STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495430	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Lifelong Health & Rehabilitation Salud	672 Gloucester Road Saluda, VA 23149

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, resident interview, staff interview, clinical record review, and facility document review, the facility failed to maintain an infection prevention and control program to provide a safe sanitary environment and assist in the prevention, development, and transmission of communicable disease and infection for all facility residents and the facility staff failed to utilize appropriate droplet precaution signage for (4) four of (6) six residents identified for droplet precautions, Resident #2, Resident #16, Resident #32, and Resident #48 and the facility staff failed to utilize appropriate personal protective equipment (PPE) for (2) two of (6) six residents on droplet precautions, Resident #16 and Resident #22 and the facility staff failed to utilize appropriate PPE during a medication pass and pour observation, Resident #48. The survey team informed the facility on 3/5/26 at 10:50 AM of the Immediate Jeopardy situation regarding Resident #2 due to the facility failing to: (1) prevent Resident #2 from eating breakfast in a common area with other residents while on droplet precautions with pending influenza test results thus placing facility residents at risk of exposure to influenza, (2) provide droplet precaution education to Resident #2. The scope and severity were originally cited at Level IV, pattern. On 3/6/26 at 10:25 AM, the Immediate Jeopardy was removed and lowered to Level II, pattern. The findings included:1. For Resident #2 the facility staff failed to prevent Resident #2 from eating breakfast in a common area with other residents while on droplet precautions with pending influenza test results and the facility staff also failed to provide droplet precaution education to Resident #2. Resident #2's diagnosis list indicated diagnoses, which included, but not limited to schizophrenia, bipolar disorder, and schizoaffective disorder. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/6/26 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. Requested and received a Flu Outbreak Line Listing report which disclosed Resident #2 began experiencing respiratory symptoms on 3/2/26. Resident #2 was seen by the nurse practitioner (NP) on 3/2/25, the progress note read in part, .Pt (patient) is seen today, 3/2/26 regarding new onset of cough.COVID [and] Flu tests were ordered, the results will be F/U (followed up). A Health Status progress note dated 3/2/26 read in part, .Resident received an {sic} covid-19 test. Results came back negative. A medical provider order with a start date of 3/3/26 read in part, .Combined Droplet and Contact Precautions.Nurse must document if the following occurred using YES or NO in the Supplementary Documentation:1. Resident in Room alone without roommate? Y 2. Resident remains in Room? Y 3. All (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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	services (rehab, activities, meals etc.) brought to room? Y every shift for Influenza-Start Date-03/03/2026 1500 (3:00 PM). On 3/4/26 at 8:25 AM, Resident #2 was observed to be sitting alone at a table in the facility dining room. There were four other residents observed at that time to be present in the room at nearby tables, approximately 6 feet away from Resident #2. On 3/4/26 at 10:34 AM, the infection preventionist (IP) and director of nursing (DON) were interviewed. The IP stated the facility staff are sending the resident flu tests out after they are obtained. The DON stated the protocol is to put residents with respiratory symptoms on droplet precautions while the tests are pending. On 3/4/26 at 10:52 AM, a droplet precaution sign was observed to be outside of Resident #2's room. Resident #2 was interviewed and stated that they walked to breakfast this morning. On 3/4/26 at 10:57 AM, certified nursing assistant #1 (CNA#1) was interviewed. When asked how Resident #2 prefers to have meals, CNA#1 stated that it varies on how the resident feels if they prefer to eat in the room or dining area. Resident #2 is able to ambulate without assistance to the dining area and had breakfast in the dining room this morning. CNA#1 reported that they did not see Resident #2 go into the dining room or they would have stopped the resident due to isolation precautions. On 3/4/26 at 11:15 AM, the IP was interviewed and asked about the process for preventing ambulatory/independently mobile residents from exiting their rooms while on droplet precautions and the IP stated that they highly encourage residents to stay in their rooms. When asked how the facility staff redirect cognitively impaired residents from exposing other residents, the IP responded that food is a good redirection for Resident #2. The IP stated that they have morning meetings where the dining director is made aware of which residents need to have meals served in their rooms while on isolation precautions. On 3/4/26 at 1:01 PM, the IP was interviewed and stated Resident #2 was tested for the flu today (3/4/26) and they were awaiting the results. A Lab Results progress note dated 3/4/26 with a reported time of 12:47 PM read in part, .Lab results for Influenza A & B, positive for Influenza A. A review of Resident #2's comprehensive person-centered care plan read in part, .is experiencing respiratory symptoms of cough.Flu test positive. with a revision date of 3/4/26. An intervention associated with this focus read in part, .Initiate transmission-based precautions until test results return and/or infection clears. (Combined Droplet and Contact Precautions for SPECIFY Nurse must document if the following occurred using YES or NO in the Supplementary Documentation: 1. Resident in Room alone without roommate? Y 2. Resident remains in Room? Y 3. All services (rehab, activities, meals etc.) brought to room? Y) Date Initiated: 03/04/2026.Revision on: 03/04/2026. This concern was discussed on 3/4/26 at 4:30 PM at the end of day meeting with the administrator and DON. The DON stated more resident flu results have come in. Resident #2 and two additional residents have tested positive for the flu. Three residents are still pending results. On 3/4/26 at 5:25 PM, the dietary manager (DM) and certified nursing assistant #3 (CNA#3) were interviewed and confirmed that Resident #2 had been eating in the dining room at breakfast and had (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	been sitting at a table alone at the left corner table in the dining area closest to the kitchen. The DM confirmed there were four residents sitting to the right of Resident #2 and two residents were sitting with a CNA at the table across from Resident #2. On 3/5/26 at 8:26 AM the IP was interviewed and stated with the current flu outbreak the first resident tested positive on 2/25/26, Three residents tested positive yesterday (3/4/26). Currently there are three residents with results pending. Requested and reviewed a facility policy titled, Droplet Precautions Procedure with a revision date of 8/19/22, which read in part, .Droplet Precautions apply to patients with known or suspected infections that are transmitted by the droplet route. Respiratory droplets are generated when an infected person coughs, sneezes, talks, or during procedures.the most common diseases requiring Droplet Precautions 1) Influenza.The resident will wear a mask if the resident has to leave the room. On 3/5/26 at 10:50 AM, the survey team notified the administrator, DON, IP, regional staff educator, and assistant chief nursing officer of the Immediate Jeopardy situation regarding Resident #2 and the facility's failure to maintain an infection prevention and control program to prevent the spread of influenza as evidenced by failing to prevent Resident #2 from eating breakfast in a common area with other residents while on droplet precautions with pending influenza test results and the facility's failure to provide droplet precaution education to Resident #2. On 3/5/26 at 2:18 PM the administrator presented the following immediate jeopardy removal plan regarding Resident #2: 1. Resident #2 will be educated by DON/designee on appropriate infection prevention and control practices, to include masking, hand hygiene, importance of remaining in room when respiratory symptoms are present and use of appropriate PPE using CDC/APIC/OSHA handouts with pictures and graphics for better understanding. 2. All independently mobile residents with a BIMS greater than 12 will be educated by the DON/Designee will on infection prevention and control practices, to include masking, hand hygiene, the importance of remaining in room when respiratory symptoms are present, and use of appropriate PPE when leaving the room using CDC/APIC/OSHA handouts and the droplet precautions with pictures and graphics for better understanding. 3. All staff will be educated by the DON, Educator, or designee on the importance of ensuring appropriate infection prevention and control practices, to include masking, hand hygiene, appropriate PPE usage, including donning and doffing, and to encourage residents on transmission-based precautions to remain in their room using transmission-based precaution signage, CDC and World Health Organization handouts, and the facility droplet precautions policy/procedure. If staff are unable to participate due to scheduling, they will be educated prior to their next scheduled shift. All residents and/or their representative will be provided with education materials by administrator/designee on appropriate infection prevention and control practices, to include masking, hand hygiene, residents remaining in room when respiratory symptoms are present, and use of appropriate PPE when leaving the room using materials from the CDC, APIC, and/or World Health organization. Meals will continue to be served in resident rooms for residents on droplet precautions. There will be continued coordination with and adherence to guidance from local epidemiologists. 4. Observations will be completed three times per shift for 10 days by Infection (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Preventionist/designee to ensure that residents are following appropriate infection prevention and control practices, such as resident masking in common areas, resident hand hygiene, and that residents on transmission-based precautions remain in their room, to prevent the spread of influenza. This plan will be approved and monitored through the QAPI team. 5. All corrective actions will be completed by March 5, 2026, at 6 p.m. On 3/5/26 at 3:15 PM, the survey team informed the administrator that the facility's immediate jeopardy removal plan was accepted. The facility presented credible evidence that the removal plan had been implemented, including evidence of facility staff and resident education as outlined in the removal plan. Interviews with the facility staff, licensed nursing staff, and residents also verified education as outlined in the removal plan. Observations were conducted on facility resident dining and common areas and it was verified that residents identified for droplet precautions were not present in these areas and received meals and activities in their rooms. Observations were conducted for proper droplet precaution signage for those residents identified to be on droplet precautions and all the droplet precaution signs were appropriate. Facility staff were interviewed for the proper protocol and the proper use of PPE prior to entering resident rooms identified for droplet precautions. Facility staff were interviewed for the proper protocol if a resident identified for droplet precautions wishes to come out of their room for the use of appropriate PPE, cough etiquette, hand hygiene, and proper practice and prevention of infection control. Observations and interviews with facility residents were performed to include their education and knowledge of symptoms of respiratory illness, hand hygiene, and the use of proper PPE when on droplet precautions for facility residents and facility staff. Residents were observed to have masks present in their rooms for utilization as needed/indicated. On 3/6/26 at 10:25 AM, the survey team notified the Administrator that the immediate jeopardy was removed. No further information regarding this concern was presented to the survey team prior to the exit on 3/6/26. 2. For the facility, the facility staff failed to utilize appropriate droplet precaution signage for the rooms of Resident #2, Resident #16, and Resident #32, and the facility staff failed to utilize appropriate personal protective equipment (PPE) prior to entrance into rooms identified for droplet precautions for Resident #16 and Resident #22. On 3/4/26 at 8:49 AM, Resident #16's room was observed with a droplet precautions sign visible outside of the door. The sign read in part, .Wear a N95 and face shield to enter room. Make sure eyes, nose and mouth are fully covered before entering room. All team members must wear gown and gloves. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Other staff#1 (OS#1) was observed to be in Resident #16's room donning only a surgical face mask. When asked what PPE was to be utilized for a droplet precaution room, OS#1 stated care was not being given, and if not performing care PPE does not have to be utilized. A review of the facility line listing for a current flu outbreak disclosed Resident #16 was on droplet precautions pending results for an influenza test. On 3/4/26 at 8:55 AM, the director of nursing (DON) was interviewed about which PPE is appropriate for residents on droplet precautions and the DON stated the expectation is not for N95 masks, a surgical mask is appropriate and facility staff should be wearing gowns and gloves as well. The DON stated the droplet precaution policy would have to be reviewed for the utilization of goggles/eye protection for droplet precaution rooms. The DON stated the expectation is for all staff to don PPE prior to entering a droplet precaution room. On 3/4/26 at 9:00 AM, other staff #2 (OS#2) was observed entering Resident #16's room without any PPE visible. When asked the protocol for entering a droplet precaution room, OS#2 stated as long as the resident is not being touched, then they do not have to wear PPE. On 3/4/26 at 9:06 AM, Resident #22's room was observed with a droplet precautions sign visible outside of the door. The sign read in part, .Wear mask to enter room.If contact with secretions is likely, wear gown, gloves and eye protection. Certified nursing assistant #1 (CNA#1) and other staff #3 (OS#3) were observed to be assisting Resident #22 with breakfast. CNA#1 and OS#2 were observed to be sitting close to the resident's bed and were observed to be wearing gowns and surgical masks. No gloves or eye protection were visible on either staff member. A review of the facility line listing for a current flu outbreak disclosed Resident #22 was on droplet precautions pending results for an influenza test. On 3/4/26 at 9:14 AM, the infection preventionist (IP) observed the droplet precaution sign on Resident #16's room and stated they are assuming the resident has a respiratory infection and the protocol is to be on droplet precautions and wear a gown, face mask, protective mask, goggles, and gloves. The IP attempted three other droplet precaution signs; these signs did not note eye protection was required. On 3/4/26 at 9:40 AM, the IP brought a droplet precaution sign for Resident #16's room. The IP stated this fourth sign was the appropriate droplet precaution sign. The sign read in part, .Make sure their eyes, nose and mouth are fully covered before room entry. The IP and facility staff were observed to change the droplet precaution signs on the rooms of the other four residents on droplet precautions on the unit to the fourth sign that was chosen by the IP. These concerns were discussed at the end of day meeting on 3/4/26 at 4:30 PM with the administrator and DON. On 3/4/26 at approximately 4:43 PM, Resident #32's room was observed to have a droplet precaution sign outside the door which read in part, .Wear mask to enter room.Patient to wear mask if transported out of room.If contact with secretions is likely, wear gown, gloves and eye protection. The IP was made aware and corrected the sign. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/5/26 at 8:26 AM, the IP, DON and staff education specialist (SES) were interviewed. The DON stated if a staff member is observed to not be following appropriate isolation precautions with appropriate PPE, then the staff members are stopped. The DON stated staff were educated this morning during a huddle meeting related to the flu outbreak in the facility. When asked about the confusion with the droplet precaution signs on 3/4/26, the SES stated the droplet precaution signs that were observed on 3/4/26 were COVID-19 isolation signs requiring an N95 mask and the correct signs were located at the nurse's station. The DON stated that the floor nurses put those signs up. A new droplet precautions sign was provided and read in part, .Everyone Must wear a mask, eye protection, gown, gloves to enter room. Make sure eyes, nose and mouth are fully covered before entering room.Patient must wear a mask if transported out of room. On 3/5/26 at 9:56 AM, Resident #2's room was observed to have a droplet precaution sign outside of the door which read in part, .Wear mask to enter room.Patient to wear mask if transported out of room.If contact with secretions is likely, wear gown, gloves and eye protection. On 3/5/26 at 10:00 AM, the IP was interviewed and observed the droplet precaution sign outside of Resident #2's room. The IP agreed this was not the correct droplet precaution sign and stated it would be replaced immediately. The IP stated staff have been wearing appropriate PPE prior to entering the room, as she has been doing observations of this room. Requested and reviewed a facility policy titled, Droplet Precautions Procedure with a revision date of 8/19/22, which read in part, .Droplet Precautions apply to patients with known or suspected infections that are transmitted by the droplet route. Respiratory droplets are generated when an infected person coughs, sneezes, talks, or during procedures.the most common diseases requiring Droplet Precautions 1) Influenza.Healthcare staff must wear a mask, eye protection, gown, and gloves upon room entry. No further information was provided to the survey team prior to exit on 3/6/26. 3. During a medication pass and pour observation, the facility staff failed to follow droplet precautions for Resident #48. While observing licensed practical nurse (LPN) #1 on 03/04/26 at 8:30 am, during a medication pass and pour, LPN #1 was observed entering Resident #48's room wearing a mask, gown and gloves. LPN #1 was not observed wearing eye protection/face shield. Certified nurse's aide (CNA) #2 was also observed entering Resident #48's room, wearing a mask, gown and gloves, but no eye protection/face shield. A Droplet Precautions sign was observed posted outside of Resident #48's room, which read in part, EVERYONE MUST: Wear a N95 and face shield to enter room. Make sure eyes, nose and mouth are fully covered before entering room. Resident #48's clinical record was reviewed and contained a physician's order summary which read in part, Combined droplet and contact precautions for .every shift for Flu type A for 10 days with a start date of 02/25/26 and an end date of 03/07/26. A facility policy entitled Droplet Precautions Procedure was provided on 03/04/26 and read in part, Below is a list of the most common diseases requiring Droplet Precautions 1) Influenza.Required Action Steps. Mask-Healthcare staff must wear a mask, eye protection, gown, and gloves upon room entry. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The concern of the facility staff not following infection control procedures was discussed with the administrator and director of nursing during an end of day meeting on 03/04/26 at 5:05 pm. 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. Based on observation, staff interview, clinical record review and facility document review the facility staff failed to develop a comprehensive care plan that included enhanced barrier precautions for one of 22 current residents in the survey sample, resident #1.The findings included:Resident #1's diagnosis list indicated diagnoses, which include, but not limited to colostomy, Parkinson's Disease and Dementia. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 2/18/2026, assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 for cognitive abilities, indicating the resident was moderately cognitive impaired. Section GG revealed functioning level of non-ambulatory, and wheelchair-bound, incontinent and colostomy, requiring assistance with activities of daily living (ADLs). Observation on 3/3/2026 10:40 am revealed an enhanced barrier precautions (EBP) sign posted near the door for Resident #1, along with gloves and gowns to be used during high contact care. Review of revised Care Plan dated 1/9/2026, revealed that Resident #1 did not have Enhanced Barrier Precautions listed on his care plan. The care plan addressed his colostomy care.On 3/4/2026 at 11:00 am, interview with Licensed Practical Nurse (LPN) #2 revealed, that Resident #1 has Enhanced Barrier Precautions because he has a colostomy and recently developed a pressure ulcer and that she follows facility policies and procedures/protocols for the prevention and treatment of skin breakdown.On 03/03/2026 at 4:24 p.m., the Administrator and Director of Nursing (DON) were present at the end of day meeting where it was discussed that the care plan for Resident #1 did not include Enhanced Barrier Precautions. On 3/5/2026 at 9:55 am, an interview with MDS Coordinator revealed that she oversees the care plans and explained that all nursing staff can update the care plan but very few of the nurses do. She will recommend more training for staff, especially upon admission. The care plan was updated during the conversation to include Enhanced Barrier Precautions (EBP) for Resident #1's care plan.On 03/04/26, the administrative staff provided the survey team with a copy of their policy titled, Comprehensive Care Planning. This policy read in part, .Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.Review of policy titled, LLP-IC-Enhanced Barrier Precautions, revised on 9/25/25, read in part, .Enhanced Barrier Precautions are indicated for residents meeting the criteria below for the duration of their stay or when risk of exposure has ended: 1)Chronic wounds such as pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and venous statis ulcers, and/or indwelling medical devices (e.g. central line, urinary catheter, feed tub, tracheostomy/ventilator), regardless of MDRO colonization status. No further information regarding this issue was provided to the survey team prior to the exit conference.

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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. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to review and revise the comprehensive care plan for 1 of 22 current residents in the survey sample, Residents #48. The findings included: The facility staff failed to review and revise the comprehensive care plan (CCP) when the resident was placed on droplet precautions. Resident #48's diagnoses included dementia, chronic diastolic congestive heart failure, and anxiety. Section C (cognitive patterns) of Resident #48's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/22/25 was coded to indicate the resident had problems with long-and short-term memory and was severely impaired in cognitive skills for daily decision making. During initial tour Resident #48 was identified by the facility staff as being positive for the flu. A droplet precaution sign and personal protective equipment (PPE) were observed outside of Resident #48's room. Resident #48's clinical record included a progress note transcribed by the nursing staff on 02/25/26 stating Resident #48 had tested positive for the flu and isolation precautions were in place. On 02/25/26, the provider ordered combined droplet and contact precautions. The end date for this order was documented as 03/07/26. A review of Resident #48's CCP revealed the facility staff had not reviewed and revised Resident #48's CCP to include droplet precautions. On 03/03/2026 at 4:10 p.m., during an interview with the Clinical Reimbursement Director this staff reviewed Resident #48's CCP and confirmed Resident #48's isolation status was not on the CCP. On 03/03/2026 at 4:20 p.m., during an end of the day meeting with the Administrator and Director of Nursing the issue with the CCP not being reviewed and revised to include Resident #48's droplet precautions were reviewed. On 03/04/26, the administrative staff provided the survey team with a copy of their policy titled, Comprehensive Care Planning. This policy read in part, .Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to follow provider orders for two of 22 residents in the survey sample, resident #3 and resident #31. 1.For Resident #3 the facility staff failed to follow a medical provider order for 1/2 side rails. Resident #3's diagnosis list indicated diagnoses that included, but were not limited to, muscle spasm, psychotic disorder with delusions, insomnia, abnormalities of gait and mobility, abnormal posture, extrapyramidal and movement disorder, difficulty in walking, and repeated falls. The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 1/23/26 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating Resident #3 was cognitively intact. On 3/4/26 at 10:40 AM, Resident #3's bed was observed to have 1/4 bilateral side rails in place and up on both sides of the bed. A review of the clinical record disclosed the following documentation: A medical provider order dated 1/19/26 read in part, .Siderails x 2 as tolerated: 1/2 side rails every shift for bed mobility and positioning and safety. A review of the TAR (treatment administration record) for 1/1/26 through 1/9/26 disclosed 1/4 side rails were in place every shift. From 1/19/26 through 1/31/26, the TAR disclosed 1/2 side rails were in place every shift. A review of the TARs for February and March 2026 disclosed 1/2 side rails were in place every shift. A review of the comprehensive person-centered care plan had a focus which read in part, .resident's preference is to perform own ADL (activities of daily living) care. The focus included an intervention which read in part, .SIDE RAILS: Bilateral 1/4 side rails for safety during care provision, to assist with bed mobility. with a revision date of 12/6/22. On 3/4/26 at 3:33 PM, the director of nursing (DON) was interviewed and stated the order for 1/4 side rails was discontinued when Resident #3 was transferred to the hospital. The DON agreed the care plan stated 1/4 side rails and when Resident #3 returned from the hospital the order was put in incorrectly for 1/2 side rails, but the resident is supposed to have 1/4 side rails. The DON provided a medical provider order dated 3/4/26 which read in part, .Siderails - Siderails x 2 as tolerated: 1/2 side rails every shift. with a discontinue date of 3/4/26. The DON also provided a medical provider order dated 3/4/26 which read in part, .Siderails x 2 as tolerated. with a start date of 3/4/26. This concern was discussed on 3/4/26 at 4:30 PM at the end of day meeting with administrator and DON. Requested and received a facility policy titled, Bed / Side Rail Entrapment Policy with an effective date of 1/17/23 which read in part, .14. The physician will be notified and a specific order for the use of bed rails (identify how many/type of bed rails, which side of the bed, and when they are to be in place) will be obtained. No further information was provided prior to exit on 3/6/26. 2. For resident #31, the facility staff failed to follow physician's orders for side rails. Resident #31's pertinent diagnoses included but were not limited to vascular dementia, dizziness and giddiness, macular degeneration, anxiety disorder and major depressive disorder. The quarterly minimum data set (MDS) assessment with an assessment reference date of 1/28/26 assigned the resident a brief interview for mental status (BIMS) score of 01/15 indicating severe cognitive impairment. The MDS also reflected that resident #31 is hearing and vision impaired and requires supervision to touching assistance with bed mobility. On 3/2/26 at 2:20 PM resident #31 was observed lying in bed with one side rail up on the right-hand side of the bed. On 3/4/26 at 9:50 AM resident #31 was observed lying in bed with the side rail on the right-hand side of the bed up, the left side rail was not up. The clinical record was reviewed and included a physician's order dated 10/25/24 that read, Siderails: 1/2 siderails x 2 as tolerated every shift for bed mobility and positioning. The most recent bed rail assessment dated [DATE] was reviewed. Under Section I, question #8 read, Has the resident expressed a desire to have side rails/assist bars for safety and/or comfort? The question was marked yes. Under Section II, the third question indicated that bilateral side rails should be up. The side rail consent form with a date of 12/17/20 also stated that 1/2 side rails should be up bilaterally. The care plan was reviewed. A focus (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that read in part, ADL (activities of daily living) self-care deficit included an intervention that read, Bilateral 1/4 side rails for safety during care provision to assist with bed mobility. On 3/4/26 at 3:20 PM the Director of Nursing (DON) was interviewed. When informed of the discrepancy between the side rail order, the care plan and the observations of just one rail up the DON stated, Let me go check into it. The DON returned and stated that resident #31 has 1/4 rails on the bed and that the care plan is correct. We've changed rooms and beds around so much, but his bed has quarter rails now, not half rails. I'm not sure why one side was down but they are up now. The DON stated that the order will be changed. When asked if the side rail assessment and consent will also be corrected the DON indicated that they would be updated. The policy entitled, Bed/side Rail Entrapment Policy with an effective date of 1/17/23 was reviewed. Under the heading entitled, Evaluate the Resident, item number 10 reads: The Bedrail/Entrapment Risk Evaluation is completed: a. Admission, b. Quarterly, c. Significant Change, and d. Any time the resident's bed complement is changed (e.g. addition of an air mattress or an additional bed rail. Item number 14 reads, The physician will be notified and a specific order for the use of bed rails (identify how many bed rails, which side of the bed, and when they are to be in place) will be obtained. The facility will document use of the bed rail in the medical record. On 3/5/26 at 3:28 PM the survey team met with the Administrator, Regional Executive Director and DON. This concern was reviewed at that time. No further information was provided to the survey team prior to the exit conference.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on staff interview, clinical record review and facility document review the facility staff failed to ensure medications were available for administration for 2 of 22 current residents in the survey sample, Residents #9 and resident #31. The findings included: 1. For Resident #9, the facility staff failed to ensure the medications Parlodel and Lansoprazole (Prevacid) were available for administration. Resident #9's diagnoses included spastic quadriplegic cerebral palsy, epilepsy and gastro esophageal reflux disease. Section C (cognitive patterns) of Resident #9's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/21/26 was coded to indicate Resident #9 had problems with long-and short-term memory and was severely impaired in cognitive skills for daily decision making. Resident #9's clinical record included provider orders for Parlodel give 1.25 mg via J-tube two times a day for dystonia and Lansoprazole oral suspension give 10 ml via J-tube one time a day for heartburn. A J-tube is a type of enteral feeding device placed through the abdomen directly into the small intestine to deliver nutrition, fluids, and medication. Resident #9's comprehensive care plan included the intervention administer medications as ordered. A review of Resident #9's medication administration records (MARs) for February 2026 revealed that for 02/20/26 the nursing staff had documented a 9 on 02/20/26 at bedtime for the medication Parlodel. The facility nursing staff had documented a 9 on the MARs for the medication Lansoprazole on 02/19/26-02/22/26 and on 02/24/26. For 02/23/26 the nursing staff documented the medication had been administered. Per the preprinted code on the MARs a 9=other/see progress notes. On 02/20/26 the facility nursing staff documented for the medication Parlodel they were Waiting on delivery from pharmacy. For the medication Lansoprazole the facility nursing staff had documented the following-02/19/26 pharmacy notified, 02/20/26 not in, reordered from pharmacy, 02/21/26 hasn't arrived from pharmacy, 02/22/26 still not in from pharmacy, and on 02/24/26 the facility nursing staff documented time changed back to 6:00 a.m. The surveyor was unable to locate any documentation to indicate this medication was administered on 02/24/26. A review of the facility med bank list (back up medications) revealed neither of these medications would have been available for administration. On 03/03/2026 at 4:20 p.m., during a meeting with the Administrator and Director of Nursing the issue with Resident #9's medications not being available for administration was reviewed. On 03/04/26, the survey team requested the facility policy on unavailable medications. The facility provided the survey team with a copy of a diagram indicating if medication was not available the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure was to contact the provider for an alternate order and/or consider a stat run from the pharmacy. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For resident #31 the facility staff failed to ensure the medication pantoprazole was available for administration. Resident #31's quarterly minimum data set (MDS) assessment with an assessment reference date of 1/28/26 assigned the resident a brief interview for mental status score (BIMS) of 01/15 indicating severe cognitive impairment. On 3/1/26 at 7:31 PM a progress note was made that read, Pantoprazole Sodium Oral Tablet Delayed Release 20 MGGive 1 tablet by mouth at bedtime for GERDNot in pixis - on order. The Medication Administration Record (MAR) was reviewed. On 3/1/26 the medication pantoprazole was coded with a 9 instead of a check mark which indicates to see nurses' notes. The med bank list, which is a list of medications available in back up stock did not include the medication pantoprazole. On 03/03/2026 at 4:20 p.m. the survey team met with the Administrator and Director of Nursing. This concern was discussed with them at that time On 03/04/26, the survey team requested the facility policy on unavailable medications. The facility provided the survey team with a copy of a diagram indicating if medication was not available the procedure was to contact the provider for an alternate order and/or consider a stat run from the pharmacy. No further information was presented to the survey team prior to the exit conference.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on staff interview and clinical record review, the facility staff failed to ensure laboratory results were reported to the provider for 2 of 22 current residents in the survey sample, Residents #6 and #31. The findings included: 1. For Resident #6, laboratory tests obtained on 01/29/26 and 02/06/26 were not reviewed by the provider until 03/05/26. Resident #6's diagnoses included vascular dementia, diabetes, and hyperlipidemia. Section C (cognitive patterns) of Resident #6's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/21/26 included a brief interview for mental status (BIMS) score of 5, indicating Resident #6 was severely impaired in cognitive skills for daily decision making. Resident #6's clinical record included provider orders dated 01/26/26 for a complete blood count, comprehensive metabolic panel, hemoglobin A1C, vitamin B12, lipid panel, vitamin D, and magnesium. The exact same laboratory tests were ordered again on 01/31/26. During the clinical record review, the surveyor was unable to locate the results for these laboratory tests. On 03/04/26, the Nurse Officer Assistant provided the surveyor with copies of laboratory results that were collected on 01/29/26 and 02/06/26. The laboratory results included initials to indicate they had been reviewed. They did not include a date. On 03/06/26 at 8:20 a.m., during an interview with the Nurse Officer Assistant this staff stated the laboratory results were not reviewed by the provider until 03/05/26. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For resident #31 the facility staff failed to report the results of laboratory tests obtained on 2/5/26 to the provider. Resident #31's diagnoses included but were not limited to: chronic kidney disease, vitamin D deficiency, deficiency of other B group vitamins, hypertension, and vascular dementia. Resident #31's minimum data set (MDS) assessment with an assessment reference date of 1/28/26 assigned the resident a brief interview for mental status (BIMS) score of 01 out of 15 indicating severe cognitive impairment. A Nurse Practitioner (NP) note entered into the clinical record on 1/30/26 read in part, Iron deficiency anemia, unspecified *: Patient has chronic anemia. Currently managed with ferrous sulfate 325mg (65mg iron) tablet daily and folic acid 1mg tablet daily. CBC (complete blood count), comprehensive metabolic panel (CMP), vitamin D, and magnesium level were ordered by pharmacy recommendation at this visit. Will continue current treatment regimen and monitor lab results for effectiveness. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurses note entered into the record on 2/5/25 at 4:05 AM read, CBC, CMP, VIT (vitamin) D, MAGNESIUM was drawn on top of right wrist/arm without difficulty. On 2/9/26 an NP read in part, Iron deficiency anemia, unspecified *: Patient has chronic anemia. Currently managed with ferrous sulfate 325mg (65mg iron) tablet daily and folic acid 1mg tablet daily. CBC, comprehensive metabolic panel, vitamin D, and magnesium level were ordered by pharmacy recommendation at this visit; however, patient's blood was not drawn for the labs and will be followed up. On 2/27/26 an NP note read in part, CBC, CMP, vitamin D, & magnesium level ordered by pharmacy recommendation at this visit - not sure the reason, but pt's (patients) blood was not drawn for the labs, will be F/U (follow-up). On the January physician's order summary, an order entered on 1/30/26 read, CBC, CMP (comprehensive metabolic panel), Vitamin D and magnesium level one time only for 2 days for pharmacy recommendation please d/c (discontinue) it after blood draw. The test was scheduled to be drawn on 2/5/26 according to the order. The results of the test were not located in the clinical record. The Director of Nursing (DON) was asked at 1:20 PM on 3/4/26 to provide the laboratory results for resident #31 that were drawn on 2/5/26. On 3/4/26 at 3:00 PM the DON brought the labs results for resident #31 which were dated 2/5/26. The DON stated, Our labs go to three different labs based on the resident's insurance. Only one of the labs is set up to send results through to the medical record portal. I had to call the lab and request these results be sent today. When asked to clarify whether or not the provider has reviewed the lab results yet she stated they have not reviewed them yet. Normally the NP will ask if she is waiting or looking for lab results and I will call the lab to get the results but I wasn't aware these hadn't been sent to us yet. When asked if there was one staff member responsible to ensure labs are done and results received timely, the DON stated there is not. On 3/5/26 at 3:28 PM the survey team met with the Administrator, Regional Executive Director and DON. This concern was reviewed at that time. No further information was provided to the survey team prior to the exit conference.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. Based on staff interview and clinical record review the facility staff failed to file provider ordered laboratory test results in the clinical record for 2 of 22 current residents in the sample, Residents #6 and #31. The findings included:1. For Resident #6, the facility staff failed to ensure provider ordered laboratory results were filed in the clinical record. Resident #6's diagnoses included vascular dementia, diabetes, and hyperlipidemia. Section C (cognitive patterns) of Resident #6's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/21/26 included a brief interview for mental status (BIMS) score of 5, indicating Resident #6 was severely impaired in cognitive skills for daily decision making. Resident #6's clinical record included provider orders dated 01/26/26 for a complete blood count, comprehensive metabolic panel, hemoglobin A1C, vitamin B12, lipid panel, vitamin D, and magnesium. The provider ordered the exact same laboratory tests on 01/31/26. During the clinical record review, the surveyor was unable to find the results for these laboratory tests in the clinical record. On 03/04/26, the Nurse Officer Assistant provided the surveyor with a copy of laboratory results obtained on 01/29/26 and 02/06/26. On 03/05/2026 at 8:25 a.m., during an interview with the Director of Education this staff stated the laboratory results should have been included in the clinical record. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For resident #31 the facility staff failed to report the results of laboratory tests obtained on 2/5/26 to the provider. Resident #31's diagnoses included but were not limited to: chronic kidney disease, vitamin D deficiency, deficiency of other B group vitamins, hypertension, and vascular dementia. Resident #31's minimum data set (MDS) assessment with an assessment reference date of 1/28/26 assigned the resident a brief interview for mental status (BIMS) score of 01 out of 15 indicating severe cognitive impairment. A Nurse Practitioner (NP) note entered into the clinical record on 1/30/26 read in part, Iron deficiency anemia, unspecified *: Patient has chronic anemia. Currently managed with ferrous sulfate 325mg (65mg iron) tablet daily and folic acid 1mg tablet daily. CBC (complete blood count), comprehensive metabolic panel (CMP), vitamin D, and magnesium level were ordered by pharmacy recommendation at this visit. Will continue current treatment regimen and monitor lab results for effectiveness. A nurses note entered into the record on 2/5/25 at 4:05 AM read, CBC, CMP, VIT (vitamin) D, MAGNESIUM was drawn on top of right wrist/arm without difficulty. (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 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/9/26 an NP read in part, Iron deficiency anemia, unspecified *: Patient has chronic anemia. Currently managed with ferrous sulfate 325mg (65mg iron) tablet daily and folic acid 1mg tablet daily. CBC, comprehensive metabolic panel, vitamin D, and magnesium level were ordered by pharmacy recommendation at this visit; however, patient's blood was not drawn for the labs and will be followed up. On 2/27/26 an NP note read in part, CBC, CMP, vitamin D, & magnesium level ordered by pharmacy recommendation at this visit - not sure the reason, but pt's (patients) blood was not drawn for the labs, will be F/U (follow-up). On the January physician's order summary, an order entered on 1/30/26 read, CBC, CMP (comprehensive metabolic panel), Vitamin D and magnesium level one time only for 2 days for pharmacy recommendation please d/c (discontinue) it after blood draw. The test was scheduled to be drawn on 2/5/26 according to the order. The results of the test were not located in the clinical record. The Director of Nursing (DON) was asked at 1:20 PM on 3/4/26 to provide the laboratory results for resident #31 that were drawn on 2/5/26. On 3/4/26 at 3:00 PM the DON brought the labs results for resident #31 which were dated 2/5/26. The DON stated, Our labs go to three different labs based on the resident's insurance. Only one of the labs is set up to send results through to the medical record portal. I had to call the lab and request these results be sent today. When asked to clarify whether or not the provider has reviewed the lab results yet she stated they have not reviewed them yet. Normally the NP will ask if she is waiting or looking for lab results and I will call the lab to get the results but I wasn't aware these hadn't been sent to us yet. When asked if there was one staff member responsible to ensure labs are done and results received timely, the DON stated there is not. On 3/5/26 at 3:28 PM the survey team met with the Administrator, Regional Executive Director and DON. This concern was reviewed at that time. No further information was provided to the survey team prior to the exit conference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review the facility staff failed to ensure the clinical record was complete and accurate for 1 of 22 current residents in the survey sample resident #10. The findings included:For resident #10 the facility staff failed to ensure the Durable Do Not Resuscitate (DDNR) order was complete and accurate in the medical record.Resident #31's diagnoses included but were not limited to vascular dementia, cerebral infarction, venous insufficiency, heart failure, and hypertension.The admission minimum data set (MDS) assessment with an assessment reference date of 2/20/26 assigned the resident a brief interview for mental status score of 7/15 indicating the resident was severely cognitively impaired. The MDS also indicated that resident #10 had a condition or chronic disease that may result in life expectancy of less than 6 months and resident was receiving hospice services.The physician's orders were reviewed. Resident #10 had an active order for do not resuscitate documented. Under miscellaneous documents the resident had a DDNR form that was signed by the Power of Attorney (POA) listed on the face sheet and dated 2/13/26. The form read, I the undersigned, state that I have a [NAME] fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. I further certify (must check 1 or 2): 1. The patient is capable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. 2. The patient is incapable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is incapable to understand the nature, extent or probable alternatives to that decision. Neither box was checked. The form went on to state that if box #2 was checked then check A, B, or C below. A. While capable of making an informed decision the patient has executed a written advanced directive which directs that life prolonging procedures be withheld or withdrawn. B. While capable of making an informed decision the patient has executed a written advanced directive which appoints a person authorized to consent on the patient's behalf with authority to direct that life-prolonging procedures be withheld or withdrawn (signature of person authorized to consent on the patient's behalf is required.) C. The patient has not executed a written advanced directive (living will, or durable power of attorney for healthcare .On 3/3/26 at 4:20 PM the survey team met with the Administrator and Director of Nursing. This concern was discussed with them at that time,No further information was provided to the survey team prior to the exit conference.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on staff interview, clinical record review, and facility document review, the facility staff failed to offer education for the declination of a pneumococcal vaccine for (1) one of (5) five residents sampled for immunization review, Resident #57. The findings included:Resident #57's diagnosis list indicated diagnoses, which included, but not limited to atherosclerosis of native arteries of extremities with rest pain, right leg, allergic rhinitis, polyneuropathy, and encounter for surgical aftercare following surgery on the circulatory system. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 2/28/26, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of Resident #57's pneumococcal vaccination history disclosed the resident received the Prevnar 13 vaccine on 05/16/2022. No evidence could be located on the clinical record that Resident #57 was offered a PCV20 (Prevnar 20) or PCV21 (21-valent Pneumococcal Conjugate Vaccine) at least one year after the administration of the PCV13, while a resident at the facility. The Centers for Disease Control and Prevention (CDC) guideline titled, Recommended Adult Immunization Schedule for Ages 19 Years or Older dated 12/28/23 read in part that adults aged 65 years or older who have previously received a dose of PCV13, should receive one dose of PCV20 or PCV21 at least one year after administration of PCV13. On 3/5/26 at 9:31 AM, the director of nursing (DON) provided an Influenza, Pneumococcal, COVID-19 and RSV Vaccine Informed Consent and Declination consent form signed by Resident #57 and dated 2/27/26. A review of the consent form disclosed Resident #57 did not consent to have a pneumococcal vaccine. In further review of the consent form, a section which read in part, .I attest that I have been provided enough education for me to make an informed decision regarding the information for the.pneumococcal.vaccines and have had all my questions answered. was not marked and was left unchecked. This concern was discussed on 3/5/26 at 3:20 PM at the end of day meeting with the administrator, director of nursing, regional director of education, and divisional executive director. Requested and received a facility policy titled, Influenza and Pneumococcal Immunization for Residents Policy with an effective date of 4/21/25 which read in part, .Education will be provided for those that.decline the vaccination. No further information was provided prior to exit on 3/6/26.