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	02/19/2026

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

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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 - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, family interview, staff interviews, clinical record review, and facility documentation review, the facility staff failed to address and implement interventions for significant weight loss for one Resident (Resident #20) in a survey sample of 16 residents, which constituted harm.The findings included:Resident #20 was admitted on [DATE]. The Resident's diagnoses included but were not limited to: Parkinsons's Disease, dementia, anemia, Stroke, Gastro-esophageal Reflux Disease (GERD), dysphagia, and esophageal obstruction.The most recent MDS (Minimum Data Set federal assessment) was completed as a quarterly assessment with an Assessment Reference Date (ARD) of 12-29-25. The assessment described the Resident with a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15 points, indicating mild cognitive impairment. The Resident required assistance from staff with eating to include supervision and touch assistance. The document recorded no rejections of care, no behaviors, and no problems with swallowing. The Resident was coded as weighing 150 pounds with no weight loss. All weights were conducted by wheelchair. The Resident was wheelchair bound.On 2-18-26 Resident #20 was observed during lunch and noted to not be eating. Staff encouraged her and fed her 3 spoonfuls of the meal and then departed to assist others. The Resident did not feed herself. On 2-19-26 the Resident was observed during lunch again and consumed a few spoonfuls with a very shaky hand, finally giving up and not eating. Staff were asked at that time what the Resident ate for breakfast and they replied, very little, just like lunch.On 2-18-26 a group council interview was held with Resident #20 in attendance. The Residents all stated that she needed help to eat, and sometimes there were no staff to help her which occurred most often on weekends and holidays.On 2-19-26 a family interview was held with a Resident present and the family member stated that feeding was an issue and that staff are too busy to just feed one person, the family further stated, they don't have enough staff to really take time with anyone.Weights were being completed monthly and documented in the clinical record. The weights follow below in a pattern of weight loss for 1 year.March 5, 2025, the weight recorded was 160.0 pounds.April 2, 2025, the weight recorded was 150.8 pounds. A loss of greater than 5 % in 1 month. May 6, 2025- 150.2 pounds, June 4, 2025- 152.6 pounds, July 2, 2025- 150.8 pounds, August 5, 2025- 152.8 pounds, September 30, 2025- 151 pounds, October 1, 2025- 149.8 pounds, November 5, 2025- 146.2 pounds, December 3, 2025- 149.8 pounds, January 1, 2026- 149.0 pounds, February 4, 2026- 139.4 pounds, which indicated a 10-pound weight loss in one month equaling a greater than 7.5% weight loss in one month.Physician's orders were reviewed and included no supplements nor orders for weight maintenance were implemented following the significant weight loss. According to the physician orders, Resident #20's diet order which was effective 10/27/25, read, Regular diet, mechanical soft texture, thin consistency. The Resident's care plan was reviewed and revealed that the Resident had a diagnosis of GERD (gastroesophageal reflux disease) and received medication to lessen symptoms. The care plan goal read, will maintain adequate nutritional status as evidenced by maintaining weight within 3% of 150 [pounds], no s/sx [signs or symptoms] of malnutrition, and consuming at least 75% of at least two mals daily through review date. Interventions included, but were not limited to: monitor for swallowing problems, pocketing, drooling, refusing to eat, or (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 0692 Level of Harm - Actual harm Residents Affected - Few	dysphagia. The interventions also listed monitoring for weight loss of 3 pounds in 1 week, greater than 5% in one month or greater than 7.5% in 3 months, should this issue arise as it would underscore a worsening condition. The focus of Nutritional Problem listed the Resident as overweight per BMI, revised on 12-29-25. The care plan also instructed for the RD (Registered Dietician) to evaluate and make diet change recommendations as needed. During the Resident's stay a continued decrease in weight, indicated a worsening condition. There is no indication that the doctor was ever notified of this. The RD placed a note in the clinical record every 3 months for the MDS and care plan assessment requirements during the past year. The notes were dated 3/29/25,6/21/25, 9/30/25, and 12/29/25. Each of the progress note entries by the RD noted, . Weight review without significant change . except one note dated 4/27/25, that noted the resisdent showing a weight change this month ., which listed no interventions to prevent further weight loss, and noted to continue with plan of care. The most recent and last RD note was on 12-29-25, documented by the RD which stated that the Resident remained overweight by BMI. There is no indication that she was ever made aware of the significant weight loss found again on 2-4-26, and the documentation pattern revealed that she would not know until the next assessment requirement for March 2026, as staff did not identify it and did not notify her.Attempts were made by telephone to reach the RD for interview, however, were unsuccessful.On 2-18-26 at 4:00 p.m., at the end of day debriefing held with the Director of Nursing (DON), and Administrator both were informed of the facility staff's failure to provide adequate nutrition for this dependent Resident. Both stated they would provide RD notes.On 2-19-26 at 2:00 p.m., at the end of day debriefing held with the Director of Nursing (DON), and Administrator the above findings were reviewed. The facility administration both stated they had nothing further to provide.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on resident interviews, family interviews, staff interviews, clinical record review, and review of facility documents, the facility staff failed to allow for a neutral binding arbitration process. The findings included: On 2-18-26 at 1:20 PM an interview was conducted with the Administrator who stated that the admissions Director had all admissions documented signed, and that they did as a company have Arbitration in the contract for admissions. A copy was requested and supplied.The facility Binding Arbitration Agreement was reviewed, and the review revealed the following.The facility had chosen the arbitrator group and chose the location (as would coincide with this chosen entity). That declaration was applied to the admission contract for signature agreement which was binding to the Resident and their Representative. This Binding Arbitration Agreement document, which was embedded in the admission contract, also included fees with the percentage payment outlined for both parties to pay in the event of arbitration. The Administrator stated all Residents admitted to the facility would be affected as the Arbitration agreement was located in the admission contract.On 2-18-26 several interviews with cognitively intact Residents and family members were conducted by several surveyors. None agreed to have been aware of Binding Arbitration Agreements removing their rights to a court decision in cases of legal disputes with the facility. When asked if they understood and agreed that by entering into this arbitration agreement, they were giving up and waiving their constitutional right to have claims decided in a court of law before a judge and jury, they all answered No.On 2-19-26 at approximately 2:20 p.m., a final interview was conducted with the [NAME] President of Operations, and it was explained that the Arbitrator could not be prechosen by the facility, and fees could not be delegated as the Virginia Bar Association will provide Arbitrators free of charge. He was asked if they had any further information to present, and he stated no.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, clinical record review and facility document review, the facility staff failed to ensure Resident #5 was free from unnecessary medications, an anti-psychotic medication, for 1 of 12 residents in the survey sample (Resident #5).Findings include:Resident #5 was admitted to the facility on [DATE] with diagnoses to include but not limited to: urinary tract infection with toxic encephalopathy, hypertension, major depressive disorder, anxiety disorder, anemia, pain in left hip, dementia with behavioral disturbance, psychotic disturbance, mood disturbance, and Parkinson's disease with dyskinesia. Resident #5's most recent MDS (Minimum Data Set) Assessment with an ARD (Assessment Reference Date) of 1/5/26 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 7 out of a possible 15 indicating severe cognitive impairment (severe problems with thinking).A review of the clinical record revealed that Resident #5 was admitted to the facility from the hospital on [DATE] with an order for Quetiapine/Seroquel 25 mg (milligram) tablet, give one half tablet by mouth every morning and one and one half tablets every evening for anxiety (Seroquel is an antipsychotic medication used to treat several kinds of mental health conditions including schizophrenia and bipolar disorder). On 12/31/25, the Nurse Practitioner gave orders to wean Resident #5 off Seroquel, starting with order to decrease Seroquel to 25mg by mouth every night for anxiety and for an evaluation by the Psych Nurse Practitioner. A review of a nurse progress note dated 1/6/2026 read, NP (nurse practitioner) gave orders to d/c (discontinue) Seroquel, RP (Responsible Party) updated. Resident #5 is her own Responsible Party.Review of Resident #5's physician orders and the Medication Administration Records from 12/31/25 through 4:05 PM on 2/19/26, revealed an order for: Quetiapine Fumarate (generic for Seroquel) tablet 25 mg, give 1 tablet by mouth at bedtime for Anxiety. The order was not discontinued as indicated in the nurse progress note dated 1/6/26. On 1/7/2026, a Multidisciplinary Care Conference was held with Resident #5 and a family member where they expressed desire for her to be seen by psych services. No review of Resident #5's order for quetiapine/Seroquel by the interdisciplinary team. On 1/24/26, Resident #5 was seen and evaluated by the Psych Nurse Practitioner with a new order to increase Sertraline 50 mg every day to 75 mg every day (Sertraline is a prescription anti-depressant used to treat depression, panic disorders, post-traumatic stress disorders, obsession compulsive disorders, social anxiety, and pre-menstrual dysphoric disorders).On 2/3/26, Resident #5 was seen by her attending physician for a 30-day recertification Resident was seen and examined. All her medications, labs and medical record were reviewed. Resident is pleasantly confused at base line, but she has been sleeping well at night. Resident #5 receives sertraline 75 mg once daily with quetiapine 25 mg at bedtime for MDD with mood disorder (major depressive disorder). There is no history of tearful moments, suicidal ideations, visual or auditory hallucinations.A review of clinical record revealed several progress notes by the nurse practitioner and the physician which read in part, Psychiatric: Resident is pleasant without any confusion, agitation or signs of depression or anxietyA review of ADL records (Activity of Daily Living documentation by the certified nursing assistants) for January and February 2026 revealed section entitled Behavior Monitoring & Interventions was coded as NB meaning no behaviors observed.On 2/19/26 an interview was conducted with LPN #1 regarding whether Resident #5 exhibited any signs of agitation, aggression, nervousness, tearfulness, or anxiety as she had an order for quetiapine 25 mg by mouth every night and she responded, No, I have not seen Mrs. (name redacted) exhibiting any behaviors, she is usually very quiet and pleasant. On 2/19/26, an interview was conducted with C.N.A #1, regarding whether Resident #5 had exhibited any signs of agitation, aggression, nervousness, tearfulness, or anxiety and she responded, Oh, no, I don't have any problems with her, she is easy to work with, no behaviors, very quiet, sweet lady".On 2/19/26 at 9:45 AM, an interview was conducted with the DON (Director of Nursing) regarding her expectations of when an antipsychotic medication would be warranted for a resident and management (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of antipsychotic medications. According to the DON, an antipsychotic would be appropriate to treat a psychiatric diagnosis or when the nurse practitioner or physician justifies a diagnosis to treat other symptoms. We manage antipsychotic medications by monitoring the behaviors and for any side effects and attempt GDR's (gradual dose reduction) as appropriate. On 2/19/26 at 2:30 PM, an interview was conducted with the DON (Director of Nursing) regarding the two pharmacy progress notes for MRR complete, see consultant pharmacist report for physician recommendations (medication regimen review by the consultant pharmacist), dated 1/22/26 and 2/14/26.Unable to locate the consultant pharmacist reports for physician recommendations in the electronic medical record. According to the DON, the consultant pharmacist recommendations for 1/22/26 had been followed up on and should have been scanned into the clinical record, however the 2/14/26 had not been returned to her from the nurse practitioner. The DON provided a copy of the recommendation dated 1/22/26 which revealed: This resident is currently receiving psychotropic medications with required Behavior Monitoring and Adverse effect tracking orders per shift for quetiapine 25 mg by mouth for anxiety. Nursing Recommendation: Please add behavior monitoring for all anti-psychotics, antidepressants, anxiolytics, hypnotics including melatonin to ensure that behaviors being treated are being helped and adverse effects are also being tracked. Please note that any medication used as a psychotropic, including antihistamines or seizure medications must be tracked for behaviors and adverse effects which will facilitate more appropriate GDR (gradual dose reduction) attempts. Please add AIMS (Abnormal Involuntary Movement Scale) monitoring baseline and every three months, unless already ordered for this resident. Report any significant changes to the prescriber as soon as possible.Resident#5 had an AIMS completed on 12/30/25 with score of 0, no abnormal movement noted.Unable to locate Behavior Monitoring and Adverse Effect Tracking on the Medication Administration Record for use of the antipsychotic medication. On 2/19/26 at 3:20 PM, during the end of the day meeting with the Administrator, Director of Nursing, and Regional Director of Operations, Resident #5's order for quetiapine/Seroquel with diagnosis of anxiety was reviewed as an unnecessary medication, and an opportunity was offered to the facility staff to present additional information. At 4:05 PM, the DON presented a copy of the 2/14/26 consultant pharmacist recommendation signed by the Nurse Practitioner to discontinue the quetiapine/Seroquel and a copy of the Nurse Practitioner's visit summary which read in part: 2/19/26 Nurse Practitioner - The resident is also being monitored for a history of generalized anxiety disorder. She was admitted from the hospital with a prescription for quetiapine (Seroquel) 25 mg orally daily. Since admission, she has demonstrated no behavioral disturbances, no agitation, no mood instability, and no observable or reported symptoms consistent with active generalized anxiety disorder. She has remained calm, cooperative, and psychiatrically stable without evidence of increased anxiety, insomnia, restlessness, or emotional distress. Given the absence of current symptoms and considering the well-documented risks associated with antipsychotic use in elderly patients, including increased risk of sedation, orthostatic hypotension, falls, metabolic effects, and black box warnings regarding mortality in older adults, it is clinically appropriate to discontinue Seroquel at this time. The potential risks of continued antipsychotic therapy outweigh any benefit in the absence of active psychiatric symptoms.Recommendation is to discontinue Seroquel 25 mg orally daily and continue to monitor closely for any recurrence of anxiety symptoms or behavioral changes. Nursing staff should observe for and report any changes in mood, behavior, sleep pattern, or functional status. The resident remains stable, and ongoing monitoring will continue to ensure safety and appropriate management.A review of the facility's policy Antipsychotic Medication Use, Paragraph entitled, Policy Interpretation and Implementation which reads in part. 1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 5. Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indication for use. The interdisciplinary team will: a. Complete a PASRR screening preadmission screening for mentally ill (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and intellectually disabled individuals), if appropriate; or b. Re-evaluate the use of antipsychotic medication at the time of admission and periodically to consider whether the medication can be reduced, tapered, or discontinued.c. Based on assessing the resident's symptoms and overall situation, the physician will determine whether to continue, adjust, or stop existing antipsychotic medication.7. Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with definition(s)in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia; b. Schizo-affective disorder; c. Schizophreniform disorder; d. Delusional disorder; e. Mood disorders (e.g. bipolar disorder, depression with psychotic features, and treatment refractory major depression); f. Psychosis in the absence of dementia; g. Medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania (e.g., high-dose steroids); h. Tourette's disorder; i. Huntington disease; j. Hiccups (not induced by other medications); or k. Nausea and vomiting associated with cancer or chemotherapy.8. Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: a. The behavioral symptoms present a danger to the resident or others; and (1) The symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); (2) Behavioral interventions have been attempted and included in the plan of care, except in an emergency.On 2/19/26 at 4:20 PM, an exit conference was held with the Administrator, Director of Nursing, Regional Director of Operations and Regional [NAME] President of Clinical Services. No further information was provided.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, family interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain an available call bell system for one Resident (Resident #14) in a sample of 16 residents as a means to call for assistance from the bedside where the call would go directly to a staff member or central location with no alternate means to call for assistance. The findings included;Resident #14 was most recently readmitted to the facility on [DATE]. The Resident's diagnoses included; Diabetes, chronic inflammatory demyelinating poly neuritis, disc degeneration, malnutrition, dementia, impaired cognitive function, and impaired mobility.The most recent MDS (Minimum Data Set federal assessment) was most recently completed as a quarterly assessment with an Assessment Reference Date (ARD) of 1-5-26. The assessment described the Resident with a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 points, indicating mild cognitive impairment. The Resident required assistance from staff with eating to include foam handle utensils and staff feeding at times. The Resident was dependent on staff for self-care and hygiene and had contractures, a urinary catheter, and pressure wounds. The Resident had recently on 2-3-26 been ordered for hospice care. The document recorded no rejections of care, and no behaviors. The Resident was mostly bed bound.On 2-17-26 during initial tour of the facility surveyors found no call bell device in the room for Resident #14.On 2-18-26 A second surveyor found no call bell device in the room for Resident #14. A staff member was in the hallway just outside of the Resident's room and was asked why the Resident had no call bell device. The staff member stated, her hands are so contracted she can't use it. The staff member was asked how they know if the Resident needs help, and she stated, we round on her more often.On 2-19-26 The Resident was again visited, and her son was visiting and sitting in a chair at the bedside. He was asked if she could use the call device around her neck, and he stated, no way. The Resident was now wearing a clearly seen call bell device the size of a quarter coin around her neck on a short lanyard that reached only her upper sternum like a necklace. The Resident was asked to push the button on the call device around her neck. The Director of Nursing (DON) approached the room and stated, she can use the call device. The Resident was noted to have a washcloth rolled up in both of her contracted hands to protect her palms from the pressure of her fingers pressing into them. The Resident shook her head and said What?. The instructions were given again, and she looked down but seemingly could not see the device. The DON was told at that time that the Resident could not access the device, and an alternative would be needed such as a large pancake device which is an example of widely used devices in the industry for those with dexterity issues. Those devices can be struck with a fist or back of hand to summon help and are easily seen and identified by residents with mobility issues. The Resident's care plan was reviewed and interventions for contracture to the left hand were denoted as a focus with a hand splint ordered for 4-6 hours per day as tolerated, however, nothing was included for the right hand which was also found to be contracted.On 2-19-26 at 3:00 PM, a facility corporate officer came to surveyors and stated the facility is process of getting a more accessible call bell device for Resident #14.Review of 3 months of the resident council minutes did not reveal concerns of this type, nor did the Resident council meeting during survey reveal issues of this type.On 2-19-26 at 3:35 PM, the facility DON and Administrator were notified of the above findings, and they stated they had nothing further to provide.