STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495428	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
August Healthcare at Richmond	1503 Michael Road Richmond, VA 23229

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to develop a comprehensive person-centered care plan for (1) one resident (Resident #1) in a survey sample of 5 residents.The findings included:For Resident #1, who was identified to be at risk for pressure ulcer development, the facility staff failed to develop a comprehensive person-centered care plan to address the development of pressure injuries.Resident #1 was originally admitted to the facility on [DATE]. On 11/8/2025, Resident #1 was re-admitted to the facility after hospitalization with diagnoses including but not limited to a history of a sacral ulcer stage II.Resident #1's most recent MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 10/9/25 coded the resident in Section M: Skin Conditions, as having no open wounds and was at risk for development of pressure ulcers.Review of the Nursing admission assessment dated [DATE] revealed skin was intact.On 12/30/25 at 11:10AM, an interview was conducted with the facility's Wound Care Nurse (LPN#3) who stated that Resident #1's pressure injury to her sacrum and the Deep Tissue Injury to her right heel was identified during a facility skin sweep. When asked why a facility skin sweep was done, LPN#3 stated. we had identified that weekly skin reviews were not being done weekly per the facility policy. When asked if the facility conducted skin risk assessments, LPN#3 replied, Yes, we do the Braden Assessment upon admission and then weekly for (4) four weeks and if or when a resident should develop any new areas. When asked what the Braden Assessment was used for, LPN#3 stated, To identify any risk factors such as moisture or poor nutrition and then putting interventions in place to address those areas to help the resident from developing a pressure wound. When asked who updates the care plans, LPN#3 stated, The Director of Nursing or the MDS (Minimum Data Set) Nurse.A review of Resident #1's Braden Scale for Predicting Pressure Sore Risk dated 11/8/25 upon re-admission revealed a Braden Score of 17 which indicates the resident was at risk for developing a pressure injury:On 12/30/25 during an interview with the facility's Wound Care Nurse Practitioner, she was asked if preventive measures such as placing the air mattress when Resident #1 was identified as at risk for development of a pressure injury and having a history of a sacral pressure injury in the past, adding a protein supplement, more frequent turning and repositioning and incontinence care and off-loading of her heels wound have perhaps prevented the development of the pressure injuries she stated, I was not aware of her having a history of a previous sacral wound, I did see her in August of this year but she refused to have me assess her sacrum, so perhaps more aggressive preventive measures may have prevented or delayed development, but again she was in a general decline. On 12/30/25 at 2:40PM, an interview was conducted with the Director of Nursing who confirmed that Resident #1 had a history of pressure injuries to her sacrum. A review of Resident #1's care plan did not reveal a care plan to address resident's risk for development of a pressure ulcer and had no interventions to address prevention of the development of pressure related injuries. On 12/30/25 at 2:40PM, an interview was conducted with the Director of Nursing (DON) on what preventive measures were put in place prior to Resident #1 acquiring two new pressure related wounds that were identified at an advanced stage on 11/20/25. The DON stated they were turning and repositioning the resident and had changed her mattress to an air mattress on 11/20/25. When asked if Resident #1 had a care plan to address preventive measures on development of pressure ulcers, the DON stated Resident #1 had a care plan for addressing potential impairment to skin integrity related to fragile skin, advanced age, chronic illness. A review of the care plan with the Director of Nursing revealed no preventive measures to prevent the development of pressure wounds and no care plan to address Resident #1's refusal of care such baths, skin assessments, dialysis treatments, etc.A review of the facility's policy, entitled Pressure Injury Prevention and Management, Policy Explanation and Compliance Guidelines, was conducted. The policy read in part, .a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan the includes measurable goals for prevention and management of pressure injuries with appropriate interventions .c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present .f. Interventions will be documented in the care plan and communicated to all relevant staff.On 12/30/25 during the exit meeting with the Director of Nursing and Administrator, the above findings were discussed, and an opportunity was offered to the facility staff to present additional information. No further comments or additional information was provided upon 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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to implement interventions, care and services to prevent the development of a pressure ulcer for one resident in a survey sample of five residents (Resident #1), which resulted in harm for Resident #1. The findings included:For Resident #1, who was identified to be at risk for pressure ulcer development, the facility staff failed to provide interventions to prevent the development of (2) two pressure-related injuries which were at an advanced stage at the time of discovery, which constituted harm.Resident #1 was originally admitted to the facility on [DATE]. On 11/8/2025, Resident #1 was re-admitted to the facility after hospitalization for a clotted arteriovenous (AV) fistula (linking a vein to an artery for medical use) following a dialysis session (medical treatment that cleans the blood by removing waste, toxins and extra fluid when one's kidneys cannot do the job) and a urinary tract infection. Resident #1 was re-admitted with diagnoses including but not limited to end stage renal disease on hemodialysis, dementia, legally blind with cataracts, hypertension, congestive heart failure, type 2 diabetes and history of a sacral ulcer stage II. Resident #1 was incontinent of bowel and bladder and wore incontinence products.Resident #1's most recent MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 10/9/25 coded the resident in Section M: Skin Conditions, as having no open wounds and was at risk for development of wounds. Review of the Nursing admission assessment dated [DATE] indicated that Resident #1's skin was intact. A review of the most recent Weekly Skin Reviews dated 8/1/25 noted skin intact and 11/20/25 revealed pressure sore on buttocks and right heel DTI (deep tissue injury), treatment in place. No Weekly Skin Reviews were found between 8/1/25 and 11/20/25. A review of the Wound Care Nurse Practitioner's assessment 11/20/25 revealed two newly acquired pressure-related injuries. An unstageable pressure injury (meaning the depth of the wound cannot be measured) to the sacrum measuring 3 x 3 x 0.3 cm with a calculated area of 9 sq cm with a wound bed of 100% slough (wet, yellow/white stringy tissue in a wound) and a pressure-induced deep tissue injury to the right heel measuring 2.5 cm x 2.5 cm x 0 cm with a calculated area of 6.25 sq cm.On 12/30/25 at 11:10AM, an interview was conducted with the facility's Wound Care Nurse (LPN#3) who stated that Resident #1's pressure injury to her sacrum and the Deep Tissue Injury to her right heel was identified during a facility skin sweep. When asked why a facility skin sweep was done, LPN#3 stated they had identified that the weekly skin reviews were not being done weekly per the facility policy. When asked if the facility conducted skin risk assessments, LPN#3 replied, Yes, we do the Braden Assessment upon admission and then weekly for (4) four weeks and if or when a resident should develop any new areas. When asked what the Braden Assessment was used for, LPN#3 stated To identify any risk factors such as moisture or poor nutrition and then putting interventions in place to address those areas to help the resident from developing a pressure wound. When asked who updates the care plans, LPN#3 stated, The Director of Nursing or the MDS (Minimum Data Set) Nurse.A review of Resident #1's Braden Scale for Predicting Pressure Sore Risk dated 11/8/25 upon re-admission revealed a Braden Score of 17 which indicates the resident is at risk for developing a pressure injury: Resident #1's Braden scale included findings of:1. Sensory perception - Ability to respond meaningfully to pressure-related discomfort - coded as 4. No impairment2. Moisture - Degree to which skin is exposed to moisture - coded as 3. Occasionally moist3. Activity - Degree of physical activity - coded as 2. Chairfast4. Mobility - Ability to change and control body position - coded as 3. Slightly limited5. Nutrition - Usual food intake pattern - coded as 2. Probable inadequate6. Friction and Shear - risk from skin rubbing or sliding against surfaces - coded as 3. No apparent problemOn 12/30/25 at 11:54AM, an interview was conducted with the Director of Nursing who stated they had completed a facility wide skin sweep after they had identified weekly skin reviews were not being completed per facility policy. During the skin sweep, Resident#1 was identified with two newly acquired pressure-related pressure injuries.On 12/30/25 at 12:44PM, a telephone interview was conducted with the facility's Wound Care Nurse Practitioner (ADM#3) regarding her assessment of Resident #1's newly acquired pressure injuries dated 11/20/25. Per the Wound Care Nurse Practitioner (ADM#3), she stated that the facility had identified weekly skin reviews had not been done consistently and wanted to complete a full house head to toe assessment on all residents, and that is when they identified Resident #1 had developed (2) newly acquired wounds. When asked to provide information on how the wounds were considered to be unavoidable as Resident #1 was re-admitted on [DATE] with skin intact and 12 days later she had developed a pressure injury at an advanced stage, she