STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Mechanicsville	7600 Autumn Parkway Mechanicsville, VA 23116

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 31753 Based on observation, staff interview, and facility document review, the facility staff failed to provide dignity for one of 35 residents in the survey sample, Resident #79. The findings include: For Resident #79 (R79), the facility staff failed to provide a dignified dining experience. A CNA (certified nursing assistant) stood over R79 while feeding the resident. On 2/25/25 at 12:50 p.m. R79 was observed sitting up in bed. CNA #3 was observed standing over R79 while feeding the resident. On 2/25/25 at 3:37 p.m., an interview was conducted with CNA #2. CNA #2 stated the, CNAs should sit in a chair when feeding residents CNA #2 stated standing up while feeding residents does not provide a dignified experience because residents are more comfortable when staff sits down. On 2/25/25 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility document titled, Resident Rights Inservice documented, The Nursing Home Reform Act established the following rights for nursing home residents: The right to be treated with dignity . No further information was presented prior to exit.

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. 32642 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide written notice of a room change for one of 35 residents in the survey sample, Resident #100. The findings include: For Resident #100 (R100), the facility staff failed to provide written notification to the resident of a room change on 9/5/24 and 1/30/25. On 2/24/25 at 1:52 p.m., R100 was interviewed. She stated she had recently moved to her current room and was still in the process of adjusting to it. She stated she does not like this room as much as she liked her previous room. A review of R100's clinical record revealed she was transferred to different room on 9/5/24 and 1/30/25. Further review of the resident's clinical record revealed no evidence that she was provided written notice prior to the room change. On 2/26/25 at 10:56 a.m., OSM (other staff member) #9, the social services assistant, was interviewed. She stated, When a resident is going to change rooms, she is responsible for notifying everyone, including the resident and/or resident representative. She added: Our policy doesn't require a written notice for a room change. On 2/26/25 at 2:43 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the assistant director of nursing, were informed of these concerns. A review of the facility policy, Room and Roommate Change Policy, revealed, in part: The facility will notify the resident/resident representative prior to a room or roommate change including the reason for the change . The facility will document that notification was completed with reason for change. No additional information was provided prior to exit.

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F 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect a residents' right to refuse some types of non-requested transfers within the nursing home. 32642 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide the reason for a room change for one of 35 residents in the survey sample, Resident #100. The findings include: For Resident #100 (R100), the facility staff failed to provide the reason for a room change on 1/30/25. On 2/24/25 at 1:52 p.m., R100 was interviewed. She stated she had recently moved to her current room and was still in the process of adjusting to it. She stated she does not like this room as much as she liked her previous room. A review of R100's clinical record revealed she was transferred to different room on 1/30/25. Further review of the resident's clinical record revealed no evidence of why the resident was transferred within the facility, or that the resident was made aware of the reason. On 2/26/25 at 10:56 a.m., OSM (other staff member) #9, the social services assistant, was interviewed. She stated, When a resident is going to change rooms, she is responsible for notifying everyone, including the resident and/or resident representative She stated the resident was having conflict with her roommate, and that is why she was moved to a new room in January 2025. She stated this was not documented anywhere. On 2/26/25 at 2:43 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the assistant director of nursing, were informed of these concerns. A review of the facility policy, Room and Roommate Change Policy, revealed, in part: The facility will notify the resident/resident representative prior to a room or roommate change including the reason for the change . The facility will document that notification was completed with reason for change. No additional information was provided prior to exit.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 42106 Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to provide notification to the physician of a residents refusal of treatment for one of 35 residents in the survey sample, Resident #359. The findings include: For Resident #359 (R359), the facility staff failed to evidence notification of the physician of R359's refusal of lab testing on 11/6/24 and 11/7/24. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/29/24, the resident scored three on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. The physician orders for R359 documented in part, - BMP (basic metabolic profile) and CBC (complete blood count); Special Instructions: BMP and CBC Once-One Time 23:00 (11:00 pm)- 07:00 (7:00am). Start Date: 11/06/2024. End Date: 11/06/2024. - BMP and CBC; Special Instructions: BMP and CBC Once- One Time 23:00 - 07:00. Start Date: 11/07/2024. End Date: 11/07/2024. The progress notes for R359 documented in part, 11/05/2024 14:51 (2:51 p.m.) New orders for Pyridium 100 mg (milligram) po (by mouth) BID (twice a day) for 3 days, Keflex 500 mg po every 8 hours for 5 days, and labs for BMP and CBC 11/6/24. RP (responsible party) [Name of RP] aware. The progress notes for R359 failed to evidence the BMP and CBC obtained, results of the BMP or CBC, documentation of refusal of the lab testing or notification of the physician of refusal of the lab testing ordered on 11/6/24 and 11/7/24. On 2/26/25 at 11:52 a.m., a request was made to ASM (administrative staff member) #1, the administrator for the results of the BMP and CBC ordered above. On 2/26/25 at 1:02 p.m., ASM #1 provided laboratory patient log sheets dated 11/6/24 and 11/7/24 which documented R359 refusing the lab testing on both dates. The log sheets failed to evidence notification of the physician of the refusal. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 1:04 p.m., an interview was conducted with RN (registered nurse) #3 who stated that when there was an order for a lab test the nurse entered the order into the electronic medical record and into the laboratory system. She stated that the night shift staff printed out the lab orders for that night and gave them to the lab technician who came in six nights a week to draw labs. She stated that when a resident refused to have labs drawn the technician notified the nurse who let the physician, and the responsible party know and documented it in the progress notes. RN #3 stated that this was done because the physician had ordered the lab tests for a reason and needed to know that it had not been obtained. On 2/26/25 at approximately 2:45 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the vice president of operations were made aware of the findings. No further information was provided prior to exit.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 31753 Based on observation, staff interview, and clinical record review, the facility staff failed to maintain an accurate MDS (minimum data set) assessment for one of 35 residents in the survey sample, Resident #35. The findings include: For Resident #35 (R35), the facility staff inaccurately coded the resident as having a restraint on the resident's quarterly MDS assessment with an ARD (assessment reference date) of 1/16/25. A review of R35's quarterly MDS assessment with an ARD of 1/16/25 revealed section P, Restraints and Alarms that coded the resident as using a chair that prevents rising less than daily. A review of R35's clinical record failed to reveal documentation regarding the use of a restraint/chair that prevents rising. Observations of R35 during the survey failed to reveal the use of a restraint/chair that prevents rising. On 2/25/25 at 9:13 a.m., RN (registered nurse) #3 (the MDS coordinator) was made aware of the above concern. On 2/25/25 at 9:24 a.m., an interview was conducted with RN #3. RN #3 stated,The coding of the use of a restraint on R35's MDS assessment was a data entry error, and she just corrected the assessment . RN #3 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when coding MDS assessments. On 2/25/25 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The CMS RAI manual documented, After determining whether or not an item listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use: Code 0, not used: if the item was not used during the 7-day look-back period or it was used but did not meet the definition. No further information was provided prior to exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31753 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to implement the comprehensive care plan for three of 35 residents in the survey sample, Residents #120, #2, and #61. The findings include: 1. For Resident #120 (R120), the facility staff failed to implement the resident's comprehensive care plan for obtaining weights. R120's comprehensive care plan dated 10/22/24 documented, Resident requires Enteral tube feeding and is at risk for dehydration, aspiration .Monitor weight per orders. A physician's order dated 1/29/25 documented, Obtain weight daily. Further review of R120's clinical record failed to reveal the resident's weight was obtained on 2/5/25, 2/14/25, 2/16/25, 2/17/25, 2/18/25, 2/19/25, and 2/22/25. On 2/25/25 at 3:46 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated the purpose of the care plan is to follow doctors' orders and nursing staff implement residents' care plans by looking at the care plans. On 2/26/25 at 10:14 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated R120's daily weights were not obtained because of time management with CNAs (certified nursing assistants) and staff were trying to figure out whether to use a Hoyer lift or a chair to obtain the resident's weights. On 2/26/25 at 2:48 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Comprehensive Care Plan Policy documented, Z) All direct care staff must always know, understand, and follow their Resident's Care Plan. No further information was presented prior to exit. 2. For Resident #2 (R2), the facility staff failed to implement the resident's comprehensive care plan for oxygen use. A review of R2's clinical record revealed a physician's order dated 2/20/25 for continuous oxygen via nasal cannula at a rate of four liters per minute for respiratory failure. R2's comprehensive care plan edited on 2/20/25 documented, At risk for altered cardiac/resp (respiratory) status .O2 (Oxygen) and neb (nebulizer) tx (treatment) as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/24/25 at 1:40 p.m. and 2/25/25 at 8:29 a.m., R2 was observed receiving oxygen via nasal cannula at a rate between two and a half and three liters per minute, as evidenced by the middle of the ball in the oxygen concentrator flowmeter positioned between the two and a half and three-liter lines. On 2/25/25 at 3:46 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated the purpose of the care plan is to follow doctors' orders and nursing staff implement residents' care plans by looking at the care plans. RN #2 stated nurses administer oxygen per the doctors' orders and the middle of the ball in the oxygen concentrator flowmeter should run through the four-liter line if the physician's order is for four liters. On 2/25/25 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 42106 3. For Resident #61 (R61), the facility staff failed to implement the comprehensive care plan to administer oxygen as ordered. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/22/25, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section O documented R61 receiving oxygen at the facility. On 2/25/25 at 8:22 a.m., an observation was made of R61 in their room. R61 was observed in bed wearing an oxygen cannula attached to an oxygen concentrator. The oxygen was observed to be set at a rate of 3.5 lpm (liters per minute). At that time an interview was conducted with R61 who stated that they wore oxygen all the time and used 3 lpm. R61 stated that the nurses set the oxygen rate, and they had a portable unit that they took with them when they left the building for appointments. An additional observation of the oxygen set at 3.5 lpm was made on 2/25/25 at 2:10 p.m. The comprehensive care plan for R61 documented in part, Problem Start Date: 06/10/2024. Category: Respiratory. Resident requires oxygen therapy. R/T COPD (chronic obstructive pulmonary disease) with shortness of breath. Resident requests longer oxygen tubing so that she can walk to the bathroom, however this allows the tubing to drag on the floor of her room sometimes. Edited: 02/13/2025 . Under Approach it documented in part, Approach Start Date: 06/10/2024, Approach End Date: 07/31/2025, Administer oxygen as ordered. Edited: 02/13/2025 . The physician orders for R61 documented in part, Oxygen: Administer oxygen (O2) via nasal cannula (NC) continuously at: 4 l/min (liters per minute) r/t (related to) respiratory failure. Add humidification if >4 L/min or for comfort, if needed. Special instructions: Check concentrator to ensure functioning and appropriate setting. Check SPO2 (oxygen saturation). Check humidifier if applicable. Every shift Day shift 07:00-15:00, Evening shift 15:00-23:00, Night shift 23:00-07:00. Start Date: 02/13/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 2:10 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that the purpose of the care plan was to know how to work with the resident and how to care for them. She stated that the care plan should be implemented to care for them. She stated that oxygen was checked at least every shift. She stated that the oxygen rate was set at eye level with the flowmeter ball centered on the number line where it ordered. LPN #4 observed R61's oxygen concentrator and stated, That it was set on 3.5 l/min (liters per minute) and not at the prescribed rate of 4 l/min. She spoke with R61 who stated that they thought they were only on 3 l/min and stated that she would clarify the rate with the nurse practitioner. On 2/25/25 at 4:12 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the vice president of operations were made aware of the concern. No further information was provided prior to exit.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 31753 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for two of 35 residents in the survey sample, Residents #79, and #75. The findings include: 1.a. For Resident #79 (R79), the facility staff failed to review and revise the resident's comprehensive care plan for adaptive eating equipment. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/10/24, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. A review of R79's clinical record revealed a physician's order dated 9/10/24 that documented, Provide 2 handled cup with lid + straw and red foam to knife and fork for all meals as tolerated. R79's comprehensive care plan edited on 2/13/25 failed to revealed documentation regarding a two handled cup with a lid and straw, or red foam to knives and forks. On 2/25/25 at 9:00 a.m., R79 was observed sitting up in bed. A cup containing coffee was observed on the resident's overbed table. The cup had one handle and no lid. Spilled coffee was observed on the overbed table. R79's right hand was observed tremoring. The resident stated she used to feed herself but now staff feed her because of her tremors. R79 stated she cannot pick up the cup, so she uses a straw. R79 stated she used to have a special cup, but it went missing and she used to have red foam handles for utensils but does not have them anymore. On 2/25/25 at 12:50 p.m., R79 was observed sitting up in bed while a CNA (certified nursing assistant) was feeding her. The cup on R79's meal tray contained no handles, and no red foam handles for R79's utensils were observed on the meal tray. R79's meal tray ticket documented, 2 handle cup wit [sic] lid; red foam build [sic] up utensils. On 2/25/25 at 2:56 p.m., an interview was conducted with OSM (other staff member) #3 (an occupational therapist who had previously treated R79). OSM #3 stated that due to an ulnar drift (a hand dysfunction where the fingers bend towards the outer arm bone), R79 has difficulty grasping objects. OSM #3 stated a two handled cup and red foam utensil handles are supposed to aid R79 with grasping objects more easily. On 2/25/25 at 3:38 p.m., an interview was conducted with CNA #1. CNA #1 stated R79 can feed herself finger foods but must be fed other foods because her hands shake. CNA #1 stated she was not aware of R79 requiring any adaptive eating equipment such as a special cup or red foam utensil handles, and she has not seen any adaptive eating equipment for R79 since she began employment in June 2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 3:46 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated the purpose of the care plan is to follow doctors' orders and nursing staff implement residents' care plans by looking at the care plans. RN #2 stated residents' care plans should be reviewed and revised for the use of special eating equipment for the continuation of patient care. On 2/25/25 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Comprehensive Care Plan Policy documented, F) The Comprehensive Care Plan is reviewed and updated at least every 90 days by the interdisciplinary team. No further information was presented prior to exit. 1.b. For Resident #79 (R79), the facility staff failed to review and revise the comprehensive care plan for the resident's weight loss in October 2024. A review of R79's clinical record revealed the resident weighed 130.4 lbs. (pounds) on 9/10/24 and 120 lbs. on 10/7/24 (a 7.98% weight loss in 30 days). A note signed by the registered dietician on 10/16/24 documented, Resident presents w/ a -7.98% loss x 1 months, significant and undesired .Previously OT (Occupational Therapy) started her on modified cup w/ cover and straw as well as fork and knife to aid with eating. Neuro (Neurology) appointment to find out if she might have Myasthenia gravis (A neuromuscular disorder that leads to weakness of skeletal muscles). Requesting to have resident as weekly weights x 4 weeks to keep close monitoring to wt (weight) . R79's comprehensive care plan initiated on 6/4/24 and edited on 2/13/25 failed to reveal documentation regarding the resident's significant weight loss in October 2024. On 2/25/25 at 3:46 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated the purpose of the care plan is to follow doctors' orders and nursing staff implement residents' care plans by looking at the care plans. RN #2 stated residents' care plans should be reviewed and revised regarding weight loss for the continuation of patient care. On 2/25/25 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 32642 2. For Resident #75 (R75), the facility staff failed to review and revise the resident's care plan to include an orthotic device and assistive devices for eating. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the following dates and times, R75 was observed. At each of these observations, the resident had a visible contracture of her right hand: 2/24/25 at 2:20 p.m., 2/25/24 at 9:05 a.m. and 1:18 p.m. At each of these observations, the resident was feeding herself with her fingers, with no evidence of adaptive eating equipment on her tray. At the 2/24/25 observation at 2:20 p.m., the resident was seated in the facility common area. In the resident's room, a carrot orthotic device was visible on the resident's bedside table. On 2/25/25 at 1:18 p.m., R75 stated she had been seen by the occupational therapy staff, and they had given her a carrot to hold to help the contracture. She stated she did not know where the carrot orthotic device was, and that the staff do not usually offer it to her. She stated she did not mind using it if it would help her right-hand contracture and skin integrity. She also said the occupational therapist had given her adaptive eating devices for her fork and spoon, but she had lost them, and had not been using them. A review of R75's occupational therapy discharge summary dated 2/18/25 revealed, in part: Recommendations .foam built up on utensils for self-feeding .R (right) hand carrot orthosis daily as tolerated. A review of R75's orders revealed the following order, dated 2/18/25: Pt (patient) to wear R (right) hand carrot orthosis daily, as tolerated, to prevent skin breakdown and prevent further contractures. Orthosis can be removed for hygiene and self-feeding. A review of R75's orders revealed the following order, dated 2/23/25: Lightweight spoon and fork when eating. A review of R75's comprehensive care plan, most recently updated on 2/4/25, revealed no information related to the resident's need for a right-hand orthotic device or adaptive eating equipment. On 2/25/25 at 2:53 p.m., OSM (other staff member) #3, an occupational therapist, was interviewed. She stated occupational therapy had recently treated and discharged R75 with a recommendation for a carrot orthosis to go in the resident's right hand. She stated, The resident had been provided the orthotic device, and the resident is able to independently pick it up and drop it as tolerated She also stated, The resident needs adaptive eating utensils, and these had been provided to the staff for the resident's use. On 2/25/25 at 3:46 p.m., RN (registered nurse) #2 was interviewed. RN #2 stated, The purpose of the care plan is to follow doctors' orders and nursing staff implement residents' care plans by looking at the care plans RN #2 stated residents' care plans should be reviewed and revised for the use of special eating equipment for the continuation of patient care. On 2/25/25 at 4:10 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the assistant director of nursing, were informed of these concerns. No additional information was provided prior to exit.

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	495413	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Mechanicsville	7600 Autumn Parkway Mechanicsville, VA 23116

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42106 Based on observation, resident interview, clinical record review, staff interview and facility document review, it was determined the facility staff failed to clarify a physician order for one of 35 residents in the survey sample, Resident #16. The findings include: For Resident #16 (R16), the facility staff failed to clarify a physician order regarding tracheostomy (1) change every two months. On the most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 12/28/2024, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact for making daily decisions. The assessment documented R16 receiving tracheostomy care at the facility. On 2/24/25 at 2:53 p.m., an observation was made of R16 in their room. At that time an interview was conducted with R16 who stated that they had a tracheostomy. R16 was observed with a bandana around their neck and proceeded to remove it to show a tracheostomy tube in place. R16 stated that they had the tracheostomy in place for many years and performed the tracheostomy care themselves. R16 stated that they had been taught how to care for the tracheostomy by the hospital prior to coming to the facility and the staff supplied them with all the supplies needed. R16 stated that the nursing staff offered to do the tracheostomy care for her, but she preferred to do it herself. The physician orders for R16 documented in part, TRACH: Shiley Uncuffed Non disposable 4 mm (millimeter); change Q2mo (every two months) & PRN (as needed). Every shift on the 27th of every 2nd Month. Day shift. Start Date: 10/01/2024 . The eMAR (electronic medication administration record) for R16 dated 12/1/24-12/31/24 documented the tracheostomy tube changed on 12/27/24. The eMAR was signed off by LPN (licensed practical nurse) #4. The progress notes failed to evidence documentation regarding the tracheostomy tube change procedure. On 2/25/25 at 2:10 p.m., an interview was conducted with LPN #4 who stated, That R16 liked to do most of the tracheostomy care themselves. She stated, That the nurses assisted R16 with the tracheostomy care by changing the ties holding the tracheostomy in place and the gauze around the stoma. When asked about the tracheostomy tube change ordered every two months, LPN #4 stated, That she was not sure who did the change and thought that the RN (registered nurse) did it. LPN #4 reviewed the eMAR for R16 with the documented tracheostomy tube change on 12/27/24 and stated that she had not changed the tracheostomy and was not sure what they were supposed to change . She stated that she needed to clarify the order with the nurse practitioner because R16 went to the ENT (ear, nose and throat) physician to follow up on the tracheostomy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Physician/Provider Orders failed to evidence guidance on clarifying physician orders. In Fundamentals of Nursing 6th edition, 2005; [NAME] A. [NAME] and [NAME] Perry; Mosby, Inc; Page 419. The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients. Therefore, all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary . On 2/25/25 at 4:12 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, vice president of operations were made aware of the concern. No further information was provided prior to exit. Reference: (1) Tracheostomy A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 29843 Based on clinical record review staff interview, the facility staff failed to maintain the resident's highest level of well-being for 1 (one) of 35 residents in the survey sample, Resident #31 (R31). The findings include: For R31, the facility staff failed to follow the physician's order for daily weights. R31 was admitted to the facility with a diagnosis that included but was not limited to CHF (congestive heart failure) (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/12/2025, R31 scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating R31 was severely impaired of cognition for making daily decisions. The physician's order for R31 documented in part, Daily weight for CHF Monitoring. Frequency: Once A Day. Repeat: Every Day. Notify MD/NP if Resident has greater than 2.5 lbs. (pounds) weight gain in 3 (three) days or greater than 5 (five) lbs. in a week. Start Date: 1/29/25. The eMAR (electronic medication administration record) for R31 dated February 2025 documented the physician's order as stated above. Further review of the EMAR for 02/07/2025, 02/10/2025, 02/17/2025, 02/22/2025 and 02/24/2025 documented O. Under Information Key it documented in part, O=Oth (Other). Review of the EHR (electronic health record) for R31 revealed a section entitled Vital Signs. Under Vital Signs the subcategory Weights failed to evidence documentation of R31's weights on 02/07/2025, 02/10/2025, 02/17/2025, 02/22/2025 and 02/24/2025. The progress notes for R31 dated 02/01/2025 through 02/25/2025 failed to evidence documentation of R31's weights on 02/07/2025, 02/10/2025, 02/17/2025, 02/22/2025 and 02/24/2025. On 02/26/2025 at approximately 1:03 p.m., an interview was conducted with RN (registered nurse) #4. When asked how it is evidenced that R31's weights were obtained RN #4 stated, The weights are documented in the Matrix (electronic health record) under Vital Signs. When asked about the coding of Other on R31's eMAR for the dates listed above, RN #4 stated,There should be an explanation. After reviewing R31's eMAR, nursing notes and vital sign section of the EHR, she could not say why R31's weights were missing on the above dates. When asked why R31's weight was being obtained daily, she stated, It was due to the diagnosis of CHF (congestive heart failure) to determine if R31 was retaining fluids. RN #4 stated, If R31 was retaining fluids it would put additional pressure on R31's heart . She further stated that if there not a weight(s), it could not be determined if R31 was retaining fluids. On 02/26/2025 at approximately 2:15 p.m., ASM #1, administrator, ASM #2, director of nursing, ASM #3, regional vice president of operations, were made aware of the above findings. No further information was provided prior to exit. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	References: (1) A condition in which the heart can't pump enough blood to meet the body's needs. This information was obtained from the website: https://medlineplus.gov/heartfailure.html.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observations, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide foot care for one of 35 residents in the sample R20. The findings include: The facility failed to evidence provision of foot care for R20. R20 was observed in bed on 2/24/25 at 2:30 PM with thick toenails on both large toes and toenails approximately one-half inch in length. R20 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CHF (congestive heart failure), prosthetic heart valve, DM (diabetes mellitus) and osteoarthritis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 115/25, coded the resident as scoring a 05 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximum assist for bed mobility/transferring/toileting and set up for eating. A review of the comprehensive care plan dated 7/9/24 revealed, PROBLEM: ADLs Functional Status/ Rehabilitation Potential Needs assistance with ADL's (activities of daily living) related to CHF, CKD3, DM, CAD, Dementia, Anemia, history of SBO, Arthritis and impaired mobility. APPROACH: Bilateral 1/4 side rails to bed, for turning and repositioning as tolerated Q shift. A review of the physician's order dated 7/15/24 revealed, Podiatry consult as needed. An interview was conducted on 2/24/25 at 2:30 PM with R20. When asked about toenail care, R20 stated, they do not cut them here, my son has to take me out to get it done. In response to request for evidence of podiatry visits, on 2/25/25 received a podiatry visit note date 11-2-22, and a note son taking her outside center to get nails clipped with no evidence in progress notes or scanned in documents of these appointments. On 2/26/25 10:00 AM An interview was conducted with LPN (licensed practical nurse) #2, when asked about toenail care, LPN #2 stated, The residents' nails are assessed by the nursing assistants on their shower days, and we are informed if the nails need trimmed . We put the resident's name on the podiatry list. If the resident has DM or thick nails, the nurses are not allowed to cut their toenails. On 2/26/25 at 2:40 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services was made aware of the findings. ASM #2 stated, the podiatrist comes next week, we will put him on the list. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's ADL (activity of daily living) policy, revealed, Provision of ADL care will be documented each shift by staff providing the care. This shall include, but not be limited to, documentation of food intake, toileting, ambulation, bathing, dressing and transferring. No further information was provided prior to exit.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 32642 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to implement interventions to prevent worsening of a contracture of 35 residents in the survey sample, Resident #75 (R75). The findings include: For Resident #75 (R75), the facility staff failed to provide an orthotic device to the resident's right hand. On the following dates and times, R75 was observed. At each of these observations, the resident had a visible contracture of her right hand: 2/24/25 at 2:20 p.m., 2/25/24 at 9:05 a.m. and 1:18 p.m. At the 2/24/25 observation at 2:20 p.m., the resident was seated in the facility common area. In the resident's room, a carrot orthotic device was visible on the resident's bedside table. On 2/25/25 at 1:18 p.m., R75 stated she had been seen by the occupational therapy staff, and they had given her a carrot to hold to help the contracture. She stated she did not know where the carrot orthotic device was, and that the staff do not usually offer it to her. She stated she did not mind using it if it would help her right-hand contracture and skin integrity. A review of R75's orders revealed the following order, dated 2/18/25: Pt (patient) to wear R (right) hand carrot orthosis daily, as tolerated, to prevent skin breakdown and prevent further contractures. Orthosis can be removed for hygiene and self-feeding. A review of R75's occupational therapy discharge summary dated 2/18/25 revealed, in part: Recommendations .R (right) hand carrot orthosis daily as tolerated. A review of R75's comprehensive care plan, most recently updated on 2/4/25, revealed no information related to the resident's need for a right-hand orthotic device. On 2/25/25 at 2:53 p.m., OSM (other staff member) #3, an occupational therapist, was interviewed. She stated occupational therapy had recently treated and discharged R75 with a recommendation for a carrot orthosis to go in the resident's right hand. She stated the resident had been provided the orthotic device, and the resident is able to independently pick it up and drop it as tolerated. On 2/25/25 at 3:32 p.m., CNA #2 was interviewed. She stated, She is very familiar with R7 and is regularly assigned to care for her She stated R 75's right hand is contracted, and therapy had given her a carrot device to hold in her hand. She stated this device keeps her contracture from getting worse, and the staff always makes sure she has it to hold. A review of the facility policy, Issuing Adaptive Equipment, revealed, in part: The primary therapist and/or assistant will issue and instruct the patient in adaptive equipment based on patient's need .written instructions will be provided to family members/primary caregivers to increase carry over .The primary therapist will disseminate the type of equipment and its function to other disciplines during team conferences as necessary to increase carry over with proper use. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 4:10 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the assistant director of nursing, were informed of these concerns. No additional information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to monitor a significant weight loss for one of 35 residents in the survey sample, Resident #120. The findings include: For Resident #120 (R120), the facility staff failed to obtain physician ordered daily weights after the resident experienced a significant weight loss. A review of R120's clinical record revealed the resident's weight was 159 lbs. (pounds) on 1/2/25 and 142 lbs. on 2/1/25 (a 10.69% weight loss in 30 days). A note signed by the RD (registered dietician) on 1/29/25 documented, Tube Feeding reviewed as weekly follow up. #CBW (Current Body Weight): 137 Lbs. BMI (Body Mass Index): 22.86 WNL (Within Normal Limits) but low for age. -14% loss less than a month, significant and concerning. RD requests reweigh for accuracy. Diet: Reg, Puree. Formula: Isosource 1.5 Cal. RD was notified by nurse on floor resident isn't eating well, formula was increased from twice daily to TID (Three Times Daily) for nutrition. If loss is true, frequency of feed will be increased to 4 times daily to combat weight loss .Resident will continue as a feeder; staff assist her with meals .Will be on daily weight to follow up with weight trend closely . A physician's order dated 1/29/25 documented, Obtain weight daily. Further review of R120's clinical record failed to reveal the resident's weight was obtained on 2/5/25, 2/14/25, 2/16/25, 2/17/25, 2/18/25, 2/19/25, and 2/22/25. On 2/26/25 at 10:14 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated, R120's daily weights were not obtained because of time management with CNAs (certified nursing assistants) and staff were trying to figure out whether to use a Hoyer lift or a chair to obtain the resident's weights. On 2/26/25 at 11:15 a.m., an interview was conducted with OSM (other staff member) #7 (the RD). OSM #7 stated, It was important for staff to obtain R120's daily weights because she wants to make sure the resident is not excessively losing weight and getting the nutrition needed. OSM #7 stated daily weights provide a more accurate reading for monitoring R120. On 2/25/25 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Resident Weight Policy documented, Weights will be obtained routinely in order to monitor nutritional health over time. Each resident's weight will be determined upon admission/readmission to the facility, weekly for the first four weeks after admission/readmission, and monthly or more often if risk is identified, or as ordered. No further information was presented prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42106 Based on observation, resident interview, clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice for two of 35 residents, Resident #61 and Resident #2. The findings include: 1. For Resident #61 (R61), the facility staff failed to administer oxygen at the prescribed rate. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/22/25, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section O documented R61 receiving oxygen at the facility. On 2/25/25 at 8:22 a.m., an observation was made of R61 in their room. R61 was observed in bed wearing an oxygen cannula attached to an oxygen concentrator. The oxygen was observed to be set at a rate of 3.5 l/min (liters per minute). At that time an interview was conducted with R61 who stated that they wore oxygen all the time and used 3 l/min . R61 stated that the nurses set the oxygen rate, and they had a portable unit that they took with them when they left the building for appointments. An additional observation of the oxygen set at 3.5 lpm was made on 2/25/25 at 2:10 p.m. The physician orders for R61 documented in part, Oxygen: Administer oxygen (O2) via nasal cannula (NC) continuously at: 4 l/min (liters per minute) r/t (related to) respiratory failure. Add humidification if >4 L/min or for comfort, if needed. Special instructions: Check concentrator to ensure functioning and appropriate setting. Check SPO2 (oxygen saturation). Check humidifier if applicable. Every shift Day shift 07:00-15:00, Evening shift 15:00-23:00, Night shift 23:00-07:00. Start Date: 02/13/2025. The comprehensive care plan for R61 documented in part, Problem Start Date: 06/10/2024. Category: Respiratory. Resident requires oxygen therapy. R/T COPD (chronic obstructive pulmonary disease) with shortness of breath. Resident requests longer oxygen tubing so that she can walk to the bathroom, however this allows the tubing to drag on the floor of her room sometimes. Edited: 02/13/2025 . On 2/25/25 at 2:10 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that, Oxygen was checked at least every shift. She stated that, The oxygen rate was set at eye level with the flowmeter ball centered on the number line where it ordered. LPN #4 observed R61's oxygen concentrator and stated that it was set on 3.5 l/min and not at the prescribed rate of 4 lpm. She spoke with R61 who stated, That they thought they were only on 3 l/min and stated that . she would clarify the rate with the nurse practitioner. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Oxygen Administration (all routes) Policy with a revision date of 7/30/2024 documented in part, .Set flow rate as prescribed or to obtain desired SpO2 . The facility provided manufacturers user's manual for R61's oxygen concentrator documented in part, .Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate . On 2/25/25 at 4:12 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the vice president of operations were made aware of the concern. No further information was provided prior to exit. 31753 2. For Resident #2 (R2), the facility staff failed to administer oxygen at the physician prescribed rate of four liters per minute. A review of R2's clinical record revealed a physician's order dated 2/20/25 for continuous oxygen via nasal cannula at a rate of four liters per minute for respiratory failure. On 2/24/25 at 1:40 p.m. and 2/25/25 at 8:29 a.m., R2 was observed receiving oxygen via nasal cannula at a rate between two and a half and three liters per minute, as evidenced by the middle of the ball in the oxygen concentrator flowmeter positioned between the two and a half and three-liter lines. On 2/25/25 at 3:46 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated, Nurses administer oxygen per the doctors' orders and the middle of the ball in the oxygen concentrator flowmeter should run through the four-liter line if the physician's order is for four liters. On 2/25/25 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Mechanicsville	7600 Autumn Parkway Mechanicsville, VA 23116

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 29843 Based on observation, staff interview, and facility document review, facility staff failed to store food in a sanitary manner in one of one facility kitchens and failed to maintain holding temperatures during lunch in one of two dining rooms observed. The findings include: 1. On 02/24/2025 at approximately 11:15 a.m., an observation of the facility's walk-in refrigerator in the facility kitchen was conducted with OSM (other staff member) #4, assistant dietary manager. An observation revealed an open three-pound package of sliced ham with approximate one pound remaining and an open bag of shredded cheddar cheese sitting on the middle shelf in the back of the walk-in refrigerator. Further observations of the packages of ham and cheese failed to evidence an open date. 2. On 02/24/2025 at approximately 11:25 a.m., an observation of the facility's walk-in freezer in the facility kitchen was conducted with OSM (other staff member) #4. An observation revealed two, 2.2 (two point two) pound bags of frozen breaded shrimp laying in an open box on the middle shelf on the left side of the freezer. Further observations revealed one bag containing approximately one pound of frozen breaded shrimp was open to the environment and the second bag of shrimp was resealed without an open date. 3. On 02/24/2025 at approximately 12:15 p.m., holding temperature were observed being obtained by OSM #5, kitchen aide, at the steam table on the facility's Winter unit. The temperature of the baked beans was at 160 degrees ( ) Fahrenheit (F), mash potatoes at 140 F, baked chicken at 160 F, BBQ pork at 120 F, pureed BBQ port at 100 F, pureed vegetables at 100 F, mixed vegetables at 100 F and hamburger at 100 F. Further observation revealed when OSM #5 finished obtaining the temperatures, he immediately began plating the resident's food. On 02/24/2025 at approximately 1:40 p.m., an interview was conducted with OSM #5 and OSM #6, dietary manager, regarding holding temperatures for resident's food. OSM #5 stated the holding temperature should by 65 F. OSM #6 stated holding temperatures for resident's food should be at a minimum of 135 F. She further stated if the holding temperatures are less than 135 F, the food is removed from the steam table, taken back to the kitchen and reheated to 165 F. She further stated the temperature of 165 F needed to be maintained for 15 seconds before being sent out to be served. When asked if the foods listed above below 135 F were sent back to the kitchen, OSM #5 stated no and OSM #6 stated that no food was sent back to the kitchen to be reheated. On 02/26/2025 at approximately 9:10 a.m., an interview was conducted with OSM #6 regarding the storage of opened food items. She stated the food should be wrapped or sealed to protect the food from contamination and dated when it was opened. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy Freezer and Refrigerator Policy documented in part, 7. All refrigerated and frozen foods must be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use-by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use-by dates indicated once food is opened. On 02/25/2025 at approximately 4:10 p.m., ASM #1, administrator, ASM #2, director of nursing, ASM #3, regional vice president of operations, were made aware of the above findings. No further information was provided prior to exit.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 29843 Based on observation and staff interview, the facility staff failed to maintain one of two dumpsters in a sanitary manner. Facility staff failed to close one of two lids on the top of a facility's dumpster. The findings include: On 02/24/2025 at approximately 11:35 a.m., an observation of the facility's two dumpsters located behind the facility was conducted with OSM (other staff member) #4, assistant dietary manager. The observation revealed the left lid of the dumpster on the right side (when facing the dumpsters) was resting on a bag(s) of trash in an open position. Further observations revealed the trach bag(s) were exposed. When asked how often the dumpsters were emptied OSM #4 stated they were emptied six days a week. When asked about the open lid on the dumpster she stated the trash should have been pushed down into the dumpster and the lid should have been closed. OSM #4 further stated the dietary department and the facility's maintenance department shared the responsibility of maintaining the dumpsters by alternating the responsibility monthly. On 02/25/2025 at approximately 11:45 a.m., an interview was conducted with OSM #1, director of environmental services regarding maintaining the facility's dumpsters. OSM #1 stated the dietary department, and the maintenance department shared the responsibility of maintaining the dumpsters by alternating the responsibility monthly. When asked how often the dumpsters were emptied OSM #4 stated they were emptied six days a week. When informed of the observation stated above, OSM #4 stated the trach should have been pushed down or removed to a secondary location so the lid would close. When asked why it was important to close the lids on the dumpsters, she stated to keep pests from getting into the trash. On 02/25/2025 at approximately 4:10 p.m., ASM #1, administrator, ASM #2, director of nursing, ASM #3, regional vice president of operations, were made aware of the above findings. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observations, resident / staff interviews, clinical record review and facility document review, it was determined the facility staff failed to evidence bed inspections for four of 35 residents in the survey sample, R20, R59, R409 and R31. The findings include: 1.The facility staff failed to perform bed rail inspections for the use of positioning / assist bars for R20. The facility's bed inspections were reviewed since last survey, they were completed 1/2023 and 2/12/2024. R20 was observed in bed on 2/24/25 at 2:30 PM and 2/25/25 at 8:14 AM in bed with 1/2 rails bilaterally. R20 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CHF (congestive heart failure), prosthetic heart valve, DM (diabetes mellitus) and osteoarthritis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 115/25, coded the resident as scoring a 05 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximum assist for bed mobility/transferring/toileting and set up for eating. A review of the comprehensive care plan dated 7/9/24 revealed, PROBLEM: ADLs Functional Status/ Rehabilitation Potential Needs assistance with ADL's (activities of daily living) related to CHF, CKD3, DM, CAD, Dementia, Anemia, history of SBO, Arthritis and impaired mobility. APPROACH: Bilateral 1/4 side rails to bed, for turning and repositioning as tolerated Q shift. On 2/24/25 at 2:00 PM, OSM (other staff member) #2, maintenance, was observed completing bed inspections on the 200s hall. When asked about the bed inspections, OSM #2 stated, they are done every year. We check the bed for safety, to make sure there are no entrapment issues and bed safety. I am from another building helping them out. An interview was conducted on 2/24/25 at 2:30 PM with R20. When asked about the bed rails, R20 stated, they help me sit up and move. On 2/25/25 at approximately 1:30 PM, an interview was conducted with OSM #1. When asked about the bed inspections, OSM #1 stated, we are working on the 2025 inspections. Here are some of them, we are not finished with them. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/25 10:00 AM An interview was conducted with LPN (licensed practical nurse) #2, when asked side rails, LPN #2 stated, there is a quarterly assessment that needs to be done for the enablers or side rails. We get their consent for the enablers and side rails. When asked if it should be on the care plan, LPN #2 stated, well most of them are enablers so it really depends on the resident. When asked the difference between a side rail and an enabler, LPN #2 stated, it is the length of the rail. On 2/26/25 at 2:40 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services was made aware of the findings. A review of the facility's Bed Identification and Safety Inspection policy, revealed, Inspections will be completed annually and as needed when bed/mattress configuration changes. The inspection Checklist will be kept current by environmental services/maintenance. No further information was provided prior to exit. 2. The facility staff failed to perform bed rail inspections for the use of positioning / assist bars for R59. The facility's bed inspections were reviewed since last survey, they were completed 1/2023 and 2/12/2024. R59 was observed in bed on 2/25/25 at 8:39 AM and 2/26/25 at 8:20 AM in bed with 1/2 rails bilaterally. R59 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident) with hemiplegia and hemiparesis, dementia and DM (diabetes mellitus). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 115/25, coded the resident as scoring a 07 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximum assist for bed mobility/transferring/toileting and set up for eating. A review of the comprehensive care plan dated 3/15/24 revealed, PROBLEM: ADLs Functional Status/ Rehabilitation Potential Needs assistance with ADL's (activities of daily living) related to CVA, DM, hemiparesis/hemiplegia and impaired mobility. APPROACH: Bilateral 1/2 side rails to bed, for turning and repositioning as tolerated Q shift. On 2/24/25 at 2:00 PM, OSM (other staff member) #2, maintenance, was observed completing bed inspections on the 200s hall. When asked about the bed inspections, OSM #2 stated, they are done every year. We check the bed for safety, to make sure there are no entrapment issues and bed safety. I am from another building helping them out. On 2/25/25 at approximately 1:30 PM, an interview was conducted with OSM #1. When asked about the bed inspections, OSM #1 stated, we are working on the 2025 inspections. Here are some of them, we are not finished with them. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/25 10:00 AM An interview was conducted with LPN (licensed practical nurse) #2, when asked side rails, LPN #2 stated, there is a quarterly assessment that needs to be done for the enablers or side rails. We get their consent for the enablers and side rails. When asked if it should be on the care plan, LPN #2 stated, well most of them are enablers so it really depends on the resident. When asked the difference between a side rail and an enabler, LPN #2 stated, it is the length of the rail. On 2/26/25 at 2:40 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services was made aware of the findings. A review of the facility's Bed Identification and Safety Inspection policy, revealed, Inspections will be completed annually and as needed when bed/mattress configuration changes. The inspection Checklist will be kept current by environmental services/maintenance. No further information was provided prior to exit. 3. The facility staff failed to perform bed rail inspections for the use of positioning / assist bars for R409. The facility's bed inspections were reviewed since last survey, they were completed 1/2023 and 2/12/2024. R409 was observed in bed on 2/24/25 at 2:09 PM and 2/25/25 at 11:52 AM in bed with 1/2 rails bilaterally. R409 was admitted to the facility on [DATE] with diagnosis that included but were not limited to cellulitis, Afib (atrial fibrillation), embolism and MRSA (methicillin resistant staph aureus). The most recent MDS (minimum data set) assessment, an admission assessment has not been completed. A review of the baseline care plan dated 2/19/24 revealed, PROBLEM: ADLs Functional Status/ Rehabilitation Potential Needs assistance with ADL's (activities of daily living) related to cellulitis and impaired mobility. APPROACH: Bilateral 1/2 side rails to bed, for turning and repositioning as tolerated Q shift. On 2/24/25 at 2:00 PM, OSM (other staff member) #2, maintenance, was observed completing bed inspections on the 200s hall. When asked about the bed inspections, OSM #2 stated, they are done every year. We check the bed for safety, to make sure there are no entrapment issues and bed safety. I am from another building helping them out. An interview was conducted on 2/25/25 at 11:52 AM with R409. When asked about the bed rails, R409 stated, they are used at times to help me turn. On 2/25/25 at approximately 1:30 PM, an interview was conducted with OSM #1. When asked about the bed inspections, OSM #1 stated, we are working on the 2025 inspections. Here are some of them, we are not finished with them. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/25 10:00 AM An interview was conducted with LPN (licensed practical nurse) #2, when asked side rails, LPN #2 stated, there is a quarterly assessment that needs to be done for the enablers or side rails. We get their consent for the enablers and side rails. When asked if it should be on the care plan, LPN #2 stated, well most of them are enablers so it really depends on the resident. When asked the difference between a side rail and an enabler, LPN #2 stated, it is the length of the rail. On 2/26/25 at 2:40 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services was made aware of the findings. No further information was provided prior to exit. 29843 4. For R31, facility staff failed to conduct a bed and bed rail safety inspection. R31 was admitted to the facility with diagnosis that included but was not limited to: muscle weakness. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/12/2025, R31 scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating R31 was severely impaired of cognition for making daily decisions. On 02/25/25 at approximately 8:36 a.m., an observation revealed R31 in bed with right side quarter bedrail raised. On 02/25/25 at approximately 1:45 p.m., an observation revealed R31 in bed with right side quarter bedrail raised. Review of the facility's Bed and Bed Rail Safety Inspection sheets dated 02/01/2025 through 02/24/2025 failed to evidence documentation of R31's bed inspection. On 2/24/25 at 2:00 p.m., OSM (other staff member) #2, maintenance, was observed completing bed inspections on the 200s hall. When asked about the bed inspections, OSM #2 stated, they are done every year and check the bed for safety, to make sure there are no entrapment issues and bed safety. OSM #1 further stated he from another facility helping out. On 2/25/25 at approximately 1:30 p.m., an interview was conducted with OSM #1. When asked about the bed inspections, OSM #1 stated, he was working on the 2025 inspections, had some of them, but was not finished with them. On 02/26/2025 at approximately 2:15 p.m., ASM #1, administrator, ASM #2, director of nursing, ASM #3, regional vice president of operations, were made aware of the above findings. No further information was provided prior to exit.