facility staff, contracted staff, and volunteers will be educated about the QAPI plan and their role in development and implementation of interventions.The facility staff were unable to provide evidence of staff training regarding the facility's QAPI program for CNA #3, RN #1, Dining Server #1, and the facility Maintenance Director. During an interview on 4/13/26 at 2:53 PM, the facility Compliance Director stated the facility provides QAPI training but does not have staff signature sheets as evidence of the trainings. On 4/13/26 at 4:38 PM, the concern of staff failing to provide evidence of QAPI training was discussed with the Administrator, Director of Compliance, and the Director of Nursing.No further information regarding this concern was presented to the survey team prior to the exit conference on 4/13/26.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview, employee record review, and facility document review, the facility staff failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property as evidence by failure to obtain a criminal background check on one (1) of 25 new hire employees, Dining Server #2.The findings included: A facility policy titled, Abuse Prohibition Policy, implemented 4/25/24, specified, The facility will screen potential employees for a history of abuse, neglect or mistreating residents by taking the following actions.Criminal background history checks will be conducted on every candidate through the Virginia State Police prior to employment. Any applicant found guilty of a barrier crime or guilty by a court of law of abuse, neglect, exploitation, misappropriation of resident property or mistreatment shall be disqualified for employment.Dining Server #2's date of employment was documented as 2/02/26; however, the provided Virginia State Police background check was received on 7/06/23 indicating no identifiable records found. During an interview on 4/10/26 at approximately 3:30 PM, the Human Resource Director stated Dining Server #2 previously worked at the facility from 7/10/23 through 3/09/25 and was re-hired on 2/02/26. She stated a criminal background check was completed prior to the employee's first employment term but was not completed when Dining Server #2 was re-hired on 2/02/26. The Human Resource Director stated with any re-hire, a new criminal background check was completed but Dining Server #2's background check got missed.On 4/13/26 at 4:38 PM, the concern of staff failing to obtain a Virginia State Police criminal background check for Dining Server #2 was discussed with the Administrator, Director of Compliance, and the Director of Nursing. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/13/26.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on staff interview, clinical record review, and facility document review, the facility staff failed to report a resident allegation of sexual abuse to the State Survey Agency for one (1) of 26 current sampled residents, Resident #48. The findings included:A facility policy titled, Abuse Prohibition Policy, implemented 4/25/24, specified, All staff shall ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made. If the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.A Resident Face Sheet revealed the facility admitted Resident #48 on 1/20/26. According to the Resident Face Sheet, Resident #48 had a medical history that included parkinsonism, vascular dementia with agitation, generalized anxiety disorder, and major depressive disorder. An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/26/26 assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 6 out of 15 indicating Resident #48 was severely cognitively impaired. Resident #48's comprehensive person-centered care plan included a problem area that indicated the resident had a diagnosis of dementia and sometimes have behaviors such as wandering, grabbing others, restlessness, delusions and agitation.A nursing progress note dated 2/22/26 at 5:27 PM revealed Male CNA [certified nursing assistant] assisted resident to his bathroom via w/c [wheelchair] per resident statement he needed to have a BM [bowel movement]. CNA then exited resident's room stating ?I can't help him in there.' When asked why, CNA stated ?I got him in front of the toilet, and then he said ?This is rape.' This nurse asked for details: CNA stated he got the resident to stand in front of the commode, resident hadn't pulled his pants down yet, and he stated those words. CNA stated he was no longer comfortable helping the resident. This nurse advised all CNAs to not enter this resident's room without another staff member as witness. At this time, resident still required assist to use bathroom at this point - 2 CNAs assisted him in the bathroom and reported no further incidents. Resident was calm when he returned to the common area after using bathroom, and made no further inappropriate statements. This nurse notified [facility name] social worker of the incident and provided known details, then called both CNAs involved and instructed them to prepare written statements today with all details and forward these statements to the social worker's secure email address.During an interview on 4/13/26 at 12:20 PM, the Administrator stated the incident involving Resident #48's statement of This is rape was not reported to the State Survey Agency because it was the same behaviors that the resident displayed while in assisted living. When pointed out that this behavior was not present on the resident's care plan, the Administrator stated the care plan had generalized behaviors. On 4/13/26 at 4:38 PM, the concern of staff failing to report Resident #48's allegation of sexual abuse to the State Survey Agency was discussed with the Administrator, Director of Compliance, and the Director of Nursing. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/13/26.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide written notification of the reason(s) for transfer/discharge to the resident representative for (1) one of (26) twenty-six current sampled residents, Resident #19. The findings included:For Resident #19, the facility staff failed to provide written notification for the reason(s) of a transfer/discharge to the resident's representative for a transfer/discharge to a higher level of care that occurred on 2/24/26. Resident #19's diagnosis list indicated diagnoses that included but were not limited to vascular dementia-severe, cerebrovascular disease, chronic kidney disease-stage 3 (three), Alzheimer's Disease, and cerebral infarction. The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 4/1/26, was coded in Section C (Cognitive Patterns), to reflect the resident as being rarely/never understood with short and long-term memory problems, and severe impairment in decision making, indicating the resident was severely impaired in cognition. A review of the clinical record disclosed Resident #19 was transferred to a higher level of care on 2/24/26. No evidence of written notification for the reason(s) of transfer/discharge being provided to the resident's representative could be located. Requested evidence of written notification for reason(s) of transfer/discharge for Resident #19's representative for the transfer/discharge that occurred on 2/24/26. On 4/10/26 at 12:06 PM, the compliance director (CD) was interviewed and stated a written transfer form was provided to the resident at the time of transfer to the hospital on 2/24/26. The CD stated they were unsure if the resident representative was provided with a written notice of the reason(s) for the transfer/discharge and they would see if evidence could be located. This concern was discussed at the end of day meeting on 4/10/26 at 4:16 PM with the administrator, director of nursing, compliance director, president/chief executive officer, and staff development coordinator. On 4/13/26 at 9:36 AM, the CD agreed there was no evidence that written notification for the reason(s) of transfer/discharge was provided to the resident's representative for the transfer/discharge on [DATE]. Requested and received a facility policy titled, Discharge of Residents with an implementation date of 7/19/17, which read in part, .7. Under emergency conditions, the resident's legal representative.shall be informed as rapidly as possible, but by the close of the business day following discharge, of the reasons for the move. No other information was provided prior to exit on 4/13/26.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review the facility staff failed to develop a baseline care plan within 48 hours for (1) one of (26) twenty-six current sampled residents, Resident #59. The findings included:For Resident #59, the facility staff failed to develop a baseline care plan within (48) forty-eight hours of admission. Resident #59's diagnosis list indicated diagnoses that included, but were not limited to, neuropathy, scoliosis, depression, and history of chronic urinary tract infections. The most recent admission minimum data set (MDS) was not completed at time of survey. A review of a brief interview for mental status (BIMS) assessment dated [DATE], assigned the resident a score of 6 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of Resident #59's clinical record disclosed that the resident was admitted to the facility on [DATE]. A baseline care plan could not be located. Requested and received a baseline care plan dated 4/7/26. On 4/13/26 at approximately 9:00 AM, the compliance director was interviewed and agreed the baseline care plan was not completed for Resident #59 within 48 hours of admission. This concern was discussed at the pre-exit meeting on 4/13/26 at 4:38 PM with the administrator, director of nursing, and compliance director. Requested and received a facility policy titled, Comprehensive Care Plans with an implementation date of 9/26/24, which read in part, .A baseline care plan is developed upon the resident's admission. No further information was provided prior to exit on 4/13/26.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to follow medical provider orders for 3 of 26 current sampled residents, Resident #50, #2, and #19. The findings included: 1. For resident #50 the facility staff failed to follow medical provider orders for a Dulcolax suppository to be administered to the resident after three days of having no bowel movement. An undated facility document entitled, Bowel Regimen read in part, Purpose: 1. To achieve control of bowel evacuation on a regular basis. 2. To avoid constipation. 3. To prevent decubiti (pressure ulcers) and skin irritation. 4. To improve morale of the resident. 5. To restore the resident's dignity and self-respect. 6. To restore the optimum level of bowel function. On page 2 of the document under the heading, Regimen item #3 read, After third day, if resident has not had a bowel movement, a laxative should be given as ordered by the physician. The Resident Face Sheet indicated the facility admitted resident #50 on 07/30/2024. According to the face sheet, the resident had a medical history that included diagnoses of constipation, Alzheimer's, psychotic disorder, mood disturbance and anxiety. A significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/02/2026 revealed that resident #50 had a brief interview for mental status (BIMS) score of 06 which indicated severe cognitive impairment. Resident #50's Care Plan included a problem statement initiated on 08/08/2024 that read, I have pain at times and am at risk for pain related to the diagnosis of polyosteoarthritis, abnormal posture, chronic pain, Basal cell carcinoma to my RLE [right lower extremity], melanoma to my neck and my hx [history] of fractures. I recently fell and have pain to the L [left] side of my face. An intervention dated 2/27/26 directed staff to, Monitor for signs and symptoms of constipation including decreased bowel movements, abdominal discomfort, bloating or difficulty passing stool. A problem statement dated 11/4/24 read, I receive medication for my diagnosis of constipation. An intervention of the same date read, 1. Administer medication and reassess for effectiveness 2. Monitor bowel movements 3. Monitor for signs and symptoms of constipation such as fewer than three stools a week, hard, dry or lumpy stools, straining or pain when passing stools, a feeling that not all stool has passed and a feeling that the rectum is blocked, abdominal pain. 4. Notify MD/NP/Hospice as indicated. The Vitals Report for resident #50 was reviewed for the time period of 03/1/26-04/8/26. The report revealed that resident #50 went from 03/30/2026 until 04/6/2026 with no bowel movement. A large bowel movement was documented at 12:03 PM on 04/06/2026. The Medication Administration Record (MAR) for resident #50 was reviewed. The MAR indicated that resident #50 was ordered and administered a Dulcolax 10 mg suppository at 10:57 AM on 04/06/2026. Resident also had an order for Senna Laxative 8.6 mg two tablets daily at bedtime since 04/04/2024. The facility staff provided the Medical Standing Orders. The document read in part, The following orders are effective except when the patient has a specific allergy to any medication listed. The following orders have been approved by the physician if any of the following arise you do not need to call the on call to get orders. Under the heading Constipation the document read in part, 1. MOM (milk (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of magnesia) 30 cc PO (by mouth) QD (every day) PRN (as needed) for no BM (bowel movement) in 3 days or c/o (complaints of) constipation from resident. 2. Dulcolax Suppository 10 mg everyday x 72 hours as needed for no bm in 3 days or c/o constipation from the resident. 3. Fleets Enema QD PRN [as needed] for no bm in 3 days or c/o constipation from resident. On 04/10/2026 at 4:16 PM the survey team met with the Director of Nursing, Administrator, and the Director of Compliance. This concern was discussed at that time. No further information was provided to the survey team prior to the exit conference. 2. For Resident #2, the facility staff failed to follow a medical provider order for bowel protocol during a seven-day period without a bowel movement from 3/29/26 through 4/4/26. Resident #2's diagnosis list indicated diagnoses that included, but were not limited to, benign neoplasm of colon, constipation, and unspecified hemorrhoids. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/2/26 assigned the resident a brief interview for mental status (BIMS) summary score of 99 indicating the resident was unable to complete the interview. Further review of Section C (Cognitive Patterns) disclosed the resident had short and long-term memory problems, and moderate impairment in daily decision making. A review of a medical provider orders disclosed an order with a start date of 9/20/25 which read in part, .Senna-S (sennosides-docusate sodium).tablet 8.6-50 mg (milligrams).1 tab (tablet).oral.constipation Twice A Day – PRN (as needed). Further review of a medical provider orders disclosed an order with a start date of 9/20/25 which read in part, .bisacodyl.suppository; 10 mg: Amount to administer; 1; rectal (inserted into the rectum).Once a day PRN.constipation. A review of the March 2026 MAR (medication administration record) disclosed Resident #2 received (1) one tablet of Senna by mouth on 3/29/26 at 10:55 PM. There was no documentation on the March 2026 MAR that Resident #2 received a bisacodyl suppository at any time during the month. A review of the April 2026 MAR disclosed Resident #2 received 1 tablet of Senna by mouth on 4/3/26 at 8:27 PM. There was no documentation on the April 2026 MAR from 4/1/26 through 4/4/26 that Resident #2 received a bisacodyl suppository. A nursing progress note dated 4/5/26 read in part, .It was reported to this nurse that the resident has not had a BM (bowel movement) for several days and has been given PRN senna with no results, a suggestion was voiced to this nurse that the resident needs to sit on the commode for a while to empty.bowel, as [Resident #2] has done in the past. Resident was placed on the commode and sat there app. (approximately) 20 minutes.resident had two XL (extra-large) BM's in the commode. A review of Resident #2's comprehensive person-centered care plan disclosed a focus with a start date of 10/1/25, which read in part, .diagnosis of constipation. Interventions associated with the focus read in part, .Monitor bowel movements. Monitor for signs and symptoms of constipation such as fewer stools in a week.straining or pain when passing stools.Administer medications as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Requested and received Resident #2's bowel elimination records for March and April 2026. A review of the records disclosed Resident #2 had one small bowel movement on 3/28/26 and two large bowel movements on 4/5/26. Requested and received the medical standing orders for bowel protocol which read in part, .The following orders are effective.The following orders have been approved by the physician if any of the following arise.CONSTIPATION.MOM (milk of magnesia) 30 cc (cubic centimeter(s), a metric unit of volume commonly used for liquid medications) PO (by mouth) QD (daily) x 72 hours as needed for no BM in 3 days.Dulcolax Suppository 10 mg every day x 72 hrs (hours) as needed for no BM in 3 days.Fleets Enema QD PRN, for no BM in 3 days. On 4/9/26 at 10:33 AM, the director of nursing (DON) was interviewed and agreed there was no evidence the bowel protocol was followed from 3/29/26 through 4/4/26 and agreed Resident #2 went seven days without a bowel movement. The DON stated no progress notes could be located if the resident refused the medications if they were offered. The DON stated the resident is on hospice services and hospice has diagnosed the resident with malnutrition. The DON stated the resident has a low percentage of meal intake and provided Resident #2's meal intake records for March and April 2026. A review of Resident #2's meal intake percentages from 3/29/26 through 4/4/26 disclosed that Resident #2 ate 26-50% of breakfast on three separate days (3/29, 4/3, 4/4/26). The resident consumed 51-75% of lunch on three separate days (3/29, 3/31, 4/4/26) and consumed 76-100% of lunch on 4/1/26. The resident consumed 26-50% of dinner on 2 separate days (3/30 and 3/31/26). This concern was discussed at the end of day meeting on 4/10/26 at 4:16 PM with the administrator, president/chief executive officer, director of nursing, staff development director, and director of compliance. Requested and received a facility policy titled, Bowel Regimen which read in part, .Regimen.3. After third day, if resident has not had a bowel movement, a laxative should be given as ordered by the physician.5.a resident should not be allowed to go for more than three days without a bowel movement. No further information was provided prior to exit on 4/13/26. 3. For Resident #19, the facility staff failed to follow a medical provider order for no straws. Resident #19's diagnosis list indicated diagnoses that included but were not limited to vascular dementia-severe, cerebrovascular disease, chronic kidney disease-stage 3 (three), Alzheimer's Disease, and cerebral infarction. The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 4/1/26, was coded in Section C (Cognitive Patterns), to reflect the resident as being rarely/never understood with short and long-term memory problems, and severe impairment in decision making, indicating the resident was severely impaired in cognition. On 4/8/2026 at 1:24 PM, Resident #19 was observed resting in bed. A water pitcher was observed on the resident's over-the-bed table with a straw present in the pitcher. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a medical provider orders disclosed an order with a start date of 3/23/26 which read in part, Regular, Pureed (diet) Special Instructions.NO STRAWS. A review of the comprehensive person-centered care plan disclosed a focus with an initiated date of 6/10/25 and a reviewed date of 4/3/26, which read in part, .Nutritional Status.at nutrition risk due to hx (history) of dementia.and stroke.hx of coughing/choking at meals and.on a mechanically altered diet.no straws with drinks to avoid coughing/choking. A goal associated with the focus read in part, .will tolerate.diet without difficulty swallowing or coughing/choking. An intervention associated with the focus read in part, .PO (by mouth) intake will be monitored regularly. Resident #19 was observed on 4/9/26 at 8:45 AM with a two-handled cup present on the over-the-bed table, no straws were present. On 4/10/26 at 3:50 PM, Resident #19 was observed. An empty glass was present on the over-the-bed table with a straw present in the glass. This concern was discussed at the end of day meeting on 4/10/26 at 4:16 PM with the administrator, director of nursing, compliance director, president/chief executive officer, and staff development director. Requested and received a facility policy titled, Physician's Orders with a revised date of 11/5/06, which read in part, .Physician's orders will be.implemented by qualified professional staff according to state, federal regulations and clinical standards of practice. No further information was provided prior to exit on 4/13/26.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure two (2) of 26 current sampled residents (Resident #6 and Resident #5) received assistive devices to prevent accidents. The findings included:1. For Resident #6, the facility staff failed to ensure safety devices including Dycem (a non-slip material used to provide grip), a perimeter mattress (mattress with raised edges to prevent rolling out of bed), and a wheelchair anti-rollback device (a safety mechanism that automatically prevents a wheelchair from rolling backward when the user stands up) were in use to prevent falls. A Resident Face Sheet revealed the facility admitted Resident #6 on 10/14/25. According to the Resident Face Sheet, the resident had a medical history that included severe vascular dementia with anxiety, generalized muscle weakness, history of falling, and abnormalities of gait and mobility. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/11/26 indicated the resident had severe impairment in cognitive skills for daily decision-making and short-term and long-term memory problems. Resident #6 was coded as having two or more falls with injury and two or more falls without injury since the prior MDS assessment on 10/20/25. Resident #6's fall risk observation dated 1/08/26 indicated the resident was a high fall risk. Resident #6's comprehensive person-centered care plan included a problem statement indicating the resident was at risk for falls related to impaired vision, decreased mobility, psychotropic medications, history of falls, and poor safety awareness. Fall prevention approaches included but were not limited to Dycem to wheelchair above and below cushion (start date 2/09/26), perimeter mattress (start date 2/06/26), and anti-rollbacks on wheelchair (start date 2/02/26). Resident #6's current medical provider orders included an order dated 1/13/26 to ensure Dycem in wheelchair and an order dated 2/06/26 indicating the resident may have a perimeter mattress. An observation on 4/08/26 at 9:23 AM revealed Certified Nursing Assistant (CNA) #1 and CNA #2 assist Resident #6 to her room in her wheelchair for a transfer. When Resident #6 was assisted to stand, there was no Dycem present in the wheelchair below or above the seat cushion. The wheelchair also did not have anti-rollbacks present. When asked if Resident #6's wheelchair had anti-rollbacks present, CNA #2 stated It does not. While in Resident #6's room it was noted that her mattress was not a perimeter mattress. When CNA #2 was asked what type of mattress was present on the bed, she stated a regular mattress.On 4/08/26 at 9:36 AM, the Administrator was observed carrying a perimeter mattress down the hall and into Resident #6's room. On 4/13/26 at 4:38 PM, the Administrator, Director of Nursing, and the Compliance Director were informed of staff failing to ensure Resident #6 had Dycem present in wheelchair, anti-rollbacks on wheelchair, and perimeter mattress in place.No further information regarding this concern was presented to the survey team prior to the exit conference on 4/13/26. 2. For Resident #5, the facility staff failed to ensure Dycem (a non-slip material used to provide grip) was present in the resident's wheelchair seat. A Resident Face Sheet indicated the facility admitted Resident #5 on 10/07/25. According to the Resident Face Sheet, the resident had a medical history that included chronic respiratory failure with hypoxia, epilepsy, generalized muscle weakness, and history of traumatic brain injury. A quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/30/26 assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 15 out of 15 indicating Resident #5 was cognitively intact. Resident #5 was coded as having two or more falls with injury and one fall without injury since the prior MDS assessment dated [DATE].Resident #5's comprehensive person-centered care plan indicated the resident was at risk for falls related to abnormalities of gait and mobility, history of falls, and desire to do things independently at times that are not safe to do without staff assistance. Interventions included but were not limited to Dycem to wheelchair as ordered. This intervention was started on 12/03/25. Resident #5's medical provider orders included an active order (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 12/03/25 to ensure Dycem is in wheelchair. During an interview with Resident #5 on 4/09/26 at 8:40 AM, she stated she would like something in her wheelchair to keep the cushion from sliding. An observation of the resident's wheelchair revealed there was no Dycem present below or on top of the wheelchair cushion. On 4/13/26 at 4:38 PM, the concern of staff failing to ensure Dycem was present in Resident #5's wheelchair was discussed with the Administrator, Director of Nursing, and the Director of Compliance.No further information regarding this concern was presented to the survey team prior to the exit conference on 4/13/26.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on staff interview, clinical record review, and facility document review, the facility staff failed to obtain medical provider ordered laboratory tests for one (1) of 26 current sampled residents, Resident #5.The findings included:For Resident #5, the facility staff failed to obtain a stool specimen for testing to include ova and parasite, lactoferrin fecal quantitative, giardia specific antigen, stool culture, and c-difficle PCR/RFLX as ordered by the gastroenterologist. A facility policy titled, Laboratory, Radiology and Other Diagnostic Services, implemented on 11/28/16, specified, Orders for diagnostic services will be promptly carried out as instructed by the physician's order.A Resident Face Sheet indicated the facility admitted Resident #5 on 10/07/25. According to the Resident Face Sheet, the resident had a medical history that included chronic respiratory failure with hypoxia, chronic constipation, and epilepsy. A quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/30/26 assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 15 out of 15 indicating Resident #5 was cognitively intact. Resident #5's clinical record included a gastroenterology consult report dated 2/16/26 indicating the resident was seen for a history of diarrhea for several months with one to two loose stools per day. Provider orders included stool studies to evaluate for infections, inflammation, and exocrine pancreatic insufficiency (EPI). The consultant report indicated the next appointment was pending the lab results. Resident #5's clinical record included a provider order dated 2/16/26 for ova and parasite, lactoferrin fecal quantitative, giardia specific antigen, stool culture, and c-difficle PCR/RFLX. A nursing progress note dated 2/21/26 at 4:45 PM read Coordinating stool sample for resident has not yet been successful. Resident states the BM [bowel movement] comes on suddenly and she forgets. Another time it was noted that resident thought the nurse simply needed to see the stool (rather than collect it). Reminders are given a couple times per shift of the need for stool sample.An additional nursing progress note dated 2/22/26 at 4:24 PM indicated no stool sample obtained yet during the shift. Resident #5's clinical record failed to include results of the provider ordered stool testing. During an interview on 4/13/26 at 10:45 AM, the Director of Nursing (DON) stated Resident #5 took herself to the bathroom and had a roommate at the time that also used the same bathroom making it difficult to collect the stool. The DON verified the testing was not completed and stated there was no documentation that the medical provider was notified. The DON stated Resident #5's diarrhea had resolved. On 4/13/26 at 4:38 PM, the Administrator, DON, and Director of Compliance were informed of the concern regarding the facility staff failing to obtain stool testing as ordered for Resident #5.No further information regarding this concern was presented to the survey team prior to the exit conference on 4/13/26.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, staff interview, clinical record review, facility document review, and review of the Quality Assurance and Performance Improvement (QAPI) program, the facility staff failed to identify a system failure regarding side rail use and safety.The findings included:The facility QAPI Plan with a reviewed date of 2/25/2026 specified The QAPI program will aim for safety and high quality with all clinical interventions and service delivery while emphasizing autonomy, choice, and quality of daily life for residents and family by ensuring our data collection tools and monitoring systems are in place and are consistent for proactive analysis, system failure analysis, and corrective action.A facility policy titled, Quality Assurance and Performance Improvement (QAPI), reviewed on 1/29/26, specified, The facility will develop, implement and maintain a QAPI program that is effective, data driven, comprehensive and will focus on indicators of the outcomes of care and quality of life. The policy also indicated The plan describes the process for identifying and correcting quality deficiencies and contains the necessary components such as.Identifying and prioritizing quality deficiencies.During an interview on 4/13/26 at 4:00 PM, the Director of Compliance stated they were unaware of an issue regarding side rails. During the survey, it was identified that the facility lacked a system to ensure residents were assessed for the risk of entrapment and appropriate alternatives were attempted prior to the installation of side rails. The facility also failed to maintain a system to ensure side rails were assessed for entrapment risk when installed on a bed or bed components were replaced. At the time of the survey, out of a census of 53 residents, 34 residents had at least one side rail attached to the bed. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/13/26.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and clinical record review, the facility staff failed to maintain an effective infection control program to prevent the spread of communicable diseases and infections for 1 of 26 residents, Resident #46.The findings included: For resident # 46, the facility staff failed to ensure the resident's foley catheter bag remained suspended off of the floor.The resident Face Sheet revealed the facility admitted the resident on 4/24/24. According to the document, resident #46 had a medical history that included diagnoses of chronic kidney disease, flaccid neuropathic bladder, neuromuscular dysfunction of the bladder and a personal history of urinary tract infections. A quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/16/26 revealed resident #46 had a brief interview for mental status score (BIMS) of 14 out of 15, which indicated the resident was cognitively intact. The Physician's Order Report for resident #46 was reviewed and included an order dated 2/1/26 that read, Change catheter q (every) month and PRN (as needed) for obstruction if flushing catheter is not successful. F (French): 16 Balloon: 10 cc, special instructions: DX (diagnosis) neurogenic bladder.The Care Plan was reviewed and included a problem statement that read, I have an indwelling foley catheter related to neuromuscular dysfunction of my bladder and flaccid neuropathic bladder. I require assistance with toileting and incontinence care. I am at risk for urinary tract infections due to my history of UTIs and presence of a foley catheter. Resident and Spouse request no leg bag to be used with foley. Under the column labeled Approach the document read in part, 1. Monitor for signs/symptoms of a UTI such as a persistent urge to urinate, burning when urinating, frequent urinating only small amounts, cloudy /strong smelling urine, pain or tenderness in flank or pelvic area, confusion or change in mental status. 2. Obtain vitals as ordered or indicated 3. Administer medications/antibiotics as ordered. 4. Foley care per MD orders 5. Labs/diagnostics as ordered/indicated 6. Follow Enhanced Barrier Precautions 7. Notify MD/NP as indicated. 04/07/2026 2:20 PM resident # 46 was observed wheeling down the hallway in a wheelchair. A scraping sound was heard as the resident was propelling and it was noted that the right corner of the catheter drainage bag was dragging the floor. On 04/08/2026 at 5:01 PM the survey team met with the Administrator, Director of Nursing (DON), Director of Compliance/Infection Preventionist, Assistant Director of Nursing (ADON) and the MDS Coordinator. This concern was discussed at that time. The Infection Preventionist agreed that the catheter should not have been touching the floor. No further information was provided to the survey team prior to the exit conference.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on staff interview and facility document review, the facility staff failed to provide behavioral health training for two (2) of five (5) sampled staff members (Maintenance Director and Dining Server #1). The findings included: On 4/13/26, the Compliance Director provided the Maintenance Director and Dining Server #1's training records. Each record failed to include evidence of previous behavioral health training. The Maintenance Director began working at the facility on 11/10/21 and the Dining Server #1 began on 1/27/25. During an interview on 4/13/26 at 3:08 PM, the Compliance Director stated non-direct care staff do not receive behavioral health training. On 4/13/26 at 4:38 PM, the concern of facility staff failing to provide behavioral health training to non-direct care staff including the Maintenance Director and Dining Server #1 was discussed with the Administrator, Director of Compliance and the Director of Nursing. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/13/26.